Summer 2012

The Effectiveness of Anger Management Programs with Court Mandated Clients: A Provider Perspective

Mary A. Sanderfer
Old Dominion University

THE EFFECTIVENESS OF ANGER MANAGEMENT PROGRAMS

WITH COURT MANDATED CLIENTS: A PROVIDER PERSPECTIVE

by

Mary A. Sanderfer
B.A. May 2005, University of Louisville
M.A. December 2007, Regent University

A Dissertation Submitted to the Graduate Faculty of
Old Dominion University
in Partial Fulfillment of the
Requirements for the Degree of

DOCTOR OF PHILOSOPHY

COUNSELING

OLD DOMINION UNIVERSITY
August 2012

Approved by:

Theodore P. Remley, Jr. (Director)

Kaprea F. Johnson (Member)

Kathleen Levingston (Member)

ABSTRACT

THE EFFECTIVENESS OF ANGER MANAGEMENT PROGRAMS WITH COURT MANDATED CLIENTS: A PROVIDER PERSPECTIVE

Mary A. Sanderfer
Old Dominion University, 2012
Director: Dr. Theodore P. Remley, Jr.

Arrest for criminal offenses sometimes result in court systems mandating that offenders attend anger management treatment programs. Mandated anger management treatment places a demand on mental health professionals to provide these services. In order to prepare counselors to be effective in providing services, it is important for counselor educators to examine counselors' beliefs and attitudes about mandated anger management treatment. Using a survey method, this study asked counselors to rate the degree they perceived the anger management treatment they provide to be effective and to rate the degree they perceived they were prepared in their training programs to provide anger management treatment to court mandated clients. This study also explored if there was a relationship between provider attitude and perceived effectiveness of court mandated anger management treatment. Results indicated that providers perceived that anger management treatment has a high level of effectiveness and that they perceived they had a moderate level of training preparedness to provide anger management services. A small, positive correlation was found between provider attitude and perceived effectiveness of court mandated anger management.

ACKNOWLEDGEMENTS

To Dr. Theodore P. Remley, Jr.: Thank you for affirming me throughout my entire time at Old Dominion University. I appreciate you and I will always remember your kind words and acts of service.

To Drs. Kaprea Johnson and Kathleen Levingston: Thank you for the hope, the accountability, hours of service as members of my dissertation committee, the encouragement, and for your helpful feedback each step of the way.

To my family and friends: Thank you Mom for the example you set with God first and then yourself. I will always remember your legacy. Thank you family and friends for believing that I have the ability to accomplish anything. You were right!

TABLE OF CONTENTS

LIST OF TABLES

CHAPTER ONE

INTRODUCTION

Background

Particularly for issues of domestic violence and child abuse, the criminal justice system sometimes mandates individuals to attend anger management treatment, often to avoid allocating stiffer repercussions, such as incarceration. Consequently, a huge demand to treat individuals with anger management issues is placed on mental health professionals by the courts, yet counselors and social workers do not yet have research-based guidelines for recognizing, diagnosing, treating, or preventing future violence (Lench, 2004). In addition to a lack of guidelines, counselors' experiences with mandated clients are underrepresented in the literature, to include perceived efficacy, types of outcomes, and factors that promote optimal client experience. "Despite the profession's implicit faith in the benefits of unwanted treatment, there is little evidence that this approach to therapeutic jurisprudence helps, and there is some reason to believe that it may cause harm" (O'Hare, 1996, p.417). Contrarily, a number of studies and reviews have shown the effectiveness of coerced treatment, suggesting that internal motivation in obtaining treatment is not a construct of dominant importance in treatment outcome (Shearer, 2003).

Purpose

The purpose of this study was to ask counselors who provide court mandated anger management programs whether they believe that the anger management treatment they provide is effective, whether they believe they were prepared in their training programs to provide anger management treatment to mandated clients, and to explore if there is a relationship between provider attitude and perceived effectiveness of court mandated anger management. For purposes of this study, providers of anger management refer to professionals with a degree in a

mental health field who provide court mandated anger management treatment. The perceived effectiveness, preparation, and correlation of attitude and effectiveness was assessed using a survey instrument asking providers to rate the degree of effectiveness, preparation, and whether they agree with the concept of courts mandating anger management treatment. Survey items were developed using the existing literature. A draft instrument was reviewed by a panel of experts and the instrument was revised. The revised instrument was administered to a group of counselors who will not be included in the population studied. Feedback from the pilot study participants resulted in a final revision of the instrument before the actual data for this study was collected. The purpose of this study was to help counselors and counselor educators develop a methodical understanding of providing court mandated anger management program services to mandated clients.

Significance of Study

Perceived Effectiveness

Many researchers have explored the risks and benefits of court mandated counseling (Feder & Dugan, 2002; O'Hare, 1996; Shearer, 2003). Individuals who oppose its use question the therapeutic effectiveness of legally mandated treatment and argue that research supporting its use in many forms is lacking (Watson, Corrigan, & Angell, 2005). There are two points of discussion in the literature that need to be considered when exploring perceived effectiveness. One concern is that "court-ordered clients have been labeled by practitioners as resistant, hard to reach, hostile, and unmotivated" (O'Hare, 1996, p. 417). The second concern is that anger management is one of the few cognitive behavioral interventions with published studies showing no treatment benefit (Sharry & Owens, 2000; Watt & Howells, 1999), although there are many studies that have found the approach to be effective (Dwivedi & Gupta, 2002; Reilly &

Shopshire, 2000; Walker et al, 2010). Given the literature, it can be deemed important to explore what providers actually think about the mandated services they provide in relation to what the research studies have suggested about treatment benefit. Perceived effectiveness of intervention may have a direct impact upon why anger management treatment has been reported by some as having no treatment benefit.

Training Preparation

A variety of therapeutic skills are expected to be gained from counselor training programs, to include group competency skills. In most master's level programs, "counselors are expected to have a working knowledge of the concepts and skills associated with task, psychoeducation, counseling, and therapy groups" (Killacky & Killacky, 2004, p. 87). This working knowledge often has to be obtained in one class because most counselor education programs require only one group counseling course (Akos, Goodnough, & Milson, 2004). Anger management is a type of psychoeducational group, in which counselors are expected to utilize basic group competency skills to facilitate such a group.

The core components of anger management involve increasing self-awareness of anger, triggers, and related behavior; coping strategies; and relaxation training (Walker & Bright, 2009). A question in this study concerns whether counselor trainees are directly taught in their programs the specific core components of anger management or whether the skills they need are learned through hands-on experience. Moreover, there is a question of whether trainees are taught in their preparation programs how to deal with clients with anger issues. According to Hess, Know, and Hill (2006), "when faced with client anger, trainees may respond defensively, use avoidance behaviors, attempt to reduce the anger by focusing on content, resort to problem solving rather than addressing and exploring the client's anger, or respond to therapist-directed

anger with reciprocal anger" (p. 282). To begin to answer the previous two inquiries, exploring how providers rate their level of preparation to conduct court mandated anger management is of vital importance.

Attitude and Perceived Effectiveness

An important finding about psychotherapy is that the outcome variance across clients is large, in which a majority of variance is due to patient and relationship factors (Sandell et al., 2007). According to Wampold (2001), therapists account for 6% to 9% of the variance, or about half the share of the outcome variance that is in any way related to client treatment. It can be assumed that court mandate influences variance and outcome as well. For example, some private practice clinicians say that working with the courts is the best "business-boosting move" they could have made (American Psychotherapy Association, 2010). On the other hand, Watson et al. (2005) have said that legal coercion into treatment involves stripping a person of some rights and liberties, and therefore, may be viewed as punishment. As a part of the study, information will be collected that will assess if there is a relationship between provider attitude and the perceived effectiveness of anger management.

Research Questions

The following are the research questions that were addressed in this study:

1. To what degree do providers of anger management treatment perceive the programs they deliver to be effective with court mandated clients?
2. To what degree do providers of anger management treatment programs perceive they were prepared in their graduate programs to provide anger management treatment to court mandated clients?

3. Is there a relationship between provider attitude and perceived effectiveness of court ordered anger management?

Limitations and Delimitations

Limitations and delimitations to this research study concerned threats to internal and external validity. Internal threats to this study may include subject effects, history, selection, instrumentation, and differences of participants. Related to subject effects, the participants may respond differently because they are a part of the study. This could mean that participants may unconsciously change their responses to fit what they believe the study is about or to fit what they believe is the researcher's hypothesis. Concerning history, participants' experiences may have an influence on responses beyond variables that will be measured by the study. For example, recent experiences or type of experience (e.g., community agency, prison, institution, etc.) with mandated clients may have a greater influence on provider perceived efficacy of anger management preventing a more accurate overall view of the perceptions of providers of treatment effectiveness. As a of result of utilizing the contacts in the member directory of the National Anger Management Association and the American Association of Anger Management to seek participation in this study, a selection bias will exists due to the convenience of the contacts, as well as the completion of the survey being voluntary. Therefore, characteristics may exist that may be different between those that choose to complete the survey instrument and those who do not. In addition, there may be differences among those who choose to participate, which also may be a threat to internal validity.

Depending on participants' views of the study and their experience with mandated clients and anger management, responses may be skewed to more favorably or unfavorably rate the effectiveness of anger management treatment. Validity threats concerning instrumentation will

exist due to researcher bias. The instrument will be created specifically for this descriptive study, which may influence items that will be included. For instance, items may be included that do not accurately represent participants' perceived efficacy of anger management, their degree of training preparedness, or their attitude measures. Moreover, important items have the potential to be excluded despite a review of literature and consultation with experts.

A delimitation of the research is that the validity of the survey instrument will be increased through the use of an expert panel to review the initial instrument. From a review of the literature, I have determined that a survey instrument does not exist that captures the provider perspective concerning the effectiveness of court mandated anger management treatment. Another delimitation of the study will be the diversity of the population. The population will be members of the National Anger Management Association and the American Association of Anger Management, in which providers of various institutions and agencies will be given opportunity to participate in the research study. Obtaining the e-mail contacts from each association's member contact list will be a direct source of providers who work with mandated clients.

Assumptions of the Study

First, this study will assume that all participants will understand the survey instrument and rate items accurately and honestly with minimal influence of social desirability. Second, it will be assumed that most providers who provide court mandated services have a preference to work with the specified population or have sought court referrals for clients in their practice. Third, it will be assumed that there will be a relationship between provider attitude and perceived effectiveness of court mandated anger management.

Terms and Definitions

Anger management- Therapeutic treatment often involving an increase of self-awareness of anger, anger triggers, and anger related behavior; coping strategies; and relaxation training.

Client-An individual with a legal obligation to enter anger management treatment.

Coerced treatment- Treatment that will result in negative consequences for non-participation (Day, Tucker, & Howells, 2004).

Mandated treatment- Legal force to enter treatment, to include an implicit evaluative component that non-compliance will in some way be unpleasant or aversive.

Mental health professional- A licensed or non-licensed counselor, social worker, psychologist, therapist, or specialist who provides mental health treatment.

Offender- Any individual who has committed an illegal offense.

Provider- A mental health professional that provides court mandated anger management treatment.

CHAPTER TWO

REVIEW OF THE LITERATURE

Introduction

Existing literature regarding mandated treatment, anger management, and anger management groups are discussed in this chapter. Literature is reviewed regarding the origin of mandated treatment, the populations most often mandated, the risks and benefits of mandated treatment, and anger management as mandated treatment. Existing studies of mandated treatment and anger management are also discussed.

Court Mandated Counseling

Court mandated mental health treatment is apportioned for a variety of reasons to include a less punitive, more therapeutic and cost efficient approach to justice. Reasoning for mandating mental health treatment is attributed to issues such as substance abuse, domestic violence, child abuse, and other legal matters. According to various estimates, the criminal justice system is responsible for 40% to 50% of referrals to community-based treatment programs (Prendergast, Farabee, Cartier, & Henkin, 2002). Programs for these groups are coercive in nature in that there are negative consequences for non-participation in treatment. There are varying degrees of consequences across jurisdictions (Day, Tucker, & Howells, 2004). From a historical perspective, the 1980s experienced a rapid growth in pro-arrest policies for domestic violence (Feder & Dugan, 2002). With increased arrest rates, and pressure on the courts to find a way to deal with domestic violence offenders, the result was a rise in the use of court-mandated counseling (Feder & Dugan, 2002). In the 1980s, the high rate of attrition from counseling programs for domestic violence offenders was very high, which caused court-mandated counseling to be viewed as one method of ensuring greater compliance with treatment programs

(Feder & Dugan, 2002). However, it served other functions as well. Mandated treatment provided the courts with an alternative to incarceration, offered the promise of shortening court proceedings, and simultaneously added to the deterrent effects of arrest, critical during a time of overcrowded jails and court dockets (Feder & Dugan, 2002).

In addition to finding a way to deal with domestic violence offenders, the criminal justice system also had to find a way to deal with drug offenders. In 1966, the federal government passed the Narcotic Addict Rehabilitation act, which permitted all states to implement coerced treatment programs (Tiger, 2011). With the explosion of crack cocaine in the 1980s, the number of drug arrests dramatically increased and the criminal justice system had to seek more effective means of intervening with these offenders (Egbert, Wesley, Church, & Byrnes, 2006). The drug court system was designed to address an overwhelming surge of drug case processing and correctional overcrowding, as well as was an attempt to address the *root cause* of involvement in crime (Goldkamp, 2000). Moreover, overarching the practicality of counseling and drug courts addressing domestic violence and drug offences exists a theoretical and philosophical foundation of court mandated treatment.

The theoretical and philosophical foundation of court-ordered treatment is based on therapeutic jurisprudence (Shearer, 2003). A concept initially used in 1987, therapeutic jurisprudence is a process in which the legal system provides therapeutic measures for people involved in criminal behavior (Shearer, 2003). Drug courts used therapeutic jurisprudence to cope with the problems of drug-addicted offenders by establishing a therapeutic foundation (Shearer, 2003). With a therapeutic foundation, a drug court judge can offer a choice between incarceration or a treatment program. Drug courts have been one of the primary settings in which clients are ordered to attend counseling. The less punitive approach of drug court is a

paradigm shift to a treatment model that reflects the concept of restorative justice (Egbert, Wesley, Church, & Byrnes, 2006).

Different from criminal justice, restorative justice is not based on balancing harm caused by the offender with more harm (punishment) to the offender. Instead, it is aimed at repairing and healing all parties involved in an offense (Feder & Dugan, 2002). It is also not easily defined because it encompasses a variety of practices at different stages of the criminal process including diversion from court prosecution, actions taken in parallel with court decisions, and meetings between victims and offenders at any stage of the criminal process (Daly, 2002). Moreover, it is used not only in criminal matters, but also in a range of civil matters including family welfare and child protection and disputes in schools and workplace settings (Daly, 2002). One practice of restorative justice is that parties involved in an offense are mandated or coerced to receive or attend mental health treatment.

Many researchers have explored the risks and benefits of court mandated counseling. Individuals who oppose its use question the therapeutic effectiveness of legally mandated treatment and argue that research supporting its use in many forms is lacking (Watson et al., 2005). Shearer (2003) expressed that therapy used as punishment means to enter an *ethical minefield* that instigates serious threats to psychotherapy. In his research, Shearer (2003) examined the various ethical risks assumed in a coerced counseling relationship, exploring how coerced counseling is not supported by informed consent. Informed consent involves a sense of voluntariness to participate, freedom to terminate, acceptance of services, etc. Other researchers and professionals in and out of the field believe that legal coercion into treatment involves stripping a person of some rights and liberties, and therefore, may be viewed as punishment (Watson et al., 2005). Another argument against court mandated treatment is that oppressed

groups are disproportionally represented among court ordered clients, thereby demonstrating the social power imbalance of over-representation (O'Hare, 1996).

