

Treating Conduct Disorder Using Cognitive-Behavioral Therapy for
Anger and Aggression in Children: A Case Study of a Male Juvenile Offender

An Empirically Supported Treatment Case Study
Submitted to the Faculty
of the Psychology Department

of

Washburn University

in partial fulfillment
of the requirements for

MASTER OF ARTS

Psychology Department

By

Jacie Harris

Topeka, Kansas

April 11, 2019

Thesis Approval
Department of Psychology
Washburn University
Topeka, Kansas

April 2019

I hereby recommend that the EST prepared under my supervision by

JACIE L. HARRIS

Entitled

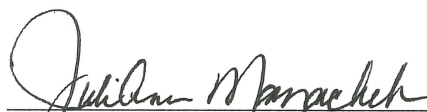
TREATING CONDUCT DISORDER USING COGNITIVE-BEHAVIORAL
THERAPY FOR ANGER AND AGGRESSION IN CHILDREN: A CASE STUDY OF
A MALE JUVENILE OFFENDER

be accepted in partial fulfillment for the

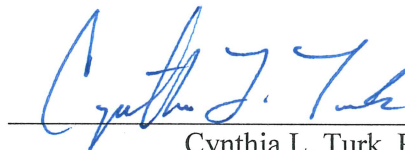
MASTER OF ARTS DEGREE



Dave Provorse, Ph.D.
Chair of the Thesis Committee

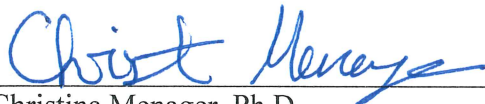


Julian Mazachek, Ph.D.
Vice President for Academic Affairs

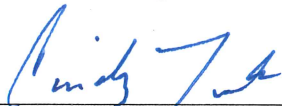


Cynthia L. Turk, Ph.D.
Head of the Department

Recommendation Concurred by



Christina Menager, Ph.D.



Cindy Turk, Ph.D.

Committee for the Thesis

Abstract

Conduct Disorder (CD) is often diagnosed in over half of males who are in correctional facilities (Teplin, Abraham, McClelland, Dulcan, & Mercial, 2002). Furthermore, CD has been found to increase rates of recidivism when left untreated (Underwood & Washington, 2016). However, empirically supported treatments for CD support the use of systemic therapies, which are not available in correctional facilities (Henggeler & Sheidow, 2012 & Mental Health Division, 2006). Due to this, anger and aggression have been identified as being important influential factors in learning how to effectively manage the symptoms of CD (Henwood et al., 2015 & Barkley, 2013). The present study used the Cognitive-Behavioral Therapy for Anger and Aggression in Children (CBT-AAC) treatment manual with a 15-year old African American male who was incarcerated in a juvenile correctional facility (Sukhodolsky & Scahill, 2012). Results indicated his levels of anger and aggression had decreased, after completing all ten weekly sessions, as he was receiving less Disciplinary Reports (DR) and Verbal Reprimands (VR). The present study did have some limitations, including: the offender's involvement in an anger management group during treatment and his opposition when completing the assessments. A discussion of the strengths and weaknesses of the present case study are also provided.

Treating Conduct Disorder Using Cognitive-Behavioral Therapy for Anger and Aggression in Children: A Case Study of a Male Juvenile Offender

For the past decade, mental health diagnoses are found to be more prevalent among children and adolescents in juvenile detention facilities compared to the general population (Burke, Mulvey, & Schubert, 2015; Fazel, Doll, & Langstrom, 2008; Gottsman & Schwarz, 2011; Teplin, Abram, McClelland, Dulcan, & Merial, 2002). Teplin et al. (2002) reported approximately two thirds of males and three quarters of females housed in juvenile correctional facilities meet criteria for at least one psychiatric disorder. Fazel et al. (2008) reported juveniles in correctional facilities are up to 10 times more likely to receive at least one diagnosis when compared to their non-incarcerated counterparts. Across a number of studies, the most common diagnoses for juvenile offenders include 21.3% with anxiety disorders (i.e., panic disorder, separation anxiety disorder, generalized anxiety disorder, and obsessive compulsive disorder), between 3% to 20% with affective disorders (i.e., major depression, dysthymia, manic episodes), 41% to 53% with disruptive behavior disorders (i.e., attention deficit/hyperactivity disorder, oppositional defiant disorder, and conduct disorder), and 51% with substance use disorders (i.e., alcohol use disorder, marijuana use disorder, and other substance use disorder) (Fazel et al., 2008; Teplin et al., 2002; Underwood & Washington, 2016).

Closer examination of this research reveals the most common disorders for males in juvenile detention centers are substance use disorders and disruptive behavior disorders (Grisso, 2008; Fazel et al., 2008; Teplin et al., 2002), with conduct disorder (one of the disruptive behavior disorders) having been estimated to occur slightly more frequently than substance use disorders (Fazel et al., 2008; Underwood, Phillips, von Dresner, & Knight, 2006). A meta-analysis of the epidemiological research on incarcerated youth suggests up to

52.8% of males in juvenile detention centers meet criteria for conduct disorder (Fazel et al., 2008). Given the high prevalence of incarcerated youth who meet criteria for conduct disorder, application of empirically-supported treatment for conduct disorder will be the focus of the present case study.

Conduct Disorder

According to the DSM-5 (APA, 2013), conduct disorder is diagnosed when an individual exhibits a repetitive and persistent disregard for social norms and rules when interacting with other people and displays a disregard for the rights of others. Symptoms are categorized into the four different categories of aggression to people and animals, destruction to property, deceitfulness and theft, and serious violations of rules. To meet criteria for conduct disorder, an individual must display at least three of the total 15 symptoms in the past 12 months, with at least one of the symptoms continuing to be present in the past six months.