However, a number of studies and reviews have supported the effectiveness of mandated treatment, despite factors such as client resistance and motivation. A study by O'Hare (1996) showed that although over 10 times as many court ordered versus voluntary clients were classified as precontemplators, over one-quarter of court-ordered clients were either thinking about changing, actively engaged in doing something about the problem, or trying to maintain previous gains in dealing with a problem. This research may indicate that client growth and change have the potential to occur despite *force* to engage in counseling. Many mental health professionals believe that internal motivation is a fundamental prerequisite to developing counseling interventions that will facilitate client growth and change. However there are studies that demonstrate the benefits of coerced treatment with evidence that internal motivation for receiving treatment is not essential (Shearer, 2003). In conjunction with factors such as client resistance and motivation, quality of care has been studied in mandated treatment relationships. Perron (2007) examined whether the quality of care for persons who are legally coerced differs from persons who attend counseling voluntarily. Results showed differences in the subjective but not objective quality of care among legally coerced and voluntary persons. There have been a number of studies and reviews of research on coerced treatment in which evidence supports the fact that coerced clients do at least as well as voluntary clients or clients under minimum levels of legal pressure (Prendergast et al., 2002).

Mandated, Coerced, and Involuntary

The terms *mandated treatment, coercion*, and *involuntary treatment* are often used interchangeably (Prendergast et al., 2002), but given the context may have dissimilar meanings and procedures. In addition to the court system mandating or coercing persons to enter treatment, other entities such as employers, colleges and universities, and child welfare agencies mandate counseling as well. In a criminal justice context, the terms mandated and coerced both involve a state of involuntariness due to varying degrees of legal pressure. Mandated and coerced treatment implies legal force to enter treatment and includes an implicit threat that non-compliance will in some way be unpleasant or aversive. The strategy of coerced treatment is created to exert extrinsic pressure on persons, in order to create a fear of more aversive sanctions (Shearer, 2003). Justification for coerced treatment is that such treatment may diminish distress and suffering in the person, in others, and in society as a whole (Day, Tucker, & Howells, 2004). It seems that mandated, coerced, or involuntary treatment is likely to have positive effects in ensuring that persons attend treatment and stay in treatment, and that retention in treatment is likely to be associated with a range of treatment outcomes for the person and others.

Anger Management Treatment

The use of disciplinary counseling has increased significantly over the past 40 years (Kiracofe & Wells, 2007). Specifically for domestic violence and child abuse cases, courts initiate referral of individuals to anger management treatment (Lench, 2004). The most popular model for use with violent mentally disordered offenders has been anger management as well (Walker & Bright, 2009). Naeem, Clarke, and Kingdon's (2009) study stated the following:

> Anger management is used with a variety of populations including: drug abusers (Awalt et al. 1997; Reilly & Shropshire, 2000), emotionally disturbed adolescents (Davis &

> Boster, 1992; Kellner & Bry, 1999; Snyder et al., 1999), parenting groups (Fetsch et al., 1999), persons with learning disabilities (Kellner & Tutin, 1995; Gilmour, 1998), prison inmates (Holbrook, 1997), patients with mild essential hypertension (Larkin & Zayfert, 1996), post-traumatic stress disorder sufferers (Gerlock, 1994), and patients with brain injury (Uomoto & Brockway, 1992). (p. 21)

Considering the variety of populations ordered to undergo treatment by courts, it can be understood why counselors may want to know more about effective ways to treat individuals with anger management issues (Lench, 2004).

Anger management treatment can be guided by a variety of theoretical orientations. However in a survey of the literature on anger, it was found that the vast majority of anger treatment outcome studies had utilized a cognitive -behavioral approach (Beck & Fernandez, 1998). The cognitive-behavioral approach allows treatment to address the cognitive complexity of problematic behavior. Core components of anger management include increasing self-awareness of anger, triggers, and related behavior; coping strategies; and relaxation training (Walker & Bright, 2009). Research has shown that offenders lack self-awareness of distress in response to their own offending, or to the prospect of re-offending (Day et al., 2004). Likewise, individuals with difficulty controlling their anger often fail to acknowledge that they have a problem or that they have demonstrated wrongful behaviors. Cognitively based anger management programs are particularly prescribed for clients who lack awareness, despite substantial evidence that their actions are destructive to themselves and others (Roffman, 2004).

Anger Management Groups

Given the previously described theoretical structure of most anger management treatment programs, the structure usually takes place in a group format. The literature describes several

reasons why the group format is appropriate for anger management treatment. Research suggests that court-referred clients with a complex set of problems may benefit from case coordination combining group, individual, and family counseling; coordinated application of various types of counseling; and education (Coll, Stewart, Morse, & Moe, 2010). In addition to being cost-effective, it has been argued that group treatment may offer psychotherapeutic advantages such as a sense of feeling understood and similar to others (Walker et al., 2010). "Members can also act as 'naturally occurring communities of enforcers' outside the group, therefore increasing the possibility of generalization of newly acquired skills" (Dwivedi & Gupta, 2000).

Although group therapy is a practical therapeutic approach only for certain clients with some being too assaultive or unstable (Lanza, 2007), studies have shown that group anger management works with specific types of clients. One study (Reilly & Shopshire, 2000) suggested that anger management group treatment may help cocaine-dependent individuals with anger control problems manage their anger. In this study, participants increased their ability to control their anger and were able to decrease their levels of anger, sustaining gains three months post treatment. In another study involving traumatic brain injury clients (Walker et al., 2010), attending group anger management was associated with decreases in angry feelings and frequency of angry expressions. More than not, the literature suggests that the effect of attending anger management group is client improvement on some level with a variety of identified issues.

In summary, individuals are mandated to attend anger management programs for a variety of problem issues. Although mandated treatment was designed as a less punitive approach to justice, there are people who support and discourage its use. Those who oppose its use question the effectiveness, and those who support its use validate the effectiveness with various populations.

CHAPTER THREE

METHODOLOGY

This chapter explains the methodology that was used in this study. The chapter is organized in the following order: purpose of the study, description of the research design, research questions, participant selection, instrumentation, data collection procedures, methods of data analysis, delimitations, limitations, and summary of methodology.

Purpose Statement

There were three primary purposes for this quantitative research study. The first purpose was to survey counselors on the efficacy of court mandated anger management they provide. The second purpose was to explore the degree to which providers of anger management perceive they were prepared in their training programs to provide anger management treatment to mandated clients. The third and final purpose was to explore provider attitude about court mandated anger management. It was intended that the results of this study would help shape the structure of court mandated anger management programs to increase their effectiveness. In addition, it was hoped that the results of this study would provide information for training programs or counselor education programs to assist counselor trainees in acquiring skills to effectively work with mandated clients. Because "court-ordered clients have been labeled by practitioners as resistant, hard to reach, hostile, and unmotivated" (O'Hare, 1996, p. 417), counselors need to be adequately prepared to provide services to this special population.

Research Design

The purpose of this study was to explore the degree to which providers believe court mandated anger management is effective, to explore the degree of preparation of providers, and to explore provider attitudes regarding court mandated clients and treatment. The design of this

study was a descriptive, non-experimental survey research project. Descriptive research designs aim to help "define the existence and delineate characteristics of a particular phenomenon" (Heppner, Wampold, & Kivlingham, 2008), which in this study was used to describe the degree of effectiveness and preparedness of court mandated anger management. Specifically, research questions one and two used this approach. The aim of survey research is to document the nature or frequency of a particular variable within a certain population, identifying facts, opinions, attitudes, behaviors, and relationships among these aspects (Heppner et al., 2008).

A correlational research design, which examines the relationship between two or more variables, was used to determine if and to what extent provider attitude correlates to the perceived effectiveness of court mandated anger management. A Pearson product moment correlation was used to describe the relationship between provider attitude and perceived effectiveness, which provided an index of the degree of linear relationships between the variables. The purpose of using these approaches in this study was to document and explore the nature of court mandated anger management from the provider perspective, with intent of identifying specific opinions, attitudes, and behaviors.

Research Questions

The following are the research questions that were addressed in this study:

1. To what degree do providers of anger management treatment perceive the programs they deliver to be effective with court mandated clients?
2. To what degree do providers of anger management treatment programs perceive they were prepared in their graduate programs to provide anger management treatment to court mandated clients?

3. Is there a relationship between provider attitude and perceived effectiveness of court ordered anger management?

Participants

The population for this study was mental health professionals who had provided anger management treatment with court mandated clients. Participants included licensed professional counselors (LPCs), licensed clinical social workers (LCSWs), licensed psychologists (LP), and non-licensed professionals. Using an "a priori" power analysis with a medium effect size (.3) and an alpha of .05, the sample size needed was 111 participants. Using a convenience sampling approach, participants were recruited through e-mail messages sent to members of the National Anger Management Association, members of the American Association of Anger Management, members of therapy directories, anger management providing agencies across the U.S, and university forensic and counseling programs across the U.S. To obtain e-mail addresses of members of the associations and directories, I went to the websites under the member directory tab to obtain a contact list. E-mail messages invited participants to partake in the study and forward the link to others.

Instrumentation

A thorough review of the literature revealed no instruments that evaluated provider perceived efficacy of anger management treatment or the degree of preparation in their training programs. Two instruments that were related were used in a study by Carlson (2010) exploring preference about how best to treat patient anger and in a study by Viaro (2010) exploring social workers' attitude toward court mandated substance abuse clients. The instrumentation used in the Carlson (2010) study involved clinical vignettes used to stimulate therapists' anxiety about negative treatment outcomes and assessing therapists' personality characteristics using survey

instrumentation. The Viaro (2010) study involved vignettes depicting client scenarios and semantic differential scales on which to rate the client. Both the previous studies utilized vignettes to stimulate or explore specific phenomena. However this study did not use vignettes. Instead participants used Likert scales to rate current thoughts, feelings, and opinions. This study intended to define the essence and delineate the characteristics of court mandated anger management, provider training, and attitudes toward court mandated treatment. A 42 item instrument that addresses the specific purposes of this study was created.

The survey instrument created for this study contained five sections. The first section used a Likert scale to collect information rating the degree in which providers believe their anger management programs are effective. The second section used a Likert scale and collected information about the degree to which providers believe they were prepared in their training program to counsel mandated clients. The third section also utilized a Likert scale and collected information assessing if there was a relationship between provider attitude and perceived effectiveness of court ordered anger management. A 5-point Likert scale was used for sections one, two, and three because Likert scales typically yield reliable scores and have flexibility in their ability to measure many types of affective characteristics (Algozzine, n.d.). Only 5-points were utilized on this Likert scale because increasing the number of points is not beneficial given that most respondents are unable to make finer distinctions and having a mid-point allows respondents to select a neutral option (Algozzine, n.d.). The fourth section collected demographic information about the participants and information about their professional background. The fifth section contained an open-ended question that asked participants to provide any thoughts they have regarding providing anger management services to mandated clients. The data from this section will be used in a follow-up study.

Rating of Perceived Effectiveness of Anger Management (PEAM)

This section was created based on a review of the literature, the Jongsma & Peterson's Adult Psychotherapy Treatment Planner, and feedback from an expert panel to identify prototypical dimensions or indicators and content analysis. It contained thirteen items, in which participants were asked to rate each item using a 5-point Likert scale (0= neither agree nor disagree, 1= strongly disagree, 2= disagree, 3= agree, 4= strongly agree). A sample item from the PEAM scale asked participants to rate the degree to which the anger management program they deliver is effective in increasing acceptance of angry feelings. Higher scores indicated a higher level of perceived effectiveness of court mandated anger management treatment. This section was scored by calculating the mean and standard deviation. The mean was used to establish cut off points ranging from either a high level of perceived effectiveness or a low level of perceived effectiveness. For example, a high mean suggests that counselors perceive court mandated anger management treatment to be effective and a low mean suggests that they perceive it not to be effective.

Rating of Training Program Preparedness (TPP)

This section was created based on a review of the literature, personal experiences in graduate school programs, and feedback from an expert panel to identify prototypical dimensions or indicators and content analysis. It contained eight items, in which participants were asked to rate each item using a 5-point Likert scale (0= neither agree nor disagree, 1= strongly disagree, 2= disagree, 3= agree, 4= strongly agree). A sample item from the TPP scale asked participants to rate the degree that their degree program prepared them counsel mandated clients. Higher scores indicated a higher level of preparedness in their degree programs. This section was scored by calculating the mean and standard deviation. The mean was used to establish cut off points

ranging from either a high level of training preparedness or a low level of training preparedness. For example, high means indicate high to moderate preparation in their degree programs, and low means indicate minimal to no preparation in their degree programs.

Attitude and Perceived Effectiveness (APE)

In addition to rating the perceived effectiveness of court mandated anger management and degree of preparedness, the survey presented opinion based questions to reflect providers' attitudes about mandated clients and treatment in general. A sample item from the APE scale asked participants to rate if they felt comfortable counseling and training mandated clients based on their current thoughts, feelings, and beliefs about anger management treatment and court mandated clients. The items in this section were created based on a review of the literature and feedback from an expert panel of reviewers. This section contained eight items, in which participants were asked to rate each item using a 5-point Likert scale (0= neither agree nor disagree, 1= strongly disagree, 2= disagree, 3= agree, 4= strongly agree). This section was analyzed by conducting a statistical analysis of a Pearson product moment correlation to describe the relationship between provider attitude and perceived effectiveness. This was an opinion based section; therefore percentages, the mean, and standard deviation were obtained for descriptive purposes.

Demographic and Clinical Experience Information

In this section participants were asked to provide information about themselves and their clinical experience. Demographic questions included the provider's sex, age, race/ethnicity, type of degree held, and the highest educational degree obtained. Questions about clinical experience included number of years of clinical experience, number of years working with mandated clients,

credentials, and area of clinical expertise. Two demographic questions about anger management included the length of programs and the service delivery type.

Item Generation and Content Validation

For developing an instrument to rate the degree of perceived effectiveness of anger management with court mandated offenders, peer-reviewed literature (Naeem, Clarke, & Kingdon, 2009) was used to uncover the effects of anger management treatment on a variety of treatment issues. Based on findings and on discussions with committee members, an initial list of items was created.

For establishing validity, the initial list of items was sent to an expert panel of five mental health professionals (two Caucasian females and three Caucasian males) with experience in the topic area of interest. The individuals chosen for the panel were considered experts as a result of having at least 20 years of clinical mental health experience, with most members having over 15 years experience with mandated clients. These experts were asked to rate the level of relevance of the items to the research questions. Experts were asked to indicate the relevance on a Likert scale with two extremes and five choices along the continuum. Additionally, experts were asked to provide any additional items that they believe should be included in the instrument, and identify items that should be clarified or removed.

The feedback received from the expert panel members pertained to the revision of the instrument items. Only one panel member actually indicated on the Likert scales the relevance of the items to the research questions. Also only one panel member suggested items to be added, which pertained to gathering demographic information about the length of anger management programs and the service delivery type. Two panel members suggested making all the items either statements or questions, while one panel member suggested that the items be statements

based off of evidenced based treatment goals, interventions, and outcomes of anger management from the most widely used mental health treatment planner. Two panel members also suggested making the scales the same, using the Likert scale of Strongly Agree to Strongly Disagree. All of the panel members suggested at least one item be simplified or written more clearly. Feedback from the expert panel was taken into consideration in solidifying the final version of the instrument.

Following the expert review, a pilot study was conducted with 6 participants. The pilot study provided opportunity to get feedback on the instrument from individuals who took it and was used to gauge how long it would take individuals to complete the instrument. Moreover, participants not only responded to the items as if they were a participant, but also were asked to identify unclear or ambiguous elements about the items. For example, pilot participants were asked to identify in writing what parts were confusing or ambiguous or write alternative wording to enhance clarity of the items.

To establish construct validity, principle component analysis (PCA) was conducted on the PEAM scale. According to Bandalos and Finney (2010), component or factor analysis should be conducted in circumstances where little empirical evidence exists to support the newly developed instrument. Given that an instrument was developed specifically for this study, PCA was used to explore the factors related to the efficacy of anger management treatment. Moreover, to further establish the psychometric properties of the instrument the Cronbach's alpha was acquired to provide information about the degree of homogeneity or internal consistency among sets of items.

Procedures

All procedures and instrumentation were reviewed and approved by the Institutional Review Board (IRB) at Old Dominion University. An exemption for the research was requested based on using survey procedures that protect the anonymity and confidentiality of participants. After approval of the study from the dissertation committee, email messages were sent to providers. The email requested the recipient (the provider) to participate in the research along with a hyperlink to the survey instrument hosted on Surveygizmo (http://www.surveygizmo.com). Surveygizmo did not reveal any information about the participants other than the information collected through the instrument.

When participants clicked on the website link, they were directed to the landing page of the survey instrument. This page presented more detailed information about the study, along with an informed consent statement. Participants were informed that by choosing to continue, that would indicate their consent to participate in the study. Following clicking to continue, participants were guided through completing the instrument. The instrument provided ongoing information to participants about the percentage of content remaining. At the end of the survey was a message thanking participants for completing the survey, information on how they could contact the researcher or the committee chair to discuss questions or concerns, and information on how to obtain access to the results of the study. As a feature of Surveygizmo, participants were able to complete the survey only once based on the unique link sent by email to individuals in the population.

Data Analysis

As part of univariate data screening, SPSS Version 20 was used to report frequencies for all variables. Data that was obviously erroneous was recoded as missing. Additional missing data

was analyzed against demographic data to look for patterns of missing data that may have distorted findings. Additionally, data was screened for outliers. Outliers were omitted from the analysis using the listwise default if they represented less than 5% of the data. Following data screening, a component analysis was used on the PEAM scale to determine core factors present in the instrument. Next, data analysis was conducted using descriptive statistics to report on degree of effectiveness, degree of preparation, correlation between attitude and effectiveness, and the variance due to factors of age, sex, years of experience, etc.

Delimitations

A delimitation of the research is that validity was increased through the use of an expert panel to review the initial instrument. From a review of the literature up to this point, a survey instrument does not exist that captures the provider perspective concerning the effectiveness of court mandated anger management treatment. Another delimitation of the study is the diversity of the population. The majority of the population were the members of the National Anger Management Association and the members of the American Association of Anger Management, in which professionals of various institutions and agencies were given opportunity to participate in the research study. Moreover, obtaining e-mails from the member listing of these associations was a direct source of finding providers who work with mandated clients.

Limitations

Limitations to this research study concerned threats to internal and external validity. Internal validity is the degree to which observed differences of dependent variables can be attributed to the independent variables and not to some other variable. External validity is concerned with generalizability of the findings to other people, settings, treatment variables, and

measurement variables (Campbell & Stanley, 1963). The validity of this survey instrument will not be firmly established.

Internal threats to this study may have included subject effects, history, selection, instrumentation, and differences of participants. Related to subject effects, the participants may have responded differently because they were a part of the study, in which demand characteristics may have taken effect. Concerning history, participants' experiences may have had an influence on responses beyond variables that were measured by the study. For example, recent experiences or type of experience (e.gl, community agency, prison, institution, etc.) with mandated clients may have had a greater influence on provider perceived efficacy of anger management preventing a more accurate overall view of treatment effectiveness. As a of result of utilizing the member listings of the National Anger Management Association and the American Association of Anger Management to seek participation in the study, a selection bias may exists due to the convenience of the contacts, as well as the completion of the survey being voluntary. Therefore, characteristics may exist that may be different between those that chose to complete the survey instrument and those who did not. In addition, there may have been differences within those who chose to participate, which also may have been a threat to internal validity. Depending on participants' view of the study and their experience with mandated clients or anger management, responses may have been skewed to more favorably or unfavorably rate the effectiveness of anger management treatment. Validity threats concerning instrumentation may exist due to researcher bias. The instrument was created specifically for this descriptive study, which may have influence items that were included. For instance, items may have been included that did not accurately represent assessing the perceived efficacy of anger management, their

degree of training preparedness, or attitude measures. Moreover, important items had the potential to be excluded despite a review of literature and consultation with experts.

Internal validity threats also represent potential threats to external validity, the generalizability of a study (Creswell, 2009). Other threats to the external validity may have been population validity, which addresses whether the results of the study are generalizable to the population at large. Although call for participation was sent out through e-mail to the members of the National Anger Management Association, members of the American Association of Anger Management, and other provider sources, the responding participants may have had specific training and cortication in anger management intervention. Thus, the findings of the study may be less generalizable to providers who do not belong to anger management associations, therapist directories, or university programs.

Summary of Methodology

This chapter has explained the methods that were used in this quantitative study of the perceived efficacy of anger management treatment on court mandated clients. The next chapter will present the results obtained with these methods.

CHAPTER FOUR

RESULTS

The purpose of this study was to explore the degree to which providers believe court mandated anger management is effective, to explore the degree of preparation of providers, and to explore provider attitudes regarding court mandated clients and treatment. This chapter provides the results of this study. This chapter is organized in the following order: preliminary data screening and provision of variables, descriptive data for participants, evaluation of instrument, and analysis of results as they relate to the research questions.

Preliminary Data Screening and Provision of Variables

Prior to analysis related to research questions, univariate data screening was performed for all variables to look for missing or invalid data using SPSS Frequencies and Reliability Analysis of the scales. For individual variables, missing data was coded and was included in the descriptive statistics of participant responses. The survey allowed for participants to skip questions at their will and still proceed to the end of the survey.

A total of 112 respondents completed the Perceived Effectiveness of Anger Management (PEAM) Scale, with responses ranging from strongly disagree (1) to strongly agree (4), with a mean of 3.17 and a standard deviation of .56. The skewness and kurtosis were also assessed. The skewness provides an indication of the symmetry of the distribution, and the kurtosis provides information about the 'peakedness' of the distribution (Pallant, 2010). The skewness value was -.81 and the kurtosis value was 1.11, which indicates a clustering of scores at the high end, peaked, with long tails. Based on these numbers, the data was determined to be normal. In addition, to further assess the normality of the distribution of scores, inspection of the scale's histogram showed that the distribution of scores appeared normal in a bell shaped curve.

A total of 112 respondents completed the Training Program Preparedness (TPP) scale, with responses ranging from neither agree nor disagree (0) to strongly agree (4), with a mean of 2.63 and a standard deviation of .99. The skewness value was -.42 and the kurtosis was -.46. This indicates a clustering of scores at the high end, with a relatively flat distribution. Based on these numbers, the data was determined to be normal. To further assess the normality of the distribution of scores, inspection of the scale's histogram showed that the distribution of scores appeared normal in a bell shaped curve.

A total of 112 respondents completed the Attitude and Perceived Effectiveness (APE) scale, with responses ranging from strongly disagree (1) to strongly agree (4), with a mean of 2.57 and a standard deviation of .53. The skewness value was -.08 and the kurtosis was -.67, indicating a clustering of scores at the high end, with a relatively flat distribution. Based on these numbers, the data was determined to be normal. To further assess the normality of the distribution of scores, inspection of the scale's histogram showed that the distribution of scores appeared normal in a bell shaped curve. Table 1 displays a summary of statistics for the scales of interest.

Table 1

Summary of Statistics for Scales of Interest

Scale	# of Items	N	Mean	*SD*	Min	Max
PEAM	13	112	3.17	.56	1	4
TPP	8	112	2.63	.99	0	4
APE	8	112	2.58	.53	1.38	3.63

Descriptive Data for Participants

A total of 821 survey instruments were distributed to members of the National Anger Management Association, American Association of Anger Management, members of therapy networks, anger management providing agencies across the U.S, and university forensic and counseling programs across the U.S. Participants were asked to take the survey and forward the survey link to others as well. Ninety email messages were returned undeliverable reducing the list of participants to 731. Of these, 112 participants completed the instrument, representing a completion rate of 15%.

Participants were asked a total of 12 demographic questions as additional data for the study and for potential future research. The first three questions pertained to personal demographics, which included sex, race/ethnicity, and general age. There were slightly more female responses (61) than male responses (50), which is representative of the mental health field. There were also more Caucasian (67) respondents than all the other racial groups combined

(44). The majority of respondents were 35 years of age and older. Frequency data for participants' responses are presented in Table 2.

Table 2

Summary of Participant Personal Demographics

Demographic	Frequency	Percentage
Sex		
Male	50	44.6%
Female	61	54.5%
No Response/Missing	1	.9%
Race/Ethnicity		
Asian/Pacific Islander	1	.9%
Blk/African American	32	28.6%
Caucasian	67	59.8%
Hispanic	9	8.0%
Other/Multiracial	2	1.8%
No Response/Missing	1	.9%
Age		
25-34	19	17.0%
35-54	49	43.8%
55+	42	37.5%
No Response/Missing	2	1.8%

Note. N=112; Blk=Black.

Participants were asked to provide a response to demographic questions about their highest level of education and their credentials. A majority of the respondents reported their highest level of education as a master's degree (51.8%), and 19.6% of the respondents reported having a doctorate. Respondents who reported having a specialist's degree (8.9%) were those who have specific post bachelor's training (e.g. anger management, behavior, etc.).

Respondents indicated their credentials, with the option to list more than one credential. Responses included 30 Anger Management Specialists (NAMA), 24 licensed professional counselors (LPC), 15 social workers (LCSW/MSW/LSW), 7 licensed psychologists (LP), 4 licensed mental health counselors (LMHC), 2 licensed marriage and family therapists (LMFT), and 3 nationally certified counselors (NCC). A total of 11 respondents did not indicate their credentials. Descriptive data for participants' responses are presented in Table 3.

Table 3

Summary of Participant Educational Demographics

Demographic	Frequency	Percentage
Highest Degree Held		
High School	1	.9%
Some College	4	3.6%
Associates	4	3.6%
Bachelors	13	11.6%
Masters	58	51.8%
Doctorate	22	19.6%
Specialists	10	8.9%
Credentials		
NAMA	30	26.8%
LPC	24	21.4%
LCSW	15	13.4%
LP	7	6.3%
LMHC	4	3.6%
LMFT	2	1.8%
LCSAC	1	.9%
Missing/No Response	11	9.8%

Note. Participants could indicate multiple credentials, therefore percentages do not total 100%.

Participants were asked to identify their years of clinical experience and their areas of clinical expertise. The same percentage of participants responded that they had either10-15 years of experience (21.4%) and 25-30+ years of experience (21.4%), totaling the majority of respondents combined. In relation to areas of clinical expertise, respondents could list more than one area of clinical expertise. A total of 34.8% of the responses indicated anger management as an area of expertise. The remaining responses identified some other area of clinical expertise to include areas such as substance abuse, domestic violence, depression, anxiety, children and adolescents, women, crisis intervention, trauma, family, relationships, etc. Descriptive data for participants' responses are presented in Table 4.

Table 4

Summary of Participant Clinical Demographics

Demographic	Frequency	Percent
Years of Clinical Experience		
0-5	18	16.1%
5-10	26	23.2%
10-15	24	21.4%
15-20	12	10.7%
20-25	8	7.1%
25-30+	24	21.4%
Areas of Clinical Expertise		
Anger Management	39	34.8%
Depression/Anxiety	24	21.4%
Substance Abuse	20	17.9%
Family	20	17.9%
Disorders	16	14.3%
Relationships	13	11.6%
Individuals	12	10.7%
Violence/Assault	6	5.4%
Trauma/Crisis	6	5.4%
No Response/Missing	22	19.6%

Note. Participants could indicate multiple areas, therefore percentages do not total 100%.

Participants were asked to indicate the length of time (days, weeks, months) of the anger management program they were currently facilitating and the service delivery type. Days of anger management programming ranged from once a week to every day. Weeks of treatment ranged from 1 week to 9 or more weeks. Months of treatment ranged from 0 months to 4 or more months. For respondents who currently provide anger management treatment, most indicated that they provide treatment several days a week, for nine or more weeks, and for up to three months. In addition, 58% of respondents indicated they provide both individual and group anger management treatment. Descriptive data for participant' responses are provided in Table 5.

Table 5

Length and Service Type

	Frequency	Percent
Length of Program		
Several Days	16	14.3%
9 or More Weeks	36	32.1%
0-3 Months	17	15.2%
Service Type		
Individual	24	21.4%
Group	21	18.8%
Both	65	58.0%

Participants were asked if they use a manualized anger management treatment program and if more than 50% of the anger management treatment they provide was court mandated. More than 50% of the participants reported that they use a manualized anger management

treatment program. Conversely, about half of the respondents reported that most of the anger management treatment they provide is court mandated and about half indicated their treatment is not court mandated. Descriptive data for participants' responses are presented in Table 6.

Table 6

Anger Management Treatment

Treatment	Frequency	Percent
Manualized		
Yes	60	53.6%
No	51	45.5%
No Response/Missing	1	.9%
Court Mandated		
More than 50%	55	49.1%
Less than 50%	57	50.9%

Note. N=112.

Evaluation of Instrument

The PEAM scale was used to assess respondents' perceived effectiveness of court mandated anger management programs. The scale included 13 items constructed from a review of the literature, Jongsma and Peterson's (2006) The Complete Adult Psychotherapy Treatment Planner, and feedback from an expert panel. A total of 112 participants completed this section of the survey. After assessing the normality, to include the skewness (-.81) and kurtosis (1.11), the data appeared to be normal and well distributed with less than 1% missing data. In this study the Cronbach alpha coefficient was .83, indicating good internal consistency. The alpha was

interpreted to mean this is a very reliable scale. The mean (3.17) revealed the overall rating of perceived effectiveness. PEAM scale descriptives are provided in Table 7.

Table 7

PEAM Scale Descriptives

Descriptive	Statistic	Standard Error
α	.83	
Mean	3.17	.05
Variance	.31	
SD	.56	
Range	3.00	
Skewness	-.81	.23
Kurtosis	1.11	.45

The 13 items of the PEAM scale were subjected to principal component analysis (PCA) using SPSS version 20. Prior to performing PCA, the suitability of data for factor analysis was assessed. Inspection of the correlation matrix revealed the presence of many coefficients of .3 and above. The Kaiser-Mayer-Olkin (KMO) value was .75, exceeding the recommended value of .6 (Kaiser, 1974) and Bartlett's Test of Sphericity (Bartlett, 1954) reached statistical significance, supporting the factorability of the correlation matrix.

Principal components analysis revealed the presence of two components with eigenvalues exceeding 1, explaining 36.50% and 11.95% of the variance respectively. An inspection of the screeplot revealed a clear break after the second component. Using Catell's (1966) scree test, it was decided to retain the two components for further investigation. This was further supported

by the results of Parallel Analysis, which showed only two components with eigenvalues exceeding the corresponding criterion values for a randomly generated data matrix of the same size. Table 8 displays the eigenvalues of the PEAM scale.

Table 8

Eigenvalues

Factor	Total	% of Variance
1	4.79	36.84
2	1.57	12.09
3	.99	7.77
4	.99	7.59
5	.92	7.05
6	.76	5.82
7	.70	5.41
8	.55	4.26
9	.51	3.89
10	.40	3.06
11	.36	2.78
12	.28	2.17
13	.17	1.28

Note. Extraction Method: Maximum Likelihood.

The two-component solution explained a total of 48.45% of the variance, with Component 1 contributing 36.50% and Component 2 contributing 11.95%. Component 1 was determined to be the primary component and was referred to as the perceived efficacy of anger

management. Items within this component related to perceptions such as anger decreasing in frequency, developing an awareness of current angry behaviors, etc. Component 2 was an unidentified and unused element of the scale. To aid in the interpretation of these two components, Varimax rotation was performed. This did not change the underlying solution, but rather presented a pattern of loadings to make interpretation easier. The rotated solution revealed the presence of simple structure (Thurstone 1947), with both components showing a number of strong loadings and all variables loading substantially on only one component. This means that component 1 and 2 possessed items that fit together, however component 1 had the strongest number of items. The results of this analysis support the use of the 13 items in the PEAM scale measuring the perceived effectiveness of anger management (Component 1). Table 9 displays the PEAM pattern and structure matrix for the Varimax rotation.

Table 9

Pattern/Structure Coefficients of Two Factor Solution of PEAM Items

Item	Unrotated Loadings		Rotated Loadings		Communalities
	Component 1	Component 2	Component 1	Component 2	
6. Increases self-awareness of angry feelings while helping develop better self-control	**.74**	-.33	**.78**	.21	.66
5. Assists clients with identifying ways anger has negatively impacted his or her daily life	**.66**	-.07	**.40**	**.32**	.44
13. Teaches clients calming techniques (e.g. muscle relaxation, paced breathing, calming imagery) as a way of appropriately responding to angry feelings when they occur	**.64**	-.44	**.77**	.05	.60
7. Increases acceptance of angry feelings	**.63**	.10	**.43**	**.47**	.41
12. Teaches conflict resolution skills to manage interpersonal problems	**.63**	.02	**.48**	**.40**	
1. Assists clients in conceptualizing anger as involving different components (cognitive, physical, affective, and behavioral)	**.60**	-.26	**.63**	.17	.43
4. Explores client self-talk that mediates angry feelings and	**.60**	-.41	**.72**	.05	.52

actions					
11. Expands clients' awareness of the negative effects that anger has on his or her health	**.59**	**.42**	.20	**.70**	
2. Decreases overall intensity of angry feelings	**.58**	**.54**	.12	**.79**	.64
9. Increases respect for others and their feelings	**.58**	.20	**.33**	**.52**	.38
8. Develops an awareness of current angry behaviors	**.55**	-.24	**.58**	.16	.36
10. Assists clients in identifying the positive consequences of managing anger	**.51**	.00	**.40**	**.32**	.26
3. Decreases overall frequency of angry feelings	**.51**	**.66**	-.02	**.83**	.69

Note. Major loadings for each item are bolded.

The TPP scale was used to explore the degree to which providers of anger management perceive they were prepared in their training programs to provide anger management treatment to mandated clients. The scale included eight items constructed from a review of the literature, personal experiences in graduate school programs, and feedback from an expert panel to identify prototypical dimensions or indicators and content analysis. A total of 112 respondents completed this section of the survey. After assessing the normality, to include the skewness (-.42) and kurtosis (-.46), the data appeared normal and well disturbed with less than 1% missing data. In this study the Cronbach alpha coefficient was .90, indicating good internal consistency. The alpha was interpreted to mean that the scale is a very reliable scale. The mean (2.63) revealed the overall rating of training program preparedness. TPP scale descriptives are provided in Table 10.

Table 10

TPP Scale Descriptives

Descriptive	Statistic	Standard Error
α	.90	
Mean	2.63	.09
Variance	.99	
SD	.99	
Range	4.00	
Skewness	-.42	.23
Kurtosis	-.46	.45

The APE scale was used to assess a relationship between provider attitude and perceived effectiveness of court mandated anger management. This scale included eight items from a review of the literature and feedback from an expert panel to identify prototypical dimensions or indicators and content analysis. A total of 112 respondents completed this section of the survey. After assessing the normality, to include the skewness (-.08) and kurtosis (-.67), the data appeared normal and well disturbed with less than 1% missing data. In this study the Cronbach alpha coefficient was .25, indicating weak internal consistency. The alpha was interpreted to mean that this is an unreliable scale. The mean (2.58) indicated the overall rating of provider attitude. APE scale descriptives are provided in Table 11.

Table 11

APE Scale Descriptives

Descriptive	Statistic	Standard Error
α	.25	
Mean	2.58	.05
Variance	.28	
SD	.53	
Range	2.25	
Skewness	-.08	.228
Kurtosis	-.67	.45

Research Question 1

The first research question sought to answer: To what degree do providers of anger management treatment perceive the programs they deliver to be effective with court mandated clients? This question was investigated through descriptive statistics of the overall ratings. A total of 112 respondents provided ratings of 13 items measuring perceived efficacy of anger management, on a 5- point Likert scale (0= neither agree nor disagree, 1= strongly disagree, 2= disagree, 3= agree, 4= strongly agree), making a total of 1,456 possible responses. With responses ranging from 1 to 4, a total mean of 3.17 and standard deviation of .56 was calculated. These results indicate a high level of perceived effectiveness, in which respondents on average agreed that anger management is effective. The mean of 3.17 was interpreted to mean "agree," showing that respondents selected 4 "strongly agree" or 3 "agree" on most of the items in the PEAM scale. The actual frequency of how many times "strongly agree" and "agree" were

selected totaled to 1,315, which equaled 90.2% of the responses. The standard deviation of .56 was interpreted to mean that there was an average .56 deviation in response from the mean, indicating that some respondents disagreed or strongly agreed with a few of the items. Table 12 shows frequency of overall rating of the perceived effectiveness of anger management.

Table 12

Frequency of Overall Ratings of PEAM scale

Likert Range	Frequency	Percent
Strongly Agree	623	42.8%
Agree	692	47.5%
Disagree	17	1.2%
Strongly Disagree	14	1.0%
Neither Agree Nor Disagree	99	6.8%
Missing	11	.8%
Total	1,456	100%

Note. N=112

Additional analysis of factors such as sex, age, and years providing court mandated anger management indicated a high level of perceived effectiveness on the PEAM scale. Similar means were found for male (N= 50, M=3.18, SD=.64) and female (N= 61, M=3.17, SD=.49) participants. The means indicated that most male and female respondents perceived anger management to be effective with court mandated clients. Of all the factors, the means for male and female participants were most identical to the overall mean of the PEAM scale.

Most respondents were between the ages of 35 and 54 (N=49, M=3.27, SD=.54). The mean for this age range indicated a high level of perceived effectiveness of anger management

programs. The mean for participants between the ages of 25-34 (N= 19, M=2.98, SD=.58), indicated perceived effectiveness, but not as highly rated as the overall mean. The mean for participants 55 and older (N=42, M=3.12, SD=.58) indicated a high level of perceived effectiveness. The means of each of the age categories were interpreted to mean "agree" using the Likert scale rating for PEAM, meaning that anger management is perceived to be effective with court mandated clients.

The number of years that most respondents have provided court mandated anger management programs was zero to five years (N=53, M=3.1, SD=.55), indicating agreeableness to the effectiveness of anger management. Means and standard deviations were calculated for factors of sex, age, and number of years providing court mandated treatment (see Table 13). A breakdown of factors confirms the interpretation of the overall mean of the PEAM scale.

Table 13

Crosstab Demographics of the PEAM Scale

Crosstab	*n*	*Min*	*Max*	*Mean*	*SD*
Sex					
Male	50	1	3	3.18	.64
Female	61	2	4	3.17	.49
Age					
25-34	19	2	4	2.98	.58
35-54	49	2	4	3.27	.54
55+	42	1	4	3.12	.58
Provider Years					
0-5	53	2	4	3.12	.55
5-10	35	2	4	3.17	.55
10-15	10	3	4	3.54	.33
15-20	9	3	4	3.31	.42
20-25	4	3	4	3.17	.45

Note. Provider years refer to the number of years having provided court mandated services.

The means and standard deviations were calculated for each of the 13 items in the PEAM scale. The three highest means were item one (M=3.62, SD=.63), item five (M=3.62, SD=.54), item four (M=3.52, SD=.65), and item six (M=3.45, SD= .64). This indicates a high level of perceived effectiveness for assisting clients in conceptualizing anger as involving different parts, assisting clients with identifying ways anger has negatively impacted his or her daily life, exploring client self-talk, and increasing self-awareness of angry feelings. The three lowest

means were item three (M= 2.62, SD=1.33), item two (M=2.72, SD=1.33), and item nine (M=2.75, SD=1.28) This indicates a moderate level of perceived effectiveness for decreasing the overall frequency of angry feelings, decreasing the overall intensity of angry feelings, and increasing respect for others and their feelings. Presented in Table 14 is detailed information about the items in the PEAM scale.

Table 14

Item Analysis of the PEAM Scale

Item	Min	Max	Mean	SD
1. Assists clients in conceptualizing anger as involving different components (cognitive, physical, affective, and behavioral)	0	4	3.62	.63
2. Decreases overall intensity of angry feelings	0	4	2.72	1.33
3. Decreases overall frequency of angry feelings	0	4	2.62	1.33
4. Explores client self-talk that mediates angry feelings and actions	0	4	3.52	.65
5. Assists clients with identifying ways anger has negatively impacted his or her daily life	1	4	3.62	.54
6. Increases self-awareness of angry feelings while helping develop better self-control	0	4	3.45	.64
7. Increases acceptance of angry	0	4	2.98	1.09

feelings				
8. Develops an awareness of current angry behaviors	0	4	3.30	.78
9. Increases respect for others and their feelings	0	4	2.75	1.28
10. Assists clients in identifying the positive consequences of managing anger	0	4	3.30	.90
11. Expands clients' awareness of the negative effects that anger has on his or her health	0	4	2.93	1.26
12. Teaches conflict resolution skills to manage interpersonal problems	0	4	3.26	.95
13. Teaches clients calming techniques (e.g. muscle relaxation, paced breathing, calming imagery) as a way of appropriately responding to angry feelings when they occur	0	4	3.44	.80

Research Question 2

The second research question sought to answer: To what degree do providers of anger management treatment programs perceive they were prepared in their degree program to provide anger management treatment to court mandated clients? This question was investigated through descriptive statistics of the overall ratings. A total of 112 respondents provided ratings of eight items measuring training program preparation on a 5- point Likert scale (0= neither agree nor disagree, 1= strongly disagree, 2= disagree, 3= agree, 4= strongly agree), making a total of 896

possible responses. With responses ranging from 0 to 4, a total mean of 2.63 and standard deviation of .99 were calculated. The results indicate a moderate level of perceived preparation in training programs. Respondents on average agreed their training program(s) prepared them to provide anger management treatment to mandated clients. The mean (2.63) was interpreted to mean "perceived moderate preparation," showing that respondents selected 4 "strongly agree" or 3 "agree" on most of the items in the TPP scale. The actual frequency of how many times "strongly agree" and "agree" were selected totaled 605, which equaled 67.6% of the responses. The standard deviation (.99) was interpreted to mean that responses deviated from a high level of preparedness, a very low level of preparedness, or mixed levels of preparedness. Table 15 shows frequency of overall rating of the TPP scale.

Table 15

Frequency of Overall Ratings of TPP Scale

Likert Range	Frequency	Percent
Strongly Agree	255	28.5%
Agree	350	39.1%
Disagree	124	13.8%
Strongly Disagree	42	4.7%
Neither Agree Nor Disagree	116	13.0%
Missing	9	1.0%
Total	896	100%

Note. N=112

Additional analysis of factors such as sex, age, and highest degree held indicated a moderate level of perceived training preparedness on the TPP scale. Similar means were found

for male (N=50, M=2.62, SD=1.07) and female (N=61, M=2.63, SD=.94) respondents, indicating a moderate level of training preparedness to provide anger management programs with court mandated clients. Of all the factors, the means of the male and female respondents were most identical to the overall mean of the TPP scale.

Most participants (N=49, M=2.76, SD=.95) were between the ages of 34 and 54, and the mean for this age range indicated a moderate level of training preparedness. Participants between the ages of 25-34 (N= 19, M= 2.45. SD=.82) indicated a moderate level of training preparedness, but slightly lower than the overall mean of the TPP scale. Participants 55 and older (N=42, M=2.58, SD=1.09) indicated a moderate level of training preparedness as well. The means were interpreted to mean "agree" using the Likert scale rating for TPP.

The highest degree held by most respondents was a master's degree (N=58, M=2.57, SD=1.02), indicating a moderate level of training preparedness. The next highest degree held by most respondents was the doctoral degree (N=22, M=2.28, SD=1.11), indicating a moderate level of training preparedness slightly lower than at the master's level. Means and standard deviations were calculated for factors of sex, age, and highest degree held (see Table 16).

Table 16

Crosstab Demographics of the TPP Scale

Crosstab	*n*	*Min*	*Max*	*Mean*	*SD*
Sex					
Male	50	0	4	2.62	1.07
Female	61	0	4	2.63	.94
Age					
25-34	19	1	4	2.45	.82
35-54	49	0	4	2.76	.95
55+	42	0	4	2.58	1.09
Highest Degree					
College, No Degree	4	2	4	2.94	.73
Associates	4	3	4	3.31	.44
Bachelors	13	2	4	2.88	.60
Masters	58	0	4	2.57	1.02
Doctorate	22	0	4	2.28	1.11
Specialists	10	2	4	2.95	1.03

Note.

The means and standard deviations were calculated for each of the 8 items in the TPP scale. The two highest means were for item 18 (M=2.77, SD=1.25), item 15 (M=2.75, SD=1.26), and item 20 (M=2.75, SD=1.29). The means indicate a moderate level of training preparedness for counseling resistant clients, counseling angry clients, and facilitating anger management

group. The three lowest means were for item 21 (M= 2.50, SD=1.34), item 17 (M=2.54, SD=1.29), and item 14 (M=2.55, SD=1.33). The means indicate a moderate level of training preparedness for facilitating groups of offenders, counseling behaviorally aggressive clients, and counseling mandated clients. Presented in Table 17 is detailed information about the items in the TPP scale.

Table 17

Item Analysis of the TPP Scale

Item	Min	Max	Mean	SD
14. Counsel mandated clients.	0	4	2.55	1.33
15. Counsel angry clients.	0	4	2.75	1.26
16. Counsel verbally aggressive clients.	0	4	2.70	1.28
17. Counsel behaviorally aggressive clients.	0	4	2.54	1.29
18. Counsel resistant clients.	0	4	2.77	1.25
19. Facilitate psycho-educational groups.	0	4	2.72	1.34
20. Facilitate anger management group.	0	4	2.75	1.29
21. Facilitate groups of offenders.	0	4	2.50	1.34

Research Question 3

The third and final research question sought to answer: Is there a relationship between provider attitude and perceived effectiveness of court ordered anger management?

The relationship between provider attitude (as measured by the APE scale) and perceived effectiveness of court mandated anger management (as measured by the PEAM scale) was investigated using Person product-moment correlation coefficient. Preliminary analysis was performed to ensure no violation of the assumptions of normality, linearity, and homoscedasticity. There was a small, positive correlation between the two variables, $r=.28$, $N=112$, $p<.01$, with high levels of positive attitude associated with high levels of perceived effectiveness. This means that respondents' beliefs about the effectiveness of anger management, correlated with their attitude about court mandated anger management and clients.

Derived scores were not calculated for this portion of this scale because it was opinion based, however percentages, the mean, and standard deviation were obtained. A total of 112 respondents provided ratings of eight items measuring provider attitude, on a 5- point Likert scale (0= neither agree nor disagree, 1= strongly disagree, 2= disagree, 3= agree, 4= strongly agree), making a total of 896 possible responses. The results totaled a mean of 2.58, which indicates that respondents selected 4 "strongly agree" or 3 "agree" on most of the items in the APE scale. The actual frequency of how many times "strongly agree" and "agree" were selected totaled 620, which equaled 69.2% of the responses. The standard deviation (.53) was interpreted to mean that respondents strongly agreed, disagreed, and neither agreed nor disagreed with many of the items. Table 18 shows frequency of overall rating of the APE scale.

Table 18

Frequency of Overall Ratings of APE Scale

Likert Range	Frequency	Percent
Strongly Agree	246	27.5%
Agree	374	41.7%
Disagree	84	9.4%
Strongly Disagree	33	3.7%
Neither Agree Nor Disagree	148	16.5%
Missing/Skipped	11	1.2%
Total	896	100%

The means and standard deviations were calculated for each of the items in the APE scale. The two highest means were item 24 (M=3.34, SD=.98) and item 22 (M=3.05, SD=1.35). The means indicate that most respondents agree to feeling comfortable counseling and training mandated clients, and most respondents agree judges should mandate anger management treatment. The three lowest means were item 26 (M=1.83, SD=1.35), item 27 (M=2.14, SD=1.40), and item 23 (M=2.35, SD=1.32). The mean for item 26 indicates that most respondents disagree that court mandated counseling ensures great compliance with treatment. Items 27 and 23 were reverse coded, indicating that most respondents agree that the potential of growth and change is less likely to occur with mandated clients than with voluntary clients and that mandated clients are always resistant. Presented in Table 19 is detailed information about the items in the APE scale.

Table 19

Item Analysis of the APE Scale

Item	Min	Max	Mean	SD
22. Judges should mandate anger management treatment	0	4	3.05	1.35
23. Mandated clients are always resistant.	0	4	2.35	1.32
24. I feel comfortable counseling and training mandated clients.	0	4	3.34	.98
25. There is a need for more research-based guidelines on how mental health providers should deliver anger management treatment to court mandated clients.	0	4	2.79	1.30
26. Court mandated counseling ensures greater compliance with treatment.	0	4	1.83	1.35
27. The potential of growth and change is less likely to occur with mandated clients than with voluntary clients.	0	4	2.14	1.40
28. Court mandated anger management treatment is a form of punishment.	0	4	2.76	1.29
29. Legal force or coercion to enter treatment is unethical.	0	4	2.60	1.33

Note: Items 23, 27, 28, and 29 were reverse coded.

Open Response Data

Additional information about participants' views regarding anger management with court mandated clients was collected through an optional free response section of the survey instrument (section V of the survey instrument). In this section, a total of 60 participants expressed their opinions about court mandated anger management. Responses ranged from expressions about the courts' expectation of mandated treatment, the attitude mandated clients have, the provider's goals in treatment, the need for actual examples of how to use anger management, the most effective interventions, appropriate treatment time, the need for state level guidelines, etc. For example, a participant who commented about the courts stated, "If you think about the stages of change the court wants them to be at the action stage however many are pre contemplative; our goal is to get them to action." Another participant expressed:

> Treatment takes longer than the court mandates. We would like to have 25 to 50 sessions for adults who come to use from the criminal justice system. Usually, the mandate is for 10 to 15 sessions. This is not enough time to produce lasting change.

A differing opinion from another participant was: "I believe AM classes for court mandated clients are one of the best ways to prevent recidivism. Without the awareness and control of AM, clients will search for answers in other ways such as Alcohol and Drug consumption, violence, over-eating, isolation, and harm to self." Another participant expressed, "Some people don't want to admit to having anger problems and would not reach out for counseling on their own. Court mandated anger management programs are important."

CHAPTER FIVE

DISCUSSION

This chapter includes a discussion of the results of this study. This chapter is organized in the following order: summary of findings, implications for anger management programs, implications for training programs, implications for providers and counselor educators, limitations of the study, and suggestions for future research.

Summary of Findings

The purpose of this study was to explore the degree to which providers believe anger management is effective, to explore the degree of preparation of providers, and to explore the relationship between provider attitude and perceived effectiveness of court mandated anger management. The research questions were assessed by surveying mental health professionals who had provided anger management treatment with court mandated clients. The population used for the survey was members of the National Anger Management Association, members of the American Association of Anger Management, members of therapy directories, anger management providing agencies across the U.S, and university forensic and counseling programs across the U.S. Of 731 e-mail messages sent to participants, with request to forward the survey to others, 112 completed the instrument for a completion rate of 15%.

A diversity of participants and providers were represented in the study. Participants in the study included professional counselors, social workers, psychologists, anger management specialists, etc. The number of male and female participants was approximately equal, with males representing 44.6% and females 54.5%. The racial composition of respondents was reflective of the mental health field with Caucasian at 59.8%, African American at 28.6%, Hispanic at 8.0%, Multiracial at 1.8%, and Asian/Pacific Islander at .9%. Ages ranged from 25 to

55 and older, with the largest number of participants in the 35-54 age range at 43.8%. Various education levels were represented from those having some college and no degree (3.6%) to those with a masters (51.8%) and doctorate degree (19.6%). Credentials also varied among the respondents with the majority being Anger Management Specialists (NAMA) (26.8%), Licensed Professional Counselors (LPC) (21.4%) and Licensed Clinical Social Workers (LCSW) (13.4%).

Participants indicated between 5 to 30 plus years of clinical experience and included areas such as anger management (34.8%), depression/anxiety (21.4%), substance abuse (17.9%), family (17.9%), relationships (14.3%), etc. The majority of respondents reported having between 1 to 10 years of providing specifically court mandated anger management treatment.

Approximately half of the participants (49.1%) indicated that 50% of the services they provide are court mandated. Most respondents (53.6%) reported using a manualized anger management treatment program to provide services. A total of 58.0% of respondents reported conducting both individual and group anger management treatment for a duration of days and weeks.

Research Question 1

The results of this study found that 90.2% perceived that anger management is highly effective. This was validated across factors such as sex, age, and years providing court mandated anger management treatment, in which the overall rating of each cross factor indicated a perceived high level of effectiveness. As addressed in Chapter 2, a concern is that anger management is one of the few cognitive behavioral interventions with published studies showing no treatment benefit (Sharry & Owens, 2000; Watt & Howells, 1999). The results of this study showed differences from published studies, indicating that providers believe in treatment benefit

of anger management. Results of this study also showed that most providers believe that anger management is effective as a less punitive approach to justice. Nearly half of the survey respondents indicated that 50% or more of the services they provide are court mandated, which may indicate belief that anger management treatment is not only a less punitive approach to justice, but an effective approach to justice.

Also addressed in Chapter 2 were studies and reviews that support the effectiveness of mandated treatment, despite factors such as client resistance and motivation. Results of this study from the provider perspective support the belief that client growth and change have the potential to occur despite *force* to engage in counseling. It can be assumed that if respondents believed that client growth and change could not occur, that responses most likely would have been different. This study also seemed to challenge the widely held belief that internal motivation is a fundamental prerequisite for developing counseling interventions that will facilitate client growth and change. The results indicate that anger management practitioners believe effectiveness is likely without internal motivation.

In addition, this study showed that the core components of anger management (increasing self-awareness of anger, triggers, and related behavior; coping strategies; and relaxation training) are believed to be effective. When reviewing the individual items of the Perceived Effectiveness of Anger Management (PEAM) scale, the mean for each item minimally deviated from the overall mean (3.17). This indicates not only a high level of perceived effectiveness overall, but a high level of perceived effectiveness with the core components of anger management concepts. As was presented in Table 14, the three highest means (M=3.62, M=3.52, M=3.45) were in response to assisting clients in conceptualizing anger as involving different parts, assisting clients with identifying ways anger has negatively impacted his or her

daily life, exploring client self-talk, and increasing self-awareness of angry feelings. This may mean that most providers believe that anger management is highly effective in helping clients in those areas, which ultimately addresses the core components of anger management treatment. Jongsma and Peterson (2006) identified some of these same areas as evidenced based goals and objectives for treating anger issues in The Complete Adult Psychotherapy Treatment Planner.

The three lowest means (M= 2.62, M= 2.72, M= 2.75) were in response to decreasing the overall frequency of angry feelings, decreasing the overall intensity of angry feelings, and increasing respect for others and their feelings. This indicated a moderately high level of perceived effectiveness, meaning that most providers may believe that anger management is effective in those areas with clients. The items in between the highest and lowest means indicated a high to moderately high level of perceived effectiveness as well. In general, this may suggest that the potential for growth and change is still likely to occur with court mandated clients, especially if the core components of anger management are addressed in treatment programs.

In addition to the aforementioned discussion, the overall and individual means of the PEAM scale provide additional support for the cognitive behavioral approach to treating anger. As was addressed in Chapter 2, the cognitive-behavioral approach allows treatment to address the cognitive complexity of problematic behavior. A majority of anger treatment outcome studies utilized a cognitive behavioral approach (Beck & Fernandez, 1998). The popularity and effectiveness of the cognitive behavioral approach may be a primary reason for the results of the PEAM scale.

Research Question 2

The results of this study found that 67.6% believe they had a moderate level of preparation in their training program to provide anger management treatment to court mandated clients. The results were the same across factors such as sex, age, and number of years providing court mandated services, in which the overall rating of each cross factor indicated a moderate level perception of training program preparedness. However, although 67.6% believed they had been given a moderate level of preparedness, a total of 32.4% experienced low levels of training preparedness or could not decide. The 32.4% of those who perceived a low level of training experience is a substantial percentage and could indicate areas of training need. Since a majority of the participants had a master's degree, the results may indicate that training needs exist at the master's level. As addressed in Chapter 2, most master's counselors are expected to have a working knowledge of the concepts and skills associated with task, psychoeducation, counseling, and therapy groups. (Killacky & Killacky, 2004). This working knowledge is often expected to be obtained in only one group counseling course (Akos, Goodnough, & Milson, 2004).

In discussing the means for each of the 8 items in the TPP scale, the two highest means (M=2.77, M=2.75) indicated a moderate level of training preparedness for counseling resistant clients, counseling angry clients, and facilitating anger management group. The three lowest means (M= 2.50, M=2.54, M=2.55) also indicated a moderate level of training preparedness, for facilitating groups of offenders, counseling behaviorally aggressive clients, and counseling mandated clients. Explanation of these results may be attributed to the amount of training specifically allotted to counseling mandated, aggressive, or resistant clients in training programs. For instance, traditional anger management programs try to prevent future anger outbursts, regulate the anger arousal, and help develop behavioral skills to manage anger (Pickover, 2010).

It can be assumed that participants who had training experiences related to the goals of anger management programs rated the level of training preparedness higher, and those who did not rated lower. As was revealed in the review of the literature, in most graduate training programs counselors are expected to have a working knowledge of task, psychoeducation, counseling, and therapy groups (Killacky & Killacky, 2004), often obtained in one group counseling course (Akos, Goodnough, & Milson, 2004). However, the results indicate that a significant amount of participants would have benefited from additional training experience.

Research Question 3

The results of this study found a small, positive correlation between provider attitude and perceived effectiveness of court mandated anger management. This means that respondents' attitude about mandated clients and treatment in general correlated with their belief about the effectiveness of anger management. Thus, the high level of perceived effectiveness indicated from research question one, correlated with more positive provider attitudes concerning court mandated treatment and clients from research question three. This was further indicated through descriptive results of the Attitude and Perceived Effectiveness (APE) scale, which showed that 69.2% of respondents had a high level of agreeableness concerning court mandated clients and treatment in general.

As was addressed in Chapter 2, there have been a number of studies and reviews of research on coerced treatment in which evidence supports the fact that coerced clients do at least as well as voluntary clients or clients under minimum levels of legal pressure (Prendergast et al., 2002). When participants were asked if judges should mandate anger management treatment, 83.9% of respondents agreed that judges should, and 92% responded that they felt comfortable counseling and training mandated clients. These two items presented in Table 20 had the highest

means (3.34 and 3.05) of the APE scale, indicating a support of court mandated counseling. Contrarily, the item with the lowest mean (1.83) indicated that participants do not believe that court mandated counseling ensures greater compliance with treatment. Individuals who oppose court mandated counseling question the therapeutic effectiveness of legally mandated treatment and argue that research supporting its use in many forms is lacking (Watson, Corrigan, & Angell, 2005). However, results of this study show a large portion of mental health professionals support its use and perceive that it is effective.

As was addressed in the review of the literature, some private practice clinicians say that working with the courts is the best move they could have made (American Psychotherapy Association, 2010), while others have said that legal coercion into treatment involves stripping a person of some rights and liberties, and therefore, may be viewed as punishment (Watson et al. 2005). In the American Psychological Association (2010) study, a total of 74.1% of respondents agreed that legal force or coercion to enter treatment is unethical and 73.3% agreed that court mandated anger management treatment is a form of punishment. While the results of this study somewhat support the results of this other study, it appears that mental health professionals continue to provide court mandated anger management despite beliefs about it being unethical or a form of punishment.

Another issue addressed in the literature concerns the label that court mandated clients are resistant (Hare, 1996). The results of this study are consistent with studies from the literature. Results from the study show that 64.3% of respondents agreed that mandated clients are always resistant. A total of 54.5% of respondents agreed that potential growth and change is less likely to occur with mandated clients than with voluntary clients. Respondents beliefs about the potential of growth or change may be based upon the belief that court mandated clients are

always resistant. It could also indicate that resistance does not equate to ineffectiveness of services. A client can be labeled as resistant, but over treatment time may become less resistant and open to growth.

A total of 78.6% of respondents believe there is a need for more research-based guidelines of how mental health providers should deliver anger management treatment to court mandated clients. The survey results are consistent with the literature. Research based guidelines may assist anger management providers with working through client resistance and help facilitate change. The guidelines may also bring some uniformity to anger management treatment on all client levels, which would in turn reinforce the inclusion of the core components of anger management.

In discussing the significance of the means of the items of the APE scale, the two highest means (M=3.34, M=3.05) indicate that most respondents agree to feeling comfortable counseling and training mandated clients, and that most respondents agree judges should mandate anger management treatment. As noted in the literature, court ordered treatment is based on therapeutic jurisprudence (Shearer, 2003), which provides therapeutic measures for people involved in criminal behavior. This may explain participant responses concerning those particular items of the APE scale. The three lowest means (M=1.83, M=2.14, M=2.35) indicate that most respondents disagree that court mandated counseling ensures great compliance with treatment, and agree that the potential of growth and change is less likely to occur with mandated clients than with voluntary clients and that mandated clients are always resistant. Participant responses are reflective of the literature concerning mandated, coerced, and involuntary treatment, in that those who oppose question the therapeutic effectiveness (Watson et al., 2005). However, opposition of mandated treatment has not been specifically narrowed to anger management.

Thus, if questioned, those who oppose mandated treatment in general, may have a differing opinion about mandated anger management treatment.

Open Response Data

The major themes presented within the open responses on the survey form are noted. The first major theme was that many providers believe that court mandated anger management is beneficial. The level of benefit seemed to vary, as some participants expressed that it is up to the client as to whether he or she wants to change. Participants also expressed that over time in treatment, many mandated clients become less hostile and aggressive. This was supported in participant responses on the APE scale, as respondents highly agreed that mandated clients are always resistant. However, from the qualitative responses, it appears that "always resistant" is indicative of the initial onset and not for the duration of treatment.

The second major theme related to the importance of the relationship between the provider and client. Participants expressed that the attitude and skills of the provider have an impact on client treatment. This was further supported with responses on the APE scale in which participants expressed they felt comfortable counseling and training mandated clients. One participant in particular expressed that "comfort in the company of the client is critical." What this may mean is that the therapeutic alliance is of utmost importance, maybe even more so with mandated clients.

The last major theme identified related to treatment time. Many participants expressed that more time is needed than the court provides. One participant stated, "the longer the program the better." Another participant expressed, "treatment takes longer than the court mandates." This theme may signify that the effectiveness of court mandated anger management treatment

may be greater with the length of treatment time. It is a possibility that treatment time could reflect recidivism rates of offenses.

Implications for Anger Management Programs

Findings from the study indicate that mental health professionals believe that anger management is effective, specifically treatment that utilizes the core content of anger management. The findings supported the use of the cognitive behavioral theoretical framework to which core content of anger management is most effective, but it would be recommended that core content be included within any theoretical framework that a provider might use.

In addition, it is recommended that more anger management programs be offered to both mandated and non-mandated clients. The literature shows that anger management is effective with a variety of client populations (Naeem, Clarke, & Kingdom 2009), thus the results of the study confirm reports of effectiveness in the literature from the provider perspective. Moreover, perhaps more anger management programs should be offered as an alternative to incarceration. Alternatives to incarceration such as anger management programs reduce the number of inmates and allocate tax payer funds to other causes.

It is also recommended that, if possible, anger management programs be offered for a longer length of treatment time. Length of treatment may vary by court system, however from the qualitative data, it appears that more treatment time (number of sessions) is desired. Educating the courts about length of treatment might be an area of advocacy for therapeutic effectiveness and reducing recidivism.

Implications for Graduate Training Programs

Results of this study found that respondents believe they were moderately prepared in their training program to provide anger management treatment to court mandated clients. This

preparation included the skills to counsel angry, aggressive, and resistant clients. Moreover, training program preparedness included the skills to facilitate psycho-educational groups, facilitate groups of offenders, and facilitate anger management groups. Conversely, a significant number of respondents indicated a low rating of training preparation. Considering that the majority of respondents had a master's degree, it can be assumed that training preparation at the master's level is one area in which training needs should be addressed. Perhaps master's level graduate training programs should require more than one group course so that counselor trainees have a stronger group facilitation foundation. Anger management is a type of psycho-educational group, however training programs most likely do not provide the experience to trainees to allow them to confidently provide services to mandated, verbally aggressive, and behaviorally aggressive clients.

Implications for Providers and Counselor Educators

The results of this study found a small, positive correlation between provider attitude and perceived effectiveness of court mandated anger management. Results indicate that there is a dichotomy that exists in participants' attitude concerning court mandated anger management. On one hand, providers indicated that they feel judges should mandate anger management treatment and that they feeling comfortable counseling mandated clients. On the other hand, participants indicated that legal force or coercion to enter treatment is unethical and that court mandated anger management is a form of punishment. Given that participants also indicated that there is a need for more research-based guidelines on how mental health providers should deliver anger management treatment to court mandated clients, it is recommended that providers and counselor educators initiate research efforts for mandated treatment. Many of the studies in the literature concerning anger management are international studies using mandated clients as the participant

pool. Research using anger management providers as the participant may generate knowledge concerning what tools and skills actually work with mandated clients.

It is also recommended that providers and counselor educators clearly define what is unethical and punishment, considering that court mandated or mandated treatment in general is often used as an alternative to incarceration or some more punitive form of disciplinary action (Feder & Dugan, 2002). Discussion of this kind would ideally take place in ethics courses in graduate training or through continuing education programs. Court-ordered treatment is based on therapeutic jurisprudence (Shearer, 2003), thus providers and counselor educators need to explore therapeutic jurisprudent in relation to the concepts of unethical treatment and punishment.

Results from the study showed that respondents believe that potential growth and change is less likely to occur with mandated clients than with voluntary clients. A review of the literature shows that mandated clients are not less likely to grow and change because of their involuntary state. Studies have shown mandated clients at various stages of change, and internal motivation has been found not to be a fundamental prerequisite to facilitate client growth and change (O'Hare, 1996; Shearer, 2003). It would be recommended that providers and counselor educators engage in self-assessment of attitude of their thoughts and beliefs about mandated clients and their experience or lack of experience with mandated clients.

Limitations of the Study

Limitations exist in this study that should be considered in the interpretation of results. These limitations relate to the instrument and the sample used.

Instrumentation limitations

As a descriptive study, the instrument utilized in the study was created specifically for this study. While steps were taken to review the validity of the instrument, its novelty increases the possibility that items were not representative of the attitudes and beliefs that anger management providers have concerning court mandated clients and treatment. Additionally, the instrument did not weight the importance of items. Thus, ratings of potentially less important areas may distort conclusions on the overall degree of training program preparation and attitudes of court mandated treatment in general.

The instrument's internal consistency may be of concern to the generalizability of the study. In particular, the APE scale indicated low reliability with a Cronbach's alpha coefficient of .25, which for the number of items ideally should have been between .5 and .7 (Pallant, 2010). Moreover, four items of the scale were negatively worded and needed to be reversed. This improved the Cronbach's alpha, however the internal consistency of the scale remained well below the recommended value for the number of items.

Sampling limitations

Related to sampling limitations, a relatively low percentage of the population surveyed completed the instrument, which may affect generalizability. Specifically, the low completion rate increases the risk of self-selection bias, the potential that differences may have existed between the providers that completed the instrument and those that did not. On this issue, a few emails were received from individuals who indicated that they were not completing the study because they did not work with a court mandated population or that their work with the population was outdated. Others may have misunderstand the definition of *court mandated* since

the terms *mandated treatment, coercion*, and *involuntary treatment* are often used interchangeably but may have dissimilar means in different context (Prendergast et al., 2002).

The sample for the survey was at first limited to members of the National Anger Management Association and the American Association of Anger Management, however due to low survey response, the sample population was expanded to members of other therapy networks, anger management providing agencies across the U.S., and university forensic and counseling programs. Inconclusively, a majority of the survey participants may have been members of NAMA and AAME. However, results of the study would likely apply to all anger management providers and counselors.

Suggestions for Future Research

As a follow up to this study, future research could explore other perspectives of anger management providers for work with court mandated clients. One suggested approach would be to analyze and code the qualitative data of this current study. Over half of the 112 participants provided additional thoughts about court mandated clients and anger management. For those participants who use a manualized treatment form, they indicated the name of the manual. It would be important to identify major themes and provide implications based on provider feedback. It would also be important to identify the most widely used manualized treatment guide.

Additionally, it is important to further explore provider attitudes about court mandated clients and treatment through a mixed methods approach. The data could then be compared and contrasted with the results of this study and the literature for a more thorough representation of provider attitude and training preparedness. Using the mixed method approach, it would be important to reach a larger population of providers for the generalizability of the results.

Similarly, it could be helpful to learn about other factors that were not presented in this study to include at what level providers felt most prepared to provide counseling services to the mandated population. This would particularly concern those who hold advanced degrees, which would further define areas of training needs. Additional areas of research include the type of therapeutic approach most providers use in providing anger management treatment, which approaches work best with specific age groups, type of treatment preference (individual or group), and the effect of anger management with the violently mental ill.

Summary

This study asked counselors who provide court mandated anger management programs whether they believe that the anger management treatment they provide is effective, whether they believe they were prepared in their training programs to provide anger management treatment to mandated clients, and explored if there is a relationship between provider attitude and perceived effectiveness of court mandated anger management. Results indicated that providers have a high level of perceived anger management effectiveness, that they experienced a moderate level of training preparedness, and that there is a small, positive correlation between provider attitude and perceived effectiveness of court mandated anger management.

The results may help counselors and counselor educators develop a methodical understanding of providing court mandated anger management program services to mandated clients. The results may also help counselors and counselor educators to begin establishing more research-based guidelines for recognizing, diagnosing, treating, or preventing future violence through anger management. Future research is recommended to further explore provider attitudes about court mandated clients and treatment and the level of training competence for working with mandated clients.

CHAPTER SIX

MANUSCRIPT

THE EFFECTIVENESS OF ANGER MANAGEMENT PROGRAMS WITH COURT MANDATED CLIENTS: A PROVIDER PERSPECTIVE

Mary Sanderfer

Theodore P. Remley, Jr.

Kaprea Johnson

Kathleen Levingston

Old Dominion University

To be submitted to the *Journal of Mental Health Counseling*

ABSTRACT

Arrest for criminal offenses sometimes result in court systems mandating that offenders attend anger management treatment programs. Mandated anger management treatment places a demand on mental health professionals to provide these services. In order to prepare counselors to be effective in providing services, it is important for counselor educators to examine counselors' beliefs and attitudes about mandated anger management treatment. Using a survey method, this study asked counselors to rate the degree they perceived the anger management treatment they provide to be effective and to rate the degree they perceived they were prepared in their training programs to provide anger management treatment to court mandated clients. This study also explored if there was a relationship between provider attitude and perceived effectiveness of court mandated anger management treatment. Results indicated that providers perceived that anger management treatment has a high level of effectiveness and that they perceived they had a moderate level of training preparedness to provide anger management services. A small, positive correlation was found between provider attitude and perceived effectiveness of court mandated anger management.

INTRODUCTION

Particularly for issues of domestic violence and child abuse, the criminal justice system sometimes mandates individuals to attend anger management treatment, often to avoid allocating stiffer repercussions, such as incarceration. Consequently, a huge demand to treat individuals with anger management issues is placed on mental health professionals by the courts, yet counselors and social workers do not yet have research-based guidelines for recognizing, diagnosing, treating, or preventing future violence (Lench, 2004). In addition to a lack of guidelines, mental health counselors' experiences with mandated clients are underrepresented in the literature, to include perceived efficacy, types of outcomes, and factors that promote optimal client experience. "Despite the profession's implicit faith in the benefits of unwanted treatment, there is little evidence that this approach to therapeutic jurisprudence helps, and there is some reason to believe that it may cause harm" (O'Hare, 1996, p. 417). Contrarily, a number of studies and reviews have shown the effectiveness of coerced treatment, suggesting that internal motivation in obtaining treatment is not a construct of dominant importance in treatment outcome (Shearer, 2003).

Perceived Effectiveness

Many researchers have explored the risks and benefits of court mandated counseling (Feder & Dugan, 2002; O'Hare, 1996; Shearer, 2003). Individuals who oppose its use question the therapeutic effectiveness of court mandated treatment and argue that research supporting its use in many forms is lacking (Watson, Corrigan, & Angell, 2005). There are two points of discussion in the literature that need to be considered when exploring perceived effectiveness. One concern is that "court-ordered clients have been labeled by practitioners as resistant, hard to reach, hostile, and unmotivated" (O'Hare, 1996, p. 417). The second concern is that anger

management is one of the few cognitive behavioral interventions with published studies showing no treatment benefit (Sharry & Owens, 2000; Watt & Howells, 1999), although there are many studies that have found the approach to be effective (Dwivedi & Gupta, 2002; Reilly & Shopshire, 2000; Walker et al., 2010). Given the mixed research results, it is important to explore what providers actually think about the mandated services they provide in relation to what the research studies have suggested about treatment benefit. Exploring the perceived effectiveness of intervention may help mental health counselors understand why mandated anger management treatment has been reported by some as having no treatment benefit and by others as being effective.

Training Preparation

A variety of therapeutic skills are expected to be gained from mental health counselor training programs, to include group competency skills. In most master's level programs, "counselors are expected to have a working knowledge of the concepts and skills associated with task, psychoeducation, counseling, and therapy groups" (Killacky & Killacky, 2004, p. 87). This working knowledge often has to be obtained in one class because most counselor education programs require only one group counseling course (Akos, Goodnough, & Milson, 2004). Anger management programs usually are delivered in a psychoeducational group format and mental health counselors are expected to utilize basic group competency skills to facilitate groups.

The core components of anger management programs involve increasing self-awareness of anger, triggers, and related behavior; coping strategies; and relaxation training (Walker & Bright, 2009). A question in this study concerned whether counselor trainees are directly taught in their programs the specific core components of anger management or whether the skills they need are learned through on the job experience. Also, there is a question of whether trainees are taught in their preparation programs how to deal with clients with anger issues. According to

Hess, Know, and Hill (2006), "when faced with client anger, trainees may respond defensively, use avoidance behaviors, attempt to reduce the anger by focusing on content, resort to problem solving rather than addressing and exploring the client's anger, or respond to therapist-directed anger with reciprocal anger" (p. 282). Exploring how providers rate their level of preparation to conduct court mandated anger management is of vital importance.

Attitude and Perceived Effectiveness

An important finding about psychotherapy is that the outcome variance across clients is large and a majority of the variance is due to patient and relationship factors (Sandell et al., 2007). According to Wampold (2001), therapists account for 6% to 9% of the variance, or about half of the outcome variance that is in any way related to client treatment. It can be assumed that court mandate influences variance and outcome as well. For example, some private practice clinicians say that working with the courts is the best "business-boosting move" they could have made (American Psychotherapy Association, 2010). On the other hand, Watson et al. (2005) have said that legal coercion into treatment involves stripping a person of some rights and liberties, and therefore, may be viewed as punishment. As a part of the study, information was collected that assessed whether there was a relationship between provider attitude and the perceived effectiveness of anger management.

Purpose

This study assessed whether counselors who provide court mandated anger management programs perceived whether the anger management treatment they provided was effective, whether they believed their training programs prepared them to provide anger management treatment to mandated clients, and whether there was a relationship between provider attitude and perceived effectiveness of court mandated anger management. Individuals with various backgrounds who provide court mandated anger management treatment were participants in this

study. The purpose of this study was to help mental health counselors and counselor educators develop a methodical understanding of providing court mandated anger management program services to mandated clients.

The primary research questions of this study were (1) To what degree do providers of anger management treatment perceive the programs they deliver to be effective with court mandated clients? (2) To what degree do providers of anger management treatment programs perceive they were prepared in their graduate programs to provide anger management treato court mandated clients? and (3) Is there a relationship between provider attitude and perceived effectiveness of court ordered anger management?

METHOD

Participants

The population for this study was mental health professionals who had provided anger management treatment with court mandated clients. Members of the National Anger Management Association, American Association of Anger Management, members of therapy networks, anger management providing agencies across the U.S, and university forensic and counseling programs across the 50 states were asked to take the survey and forward the survey link to others as well. A total of at least 731 mental health professionals were solicited in the study. Of these, 112 participants completed the instrument, representing a completion rate of 15%.

Of the 112 participants, 61 were female and 50 were male. The majority of the participants were Caucasian (n=67). Several other racial groups were also represented in the population: African American (n=32); Hispanic (n=9); Multiracial (n=2); and Asian/Pacific Islander (N=1). The majority of respondents (n=91) were 35 years of age or older.

A majority of the participants (n=58) identified the highest level of education as a master's degree. A second majority of participants (n=22) identified a doctorate degree as the highest level of education. Respondents included 30 Anger Management Specialists (NAMA), 24 licensed professional counselors (LPC), 15 social workers (LCSW/MSW/LSW), 7 licensed psychologists (LP), 4 licensed mental health counselors (LMHC), 2 licensed marriage and family therapists (LMFT), and 3 nationally certified counselors (NCC).

The majority of participants had between 10 and 30 or more years of clinical experience. Thirty-nine of the participants indicated anger management as an area of expertise. Other participants identified some other area of clinical expertise including substance abuse, domestic violence, depression, anxiety, children and adolescents, women, crisis intervention, trauma, family, and relationships.

Procedure

The study was conducted online using a web-based survey. Email messages were sent to providers asking them to participate in the research study and they were given a hyperlink to the survey instrument that was hosted on Surveygizmo (http://www.surveygizmo.com). Surveygizmo did not reveal any information about the participants other than the information collected through the instrument. Participants were also asked to forward the link to others who they knew who provided court mandated anger management services.

Instrument

The survey instrument collected demographic information, asked the degree to which providers believed court mandated anger management was effective, explored the degree of preparation of providers, and assessed provider attitudes regarding court mandated clients and

treatment. Open response comments indicated qualitative provider feedback about mandated clients and treatment.

Demographic Information. Participants were asked to provide information about themselves and their clinical experience. Demographic questions included the provider's sex, age, race/ethnicity, type of degree held, and their highest educational degree obtained. Questions about clinical experience included number of years of clinical experience, number of years working with mandated clients, credentials, and areas of clinical expertise. Two demographic questions about the anger management programs they provided included the length of the programs and the service delivery type.

Rating of Perceived Efficacy of Anger Management (PEAM). Items were created for the PEAM portion of the survey instrument based on a review of the literature, Jongsma & Peterson's (2006) The Complete Adult Psychotherapy Treatment Planner, and feedback from an expert panel to identify prototypical dimensions or indicators and content analysis. Participants were asked to rate each of the 13 items using a 5-point Likert scale (0= neither agree nor disagree, 1= strongly disagree, 2= disagree, 3= agree, 4= strongly agree). Higher scores indicated a higher level of perceived effectiveness of court mandated anger management treatment. The mean was used to establish cut off points ranging from either a high level of perceived effectiveness or a low level of perceived effectiveness.

Rating of Training Program Preparedness (TPP). Items were created for the TPP portion of the instrument based on a review of the literature, personal experiences in graduate school programs, and feedback from an expert panel to identify prototypical dimensions or indicators and content analysis. It contained eight items, in which participants were asked to rate each item using a 5-point Likert scale (0= neither agree nor disagree, 1= strongly disagree, 2=

disagree, 3= agree, 4= strongly agree). Higher scores indicated a higher level of preparedness in their degree programs. The mean was used to establish cut off points ranging from either a high level of training preparedness or a low level of training preparedness.

Attitude and Perceived Effectiveness (APE). Items were created for the APE portion of the instrument based on a review of the literature and feedback from an expert panel of reviewers. It contained eight items, in which participants were asked to rate each item using a 5-point Likert scale (0= neither agree nor disagree, 1= strongly disagree, 2= disagree, 3= agree, 4= strongly agree). A Pearson product moment correlation was used to describe the relationship between provider attitude and perceived effectiveness. This was an opinion based section to reflect providers' attitudes about mandated clients and treatment in general.

Expert Review and Pilot Study. For establishing validity, the initial list of items was sent to an expert panel of five mental health professionals with at least 20 years of clinical mental health experience. Based on feedback from experts, items were added or modified in the instrument. Following the expert review, a pilot study was conducted with 10 participants. Six instruments were completed in the pilot study for a completion rate of 60%. Item analysis was conducted on the PEAM scale of the instrument. All items had correlations greater than .50. The coefficient alpha for the 13 items of the PEAM scale was .83.

Data Analysis

Following data collection, an item analysis and principle component analysis (PCA) using principle component extraction and Varimax rotation were conducted to determine core factors present in the instrument and to verify that the items in the instrument were appropriate for the purposes of this study. The PCA was conducted on the 13 items rating the degree to which providers believe that anger management is effective. Prior to performing PCA, the

suitability of the data for factor analysis was assessed. All items had correlations greater than .30 and the coefficient alpha for the 13 items was .83. The Kaiser-Mayer-Olkin (KMO) value was .75, indicating the sample was adequate for factor analysis. Bartlett's Test of Sphericity reached statistical significance, ($p<001$) and thus rejected the null hypothesis of lack of sufficient correlation between the variables. An inspection of the screeplot revealed a clear break after a second component. It was decided to retain the two components for further investigation. This was further supported by the results of Parallel Analysis, which showed only two components with eigenvalues exceeding the corresponding criterion values for a randomly generated data matrix of the same size.

The two-component solution explained a total of 48.45% of the variance, with Component 1 contributing 36.50% and Component 2 contributing 11.95%. Component 1 was determined to be the primary component and was referred to as the perceived efficacy of anger management. Items within this component related to perceptions such as anger decreasing in frequency, developing an awareness of current angry behaviors, etc. Component 2 was an unidentified and unused element of the scale. To aid in the interpretation of these two components, Varimax rotation was performed. The rotated solution revealed both components showing a number of strong loadings and all variables loading substantially on only one component. Component 1 had the strongest number of loadings and variables. Results from the item analysis and PCA support the use of the 13 items in the PEAM scale measuring the perceived effectiveness of anger management (Component 1).

Following the analysis of the instrument, descriptive and frequency statistics were used to evaluate the degree of effectiveness, degree of preparation, correlation between attitude and effectiveness, and the variance due to factors of age, sex, years of clinical experience, and years

of mandated counseling experience. The mean was used to establish cut off points in ranging degrees of effectiveness and preparation. A Pearson product moment correlation was used to describe the relationship between provider attitude and perceived effectiveness, which provided an index of the degree of linear relationships between the variables.

RESULTS

Perceived Effectiveness

Among the participants, 90.2% had a high level of perception that anger management is effective. This was validated across factors such as sex, age, and years providing court mandated anger management treatment, in which the overall rating of each cross factor indicated a perceived high level of effectiveness. Specifically, this study showed that the core components of anger management (increasing self-awareness of anger, triggers, and related behavior; coping strategies; and relaxation training) were perceived as effective. For the purposes of rating the degree of effectiveness, a numeric value was assigned to each of the Likert-scale values beginning with a 0 for neither agree nor disagree to a 4 for strongly agree. Means and standard deviations were then calculated for the overall rating of effectiveness (see Table 1). Using this method, anger management was rated at a high level of perceived effectiveness ($M = 2.58$, $SD = .53$, $N = 112$).

Training Program Preparedness

A total of 67.6% of the participants had a moderate level of training program preparedness to deliver anger management services. This was validated across factors such as sex, age, and highest degree held, in which the overall rating of each cross factor indicated a perceived moderate level of training program preparedness. For the purposes of rating training program preparedness, a numeric value was assigned to each of the Likert-scale values beginning

with a 0 for neither agree nor disagree to a 4 for strongly agree. Means and standard deviations were then calculated for the overall rating of training program preparedness (see Table 2). Using this method, preparedness was rated at a moderate level ($M = 2.63$, $SD = .99$, $N = 112$).

Attitude and Perceived Effectiveness

A small, positive correlation between attitude and perceived effectiveness was found in this study. The relationship between provider attitude (as measured by the APE scale) and perceived effectiveness of court mandated anger management (as measured by the PEAM scale) was investigated using a Person product-moment correlation coefficient ($r=.28$, $N=112$, $p<.01$). Respondents' beliefs about the effectiveness of anger management correlated with their attitude about court mandated anger management and clients. Descriptive details of the APE scale are presented in Table 3.

DISCUSSION

Research Question 1

Most of the participants (90.2%) had a high level of perception that anger management is effective. A concern in the literature is that anger management is one of the few cognitive behavioral interventions with published studies showing no treatment benefit (Sharry & Owens, 2000; Watt & Howells, 1999). The results of this study showed that providers believe in treatment benefit of anger management. Results of this study also showed that providers believe that anger management is effective as a less punitive approach to justice. Nearly half of the survey respondents indicated that 50% or more of the services they provide are court mandated. There are studies and reviews that support the effectiveness of mandated treatment despite factors such as client resistance and motivation. Results of this study from the provider perspective support the belief that client growth and change have the potential to occur despite

force to engage in counseling as well as the belief that internal motivation is a fundamental prerequisite to developing counseling interventions that will facilitate client growth and change. In addition, this study showed that the core components of anger management (increasing self-awareness of anger, triggers, and related behavior; coping strategies; and relaxation training) are perceived by service providers as being effective.

Research Question 2

Of the study participants, 67.6% believed they had been prepared to a moderate level in their training program to provide anger management treatment to court mandated clients. Although 67.6% perceived they had been prepared to a moderate level, a total of 32.4% perceived their preparation to be at a low level or could not decide. Since32.4% is a substantial percentage, the results could indicate more training is needed. Since a majority of the participants had a master's degree, the results may indicate that training needs exist at the master's level. Most master's mental health counselors are expected to have a working knowledge of the concepts and skills associated with task, psychoeducation, counseling, and therapy groups (Killacky & Killacky, 2004). This working knowledge is often expected to be obtained in only one group counseling course (Akos, Goodnough, & Milson, 2004).

Research Question 3

The results of this study found a small, positive correlation between provider attitude and perceived effectiveness of court mandated anger management. Respondents' attitude about mandated clients and treatment in general correlated with their belief about the effectiveness of anger management. This was further indicated through descriptive results of the APE scale, which showed that 69.2% of respondents had a high level of agreeableness concerning court mandated clients and treatment in general.

There have been a number of studies and reviews of research on coerced treatment in which evidence supported the fact that coerced clients do at least as well as voluntary clients or clients under minimum levels of legal pressure (Prendergast et al., 2002). When participants were asked if judges should mandate anger management treatment, 83.9% of respondents agreed that judges should, and 92% responded that they felt comfortable counseling and training mandated clients. Individuals who oppose court mandated counseling question the therapeutic effectiveness of legally mandated treatment and argue that research supporting its use in many forms is lacking (Watson, Corrigan, & Angell, 2005). However, results of this study show a large portion of mental health professionals support its use.

A total of 74.1% of the study participants responded that legal force or coercion to enter treatment is unethical and 73.3% indicated that court mandated anger management treatment is a form of punishment. While the results of this study support conclusions made in the literature, it appears that mental health professionals continue to provide court mandated anger management despite beliefs about it being unethical or a form of punishment.

Another issue addressed in the literature concerns the label that court mandated clients are resistant (Hare, 1996). The results of this study are consistent with studies from the literature. Results from the study show that 64.3% of respondents agreed that mandated clients are always resistant. A total of 54.5% of respondents agreed that potential growth and change is less likely to occur with mandated clients than with voluntary clients. Respondents beliefs about the potential of growth or change may be based upon the belief that court mandated clients are always resistant. It could also indicate that resistance does not equate to ineffectiveness of services. A client can be labeled as resistant, but over treatment time may become less resistant and open to growth.

A total of 78.6% of respondents believed there is a need for more research-based guidelines of how mental health providers should deliver anger management treatment to court mandated clients. The survey results are consistent with the literature. Research based guidelines may assist anger management providers with working through client resistance and help facilitate change. The guidelines may also bring some uniformity to anger management treatment on all client levels, which would in turn reinforce the inclusion of the core components of anger management.

Implications for Graduate Training Programs

Results of this study found that respondents believe they were moderately prepared in their training program to provide anger management treatment to court mandated clients. This preparation included the skills to counsel angry, aggressive, and resistant clients. Moreover, training program preparedness included the skills to facilitate psycho-educational groups, facilitate groups of offenders, and facilitate anger management groups. Conversely, a significant number of respondents indicated a low rating of training preparation. Considering that the majority of respondents had a master's degree, it can be assumed that training preparation needs at the master's level should be addressed. It would be recommended that master's level graduate training programs offer more than one group course so that mental health counselor trainees have a stronger group facilitation foundation. Anger management is a type of psycho-educational group, however training programs may not provide the experience to confidently provide services to mandated, verbally aggressive, and behaviorally aggressive clients.

Implications for Providers and Counselor Educators

The results of this study found a small, positive correlation between provider attitude and perceived effectiveness of court mandated anger management. Results indicate that there is a

dichotomy that exists in participants' attitude concerning court mandated anger management. On one hand, providers indicated that they believe judges should mandate anger management treatment and that they feel comfortable counseling mandated clients. On the other hand, some participants indicated that legal force or coercion to enter treatment is unethical and that court mandated anger management is a form of punishment. Given that participants also indicated that there is a need for more research-based guidelines on how mental health providers should deliver anger management treatment to court mandated clients, it would be recommended that providers and counselor educators initiate research efforts for mandated treatment. Many of the studies in the literature concerning anger management are international studies using mandated clients as the participant pool. Research using anger management providers as the participant may generate knowledge concerning what tools and skills actually work with mandated clients.

It is recommended that providers and counselor educators clearly define what is unethical and punishment, considering that court mandated or mandated treatment in general is often used as an alternative to incarceration or some more punitive form of disciplinary action (Feder & Dugan, 2002). The likely place for a discussion of this kind would ideally take place in ethics courses of graduate training or continuing education. Court-ordered treatment is based on therapeutic jurisprudence (Shearer, 2003), thus providers and counselor educators need to explore therapeutic jurisprudent in relation to unethical treatment and punishment.

Results from the study showed that respondents believed that potential growth and change is less likely to occur with mandated clients than with voluntary clients. A review of the literature shows that mandated clients are not less likely to grow and change because of their involuntary state. Studies have shown mandated clients at various stages of change, and internal motivation has been found not to be a fundamental prerequisite to facilitate client growth and

change (O'Hare, 1996; Shearer, 2003). It is recommended that providers and counselor educators engage in self-assessment of attitude of their thoughts and beliefs about mandated clients and their experience or non-experience with the mandated population.

Limitations and Areas of Future Research

Limitations exist in this study that should be considered in the interpretation of results. These limitations relate to the instrument and the sample used. As a descriptive study, the instrument utilized in the study was created specifically for this study. While steps were taken to review the validity of the instrument, its novelty increases the possibility that items were not representative of the attitudes and beliefs that anger management providers have concerning court mandated clients and treatment. Additionally, the instrument did not weight the importance of items. Thus, ratings of potentially less important areas may distort conclusions on the overall degree of training program preparation and attitudes of court mandated treatment in general.

The instrument's internal consistency may be of concern to the generalizability of the study. In particular, the APE scale indicated low reliability with a Cronbach's alpha coefficient of .25, which for the number of items ideally should have been between .5 and .7 (Pallant, 2010). Moreover, four items of the scale were negatively worded and needed to be reversed. This improved the Cronbach's alpha, however the internal consistency of the scale remained well below the recommended value for the number of items.

Sampling limitations

Related to sampling limitations, a relatively low percentage of the population surveyed completed the instrument, which may affect generalizability. Specifically, the low completion rate increases the risk of self-selection bias, the potential that differences may have existed

between the providers that completed the instrument and those that did not. On this issue, a few emails were received from individuals who indicated that they were not completing the study because they did not work with a court mandated population or that their work with the population was outdated. Others may have misunderstand the definition of *court mandated* since the terms *mandated treatment, coercion*, and *involuntary treatment* are often used interchangeably but may have dissimilar means in different context (Prendergast et al., 2002).

The sample for the survey was at first limited to members of the National Anger Management Association and the American Association of Anger Management, however due to survey response, the sample population was expanded to members of other therapy networks, anger management providing agencies across the U.S., and university forensic and counseling programs. Inconclusively, a majority of the survey participants may have been members of two anger management associations. However, results of the study would likely apply to anger management providers and mental health counselors.

Table 1

PEAM Scale Descriptives

Descriptive	Statistic	Standard Error
α	.83	
Mean	3.17	.05
Variance	.31	
SD	.56	
Range	3.00	
Skewness	-.81	.23
Kurtosis	1.11	.45

Table 2

TPP Scale Descriptives

Descriptive	Statistic	Standard Error
α	.90	
Mean	2.63	.09
Variance	.99	
SD	.99	
Range	4.00	
Skewness	-.42	.23
Kurtosis	-.46	.45

Table 3

APE Scale Descriptives

Descriptive	Statistic	Standard Error
α	.25	
Mean	2.58	.05
Variance	.28	
SD	.53	
Range	2.25	
Skewness	-.08	.228
Kurtosis	-.67	.45

REFERENCES FOR CHAPTER SIX

Akos, P., Goodnough, G. E., & Milsom, A. S. (2004). Preparing school counselors for group work. *The Journal for Specialists in Group Work, 29*, 127-136.

doi: 10.1080/01933920490275637

American Psychotherapy Association. (Spring, 2010). Court-referred clients: How to grow your private practice by partnering with the court system. *Annals of the American Psychotherapy Association*, 10-11.

Dwivedi, K., & Gupta, A. (2002). Keeping cool: Anger management through group work. *Support for Learning, 15*, 76-81.

Feder, L., & Dugan, L. (2002). A test of the efficacy of court mandated counseling for domestic violence offenders: The Broward experiment. *Justice Quarterly, 19*, 343-377.

Hex, S., Knox, S., & Hill, C. (2006). Teaching graduate trainees how to manage client anger: A comparison of three types of training. *Psychotherapy Research, 16*, 282-292.

doi: 10.1080/10503300500264838

Jongsma, A. E., Jr., & Peterson, L. M. (2006). *The complete adult psychotherapy treatment planner* (4th ed.). T. J. Bruce. (Ed.). Hoboken, NJ: John Wiley & Son.

Killacky, J., & Hulse-Killacky, D. (2004). Group work is not just for the group class anymore: Teaching generic group competency skills across the counselor education curriculum. *The Journal for Specialists in Group Work, 29*, 87-96. doi: 10.1080=01933920490275510

Lench, H. (2004). Anger management: Diagnostic differences and treatment implications. *Journal of Social and Clinical Psychology, 23*, 512-531.

O'Hare, T. (1996). Court-ordered versus voluntary clients: Problem differences and readiness to change. *Social Work, 41*, 417-422.

Prendergast, M. L., Farabee, D., Cartier, J., & Henkin, S. (2002). Involuntary treatment within a prison setting: Impact of psychosocial change during treatment. *Criminal Justice and Behavior, 29*, 5-26. doi: 10.1177/0093854802029001002

Reilly, P. M., & Shopshire, M. S. (2000). Anger management group treatment for cocaine dependence: Preliminary outcomes. *American Journal of Drug & Alcohol Abuse, 26*, 161-177. doi: 10.1081/ADA-100100598

Sandell,R., Lazar, A., Grant, J., Carlsson, J., Schubert, J., & Broberg, J. (2007). Therapist attitudes and patient outcomes: II. Therapist attitudes influence change during treatment. *Psychotherapy Research, 17*, 201-211. doi:10.1080/10503300600608439

Sharry, J., & Owens, C. (2000). 'The rules of engagement': A case study of a group with 'angry' adolescents. *Clinical Child Psychology and Psychiatry, 5*, 53–62.

Shearer, R. A. (2003). Court ordered counseling: An ethical minefield for psychotherapists. *Annuals of the American Psychotherapy Association.* Retrieved from http://www.questia.com/googleScholar.qst?docId=5002564929

Walker, A. J., Nott, M. T., Doyle, M., Onus, M., McCarthy,M., & Bugley, I. J. (2010). Effectiveness of a group anger management programme after severe traumatic brain injury. *Brain Injury, 24*, 517-524. doi: 10.3109/02699051003601721

Walker, J. & Bright, J. (2009). Cognitive therapy for violence: Reaching the parts that anger management doesn't reach. *The Journal of Forensic Psychiatry & Psychology, 20*, 174-201. doi: 10.1080/14789940701656832

Wampold, B. E. (2001). *The great psychotherapy debate. Models, methods, and findings.* Mahwah, NJ: Erlbaum.

Watson, A., Corrigan, P., & Angell, B. (2005). What motivates public support for legally mandated mental health treatment? *Social Work Research, 29*, 87-94.

Watt, B. D., & Howells, K. (1999). Skills training for aggression control: Evaluation of an anger management programme for violent offenders. *Legal and Criminological Psychology, 4*, 285-300.

REFERENCES

Akos, P., Goodnough, G. E., & Milsom, A. S. (2004). Preparing school counselors for group work. *The Journal for Specialists in Group Work, 29*, 127-136.

doi: 10.1080/01933920490275637

Algozzine, B. (n.d.). Tips for developing Likert rating scales. Retrieved from http://www.docstoc.com/docs/82510870/likerttips

American Psychotherapy Association. (Spring, 2010). Court-referred clients: How to grow your private practice by partnering with the court system. *Annals of the American Psychotherapy Association*, 10-11.

Bandalos, D. L., & Finney, S. J. (2010). Factor analysis: Exploratory and confirmatory. In G. R. Hancock & R. O. Mueller (Eds.), *The reviewer's guide to quantitative methods in the social sciences* (pp. 93-114). New York: Routledge.

Bartlett, M. S. (1954). A note on the multiplying factors for various chi square approximations. *Journal of the Royal Statistical Society, 16*, 296-298.

Beck, R., & Fernandez, E. (1998). Cognitive-behavioral therapy in the treatment of anger: A meta-analysis. *Cognitive Therapy and Research, 22*, 63-74.

doi: 10.1023/A: 1018763902991

Campbell, D., & Stanley, J. (1963). *Experimental and quasi experimental designs for research.* Chicago: Rand-McNally.

Caplan, A. (2006). Ethical issues surrounding forced, mandated, or coerced treatment. *Journal of Substance Abuse Treatment, 31*, 117-120. doi: 10.1016/j.jsat.2006.06.009

Carlson, J. (2010). Assessing therapists' attitudes toward patient anger. *Dissertation Abstractions International*, *71*, 2040B.

Carroll, J. (1991). Consent to mental health treatment: A theoretical analysis of coercion, freedom, and control. *Behavioral Sciences and the Law, 9*, 129-142.

Catell, R. B. (1966). The scree test for number of factors. *Multivariate Behavioral Research, 1*, 245-276.

Coll, K. M., Stewart, R. A., Morse, R., & Moe, A. (2010). The value of coordinated services with court-referred clients and their families: An outcome study. *Child Welfare, 89*, 61-79.

Creswell, J. W. (2009). *Research design: Qualitative, quantitative, and mixed methods approaches* (3rd ed.). Los Angeles: Sage.

Day, A., Tucker, K., & Howells, K. (2004). Coerced offender rehabilitation: A defensible practice? *Psychology, Crime & Law, 10*, 259-269.

doi: 10.1080/10683160410001662753

Daly, K. (2002). Restorative justice: The real story. *Punishment & Society, 4*, 55-79.

doi: 10.1177/14624740222228464

Dwivedi, K., & Gupta, A. (2002). Keeping cool: Anger management through group work. *Support for Learning, 15*, 76-81.

Egbert, S. C., Church, II, W. T., & Byrnes, E. (2006). Justice and treatment collaboration: A process evaluation of a drug court. *Best Practices in Mental Health: An International Journal, 2*, 74-90.

Feder, L., & Dugan, L. (2002). A test of the efficacy of court mandated counseling for domestic violence offenders: The Broward experiment. *Justice Quarterly, 19*, 343-377.

Goldkamp, J. R. (2000). The drug court response: Issues and implications for justice change. *Albany Law Review, 63*, 923-961.

Harvard Health Publications. (2006). Outpatient Commitment. *Harvard Mental Health Letters*: Present and Fellows of Harvard College.

Heppner, P. P., Wampold, B. E., & Kivlingham, D. M., Jr. (2008). *Research design in counseling* (3rd ed.). Belmont, CA: Thomson Brooks/Cole.

Hex, S., Knox, S., & Hill, C. (2006). Teaching graduate trainees how to manage client anger: A comparison of three types of training. *Psychotherapy Research, 16*, 282-292.

doi: 10.1080/10503300500264838

Jongsma, A. E., Jr., & Peterson, L. M. (2006). *The complete adult psychotherapy treatment planner* (4th ed.). T. J. Bruce. (Ed.). Hoboken, NJ: John Wiley & Son.

Kaiser, H. (1974). An index of factorial simplicity. *Psychometrika, 39*, 31-36.

Killacky, J., & Hulse-Killacky, D. (2004). Group work is not just for the group class anymore: Teaching generic group competency skills across the counselor education curriculum. *The Journal for Specialists in Group Work, 29*, 87-96.

doi: 10.1080=01933920490275510

Kiracofe, N., & Wells, L. (2007). Mandated disciplinary counseling on campus: Problems and possibilities. *Journal of Counseling and Development, 85*, 259-268.

Lanza, M. L. (2007). Modeling conflict resolution in group psychotherapy. *Journal of Group Psychotherapy, Psychodrama, & Sociometry,* 147-158.

Lench, H. (2004). Anger management: Diagnostic differences and treatment implications. *Journal of Social and Clinical Psychology, 23*, 512-531.

Miller, S., & Perelman, A. (2009). Mental health courts: An overview and redefinition of tasks and goals. *Law & Psychology Review, 33*, 113-123.

Naeem, F., Clarke, I., & Kingdon, D. (2009). A randomized controlled trial to assess an anger management group programme. *The Cognitive Behaviour Therapist, 2*, 20-31.

doi: 10.1017/S1754470X08000123

O'Hare, T. (1996). Court-ordered versus voluntary clients: Problem differences and readiness to change. *Social Work, 41*, 417-422.

Pallant, J. (2010). *SPSS Survival Manual* (4th ed.). New York: McGraw Hill.

Perron, B. (2007). A comparison in the quality of care among legally coerced and voluntary clients in outpatient substance abuse treatment programs. *BMC Psychiatry, 7*, 15. doi:10.1186/1471-244X-7-S1-P15

Pickover, S. (2010). Emotional skills-building curriculum. *Journal of Addictions & Offender Counseling, 31*, 52-58.

Prendergast, M. L., Farabee, D., Cartier, J., & Henkin, S. (2002). Involuntary treatment within a prison setting: Impact of psychosocial change during treatment. *Criminal Justice and Behavior, 29*, 5-26. doi: 10.1177/0093854802029001002

Reilly, P. M., & Shopshire, M. S. (2000). Anger management group treatment for cocaine dependence: Preliminary outcomes. *American Journal of Drug & Alcohol Abuse, 26*, 161-177. doi: 10.1081/ADA-100100598

Roffman, A. E. (2004). Is anger a thing to be managed? *Psychotherapy: Theory, Research, Practice, Training, 41*, 161-171. doi: 10.1037/0033-3204.41.2.161

Sandell, R., Lazar, A., Grant, J., Carlsson, J., Schubert, J., & Broberg, J. (2007). Therapist attitudes and patient outcomes: II. Therapist attitudes influence change during treatment. *Psychotherapy Research, 17*, 201-211. doi:10.1080/10503300600608439

Sharry, J., & Owens, C. (2000). 'The rules of engagement': A case study of a group with 'angry' adolescents. *Clinical Child Psychology and Psychiatry, 5*, 53–62.

Shearer, R. A. (2003). Court ordered counseling: An ethical minefield for psychotherapists. *Annuals of the American Psychotherapy Association.* Retrieved from http://www.questia.com/googleScholar.qst?docId=5002564929

Tiger, R. (2011). Drug courts and the logic of coerced treatment. *Sociological Forum, 26*, 169-182. doi: 10.1111/j.1573-7861.2010.01229.x

Viaro, E. (2010). Social worker attitudes toward court-mandated substance- abusing clients. *Journal of Social Work Practice in the Addictions, 10*, 81-98.

Walker, A. J., Nott, M. T., Doyle, M., Onus, M., McCarthy,M., & Bugley, I. J. (2010). Effectiveness of a group anger management programme after severe traumatic brain injury. *Brain Injury, 24*, 517-524. doi: 10.3109/02699051003601721

Walker, J., & Bright, J. (2009). Cognitive therapy for violence: Reaching the parts that anger management doesn't reach. *The Journal of Forensic Psychiatry & Psychology, 20*, 174-201. doi: 10.1080/14789940701656832

Wampold, B. E. (2001). *The great psychotherapy debate. Models, methods, and findings.* Mahwah, NJ: Erlbaum.

Watson, A., Corrigan, P., & Angell, B. (2005). What motivates public support for legally mandated mental health treatment? *Social Work Research, 29*, 87-94.

Watt, B. D., & Howells, K. (1999). Skills training for aggression control: Evaluation of an anger management programme for violent offenders. *Legal and Criminological Psychology, 4*, 285-300.

Appendix A

Survey Instrument

The purpose of this instrument is to examine providers' perception of court mandated anger management, provider training, and attitude toward court mandated treatment.

Section 1: Perceived Efficacy of Anger Management*

Rate the degree to which the anger management program you deliver is effective in the following areas:

1. Addresses the cognitive complexity of explosive, aggressive outbursts out of proportion with any precipitating stressors.

Neither Agree Nor Disagree	Strongly Disagree	Disagree	Agree	Strongly Agree
0	1	2	3	4

2. Decreases overall intensity and frequency of angry feelings.

Neither Agree Nor Disagree	Strongly Disagree	Disagree	Agree	Strongly Agree
0	1	2	3	4

3. Decreases the frequency of angry expressions, to include assaultive acts, destruction of property, over-reactive hostility, passive-aggressive behavior, disrespectful attitudes toward authority, swift and harsh judgmental statements, and abusive language to intimidate others.

Neither Agree Nor Disagree	Strongly Disagree	Disagree	Agree	Strongly Agree
0	1	2	3	4

4. Increases client capability of handling angry feelings in constructive ways that enhance daily functioning.

Neither Agree Nor Disagree	Strongly Disagree	Disagree	Agree	Strongly Agree
0	1	2	3	4

5. Increases self-awareness and acceptance of angry feelings while developing better control and more serenity.

Neither Agree Nor Disagree	Strongly Disagree	Disagree	Agree	Strongly Agree
0	1	2	3	4

6. Develops an awareness of current angry behaviors, clarifying origins of and alternatives to aggressive anger.

Neither Agree Nor Disagree	Strongly Disagree	Disagree	Agree	Strongly Agree
0	1	2	3	4

7. Increases respect for others and their feelings.

Neither Agree Nor Disagree	Strongly Disagree	Disagree	Agree	Strongly Agree
0	1	2	3	4

8. Assists client in identifying the positive consequences of managing anger.

Neither Agree Nor Disagree	Strongly Disagree	Disagree	Agree	Strongly Agree
0	1	2	3	4

9. Expands client's awareness of the negative effects that anger has on his/her health.

Neither Agree Nor Disagree	Strongly Disagree	Disagree	Agree	Strongly Agree
0	1	2	3	4

10. Teaches problem-solving and/or conflict resolution skills to manage interpersonal problems.

Neither Agree Nor Disagree	Strongly Disagree	Disagree	Agree	Strongly Agree
0	1	2	3	4

Section 2: Training Program Preparedness

Rate the degree to which you were prepared in your degree program to do the following:

11. Counsel mandated clients.

Neither Agree Nor Disagree	Strongly Disagree	Disagree	Agree	Strongly Agree
0	1	2	3	4

12. Counsel angry clients.

Neither Agree Nor Disagree	Strongly Disagree	Disagree	Agree	Strongly Agree
0	1	2	3	4

13. Counsel verbally or behaviorally aggressive clients.

Neither Agree Nor Disagree	Strongly Disagree	Disagree	Agree	Strongly Agree
0	1	2	3	4

14. Counsel resistant clients

Neither Agree Nor Disagree	Strongly Disagree	Disagree	Agree	Strongly Agree
0	1	2	3	4

15. Facilitate pycho-educational groups

Neither Agree Nor Disagree	Strongly Disagree	Disagree	Agree	Strongly Agree
0	1	2	3	4

16. Facilitate anger management group

Neither Agree Nor Disagree	Strongly Disagree	Disagree	Agree	Strongly Agree
0	1	2	3	4

17. Facilitate groups of offenders

Neither Agree Nor Disagree	Strongly Disagree	Disagree	Agree	Strongly Agree
0	1	2	3	4

Section 3: Attitude, Anger Management, and Mandated Clients

Rate the following statements based on your current thoughts, feelings, and beliefs about anger management treatment and court mandated clients:

18. Judges should mandated services.

Neither Agree Nor Disagree	Strongly Disagree	Disagree	Agree	Strongly Agree
0	1	2	3	4

19. Mandated clients are always resistant.

Neither Agree Nor Disagree	Strongly Disagree	Disagree	Agree	Strongly Agree
0	1	2	3	4

20. I feel comfortable counseling mandated clients.

Neither Agree Nor Disagree	Strongly Disagree	Disagree	Agree	Strongly Agree
0	1	2	3	4

21. There is a need for more research- based guidelines on how mental health providers should deliver anger management treatment to court mandated clients.

Neither Agree Nor Disagree	Strongly Disagree	Disagree	Agree	Strongly Agree
0	1	2	3	4

22. Court mandated counseling ensures greater compliance with treatment.

Neither Agree Nor Disagree	Strongly Disagree	Disagree	Agree	Strongly Agree
0	1	2	3	4

23. The potential of growth and change is less likely to occur with mandated clients than with voluntary clients.

Neither Agree Nor Disagree	Strongly Disagree	Disagree	Agree	Strongly Agree
0	1	2	3	4

24. Court mandated anger management treatment is a form of punishment.

Neither Agree Nor Disagree	Strongly Disagree	Disagree	Agree	Strongly Agree
0	1	2	3	4

25. Legal force or coercion to enter treatment is unethical.

Neither Agree Nor Disagree	Strongly Disagree	Disagree	Agree	Strongly Agree
0	1	2	3	4

Section 4: Demographic and Clinical Experience Information

Please provide a response to the following information:

26. Sex: Male or Female

27. Race/Ethnicity: American Indian or Alaska Native, Asian, Black or African American, Native Hawaiian or Other Pacific Islander, Hispanic or Latino, and White

28. Age

29. Highest degree held: high school diploma or less; two-year associate's degree; four-year bachelor's degree; master's degree; specialist's degree; doctoral degree; other, specify: _____.)

30. Number of years of clinical experience

31. Number of years of experience providing professional services to mandated clients

32. Credentials (certifications and licenses):

33. Areas of clinical expertise

34. Length (days, weeks, months) of anger management programs:

35. Anger Management service delivery type: individual, group, or both

Section 5: Additional Thoughts

Please provide any thoughts you have regarding providing anger management services to mandated clients:

VITA

Mary A. Sanderfer earned a Bachelor's of Art degree in Psychology in 2005 from the University of Louisville and a Master's degree in Community Counseling from Regent University in 2007. She is a National Certified Counselor (NCC) and is currently completing her residency requirements for licensure as a professional counselor. She specializes in counseling children and adolescents and play therapy.

Ms. Sanderfer has served as a counselor and supervisor in a variety of settings including a crisis center, day treatment agencies, alternative schools, and in-home counseling agencies. While attending Old Dominion University's Counseling Ph.D. program, she was awarded a Ph.D. assistantship. She has co-taught master's level counseling courses, and served as a supervisor to counseling students completing their practicum and internship field experience. In addition, she is a Golden Key scholar and member of Chi Sigma Iota international honor society.

Ms.Sanderfer has collaborated on and coordinated research and writing projects covering topics such as maternal anxiety and depression, children's attentional abilities, complementary, alternative, and integrative therapies, neurofeedback, and military connected children and families. In 2004, she was awarded the President for Research Undergraduate Research Grant. She has attended and presented at national conferences.