The DSM-5 also stipulates the diagnosing clinician clarify the three different specifiers of age of onset, symptom severity, and limited prosocial emotions when a diagnosis of conduct disorder is given (APA, 2013). Age of onset is categorized into three different specifiers: childhood (prior to 10 years old), adolescent (no symptoms prior to age 10), and unspecified (age of onset is unclear). Severity of symptoms are classified as mild, moderate, or severe. As elaborated by Sakai et al. (2016), the limited prosocial emotions specifier can be classified into four different domains: lack of remorse or guilt, callous and lacks empathy, unconcerned about performance, and shallow or deficient affect.

Correlational research designs have identified disruptive behavior disorders, including conduct disorder, to be the strongest predictors for a juvenile offender to violently reoffend (Aebi, Barra, Steinhausen, Walitza, & Plattner, 2016). Furthermore, Barkley (2013) has

suggested juveniles with conduct disorder are more likely to develop antisocial behavior qualities in adulthood. Juvenile offenders who exhibit an elevated level of conduct disorder are more likely than children and adolescents without records to continue to offend when they become adults (Byrd, Loeber, & Pardini, 2012; Fisher et al., 2014).

Systemic Therapies for Treating Conduct Disorder. Knowing conduct disorder serves as a predictor of reoffending for juvenile youth, and patterns of criminal behavior established in adolescence are likely to continue into adulthood, it becomes imperative to identify mental health treatments to disrupt the pattern of reoffending. Using empirical studies to identify specific treatments to provide incarcerated youth with strategies they can employ to more effectively manage conduct disorder-related symptoms would promote rehabilitation and reduce recidivism (Fazel et al., 2008; Henwood, Chou, & Browne, 2015; Underwood et al., 2006; Underwood & Washington, 2016).

This author's review of literature found much of the treatment research has focused on the use of different forms of systems therapy, which generally requires the active participation of members of the child or adolescent's family (Henggeler & Sheidow, 2012; Underwood & Washington, 2016). Systems-based therapy approaches have been shown to lead to improvements in the offender's behavior within the community following release (Henggeler & Sheidow; Mental Health Division, 2006; Underwood & Washington). Effective system-based therapies include multi-systemic therapy, functional family therapy, brief strategic family therapy, and multidimensional treatment foster care (Henggeler & Sheidow; Mental Health Division, 2006; Underwood & Washington). The foundation for the effectiveness of such systems-based treatments is based on the premise that if one can improve a juvenile's family

functioning, it will cause improvements in the juvenile's peer, school, and community relationships as well (Henggeler & Sheidow).

While the range of systemic treatments are effective when therapy is able to work with the individual in conjunction with members of their families and/or parents, the reliance upon family involvement becomes a major limitation when attempting to help juvenile offenders residing in detention centers. The inability to involve detention center-based juvenile offender's family members creates a problem when attempting to implement these treatments. Due to the importance of offenders receiving treatment while incarcerated and the lack of ability to involve offender's family members, research efforts have shifted to developing treatments that can be delivered as individual therapy, absent family involvement.

Individual Therapy for Treating Conduct Disorder. The shift from family-focused therapies to individual therapy has included utilizing interventions focused on addressing anger. Symptoms of conduct disorder tend to be associated with persistent anger and the aggressive behaviors associated with anger (Henwood et al., 2015; Sukhodolsky, Kassinove, & Gorman, 2004; Ozabaci, 2011). Therapies targeting the persistent anger associated with conduct disorder purport feelings of anger simmer beneath the surface and increase in intensity—eventually manifesting as disruptive behavior (Sukholdosky & Scahill, 2012).

Previous research has demonstrated individuals who have been diagnosed with any mental health disorder, including conduct disorder, are significantly more likely to experience state and trait anger when compared to the general population (Schamborg, Tully, & Browne, 2016). Anger has been defined in the literature as “an emotional state consisting of feelings varying in intensity, from mild irritation or annoyance to intense fury and rage” (Speilberg, Jacobs, Russell, & Crane, 1983, p.16). Deffenbacher (2011) theorized anger appears to be

similar to other unpleasant emotions individuals experience because it is often a product of a combination of an emotional arousal, physiological arousal, and cognitive components.

Aggression. Aggression has been defined as a behavior one uses to cause harm on another individual or their property (Howells, Daffern, & Day, 2008). Although anger is not necessarily expressed as physical aggression, aggression is one common way the emotion of anger is expressed (Deffenbacher, 2011; Henwood et al., 2015). Deffenbacher (2011) offers several guidelines for understanding the relationship between anger and aggression. First, aggression is described as the result or action carried out when the individual intends to show extreme dissatisfaction. Second, aggression can look different in different people, circumstances, or situations. Third, when anger is mild in nature, individuals typically have the ability to manage their anger with a prosocial response. However, when the anger becomes too strong to manage, the aggressive impulses tend to become more dysfunctional and violent in nature.

Specific to conduct disorder, physical aggression and verbal aggression have been found to frequently coexist (Barkley, 2013). Due to the individual's aggressive behavioral response to anger provoking situations, the individual is likely to use verbal aggression in an attempt to hurt another person's feelings (e.g., "I hate you," "You are stupid,"). Verbal aggression often leads to an escalation of the situation and causes the individual with conduct disorder to react using some form of physical aggression, which makes them more likely to harm another individual or their property (Barkley, 2013; Deffenbacher, 2011).

Research has suggested using cognitive-behavioral anger-based treatments may be effective at helping juvenile offenders learn to manage their anger more effectively (Henwood et al., 2015; Underwood et al., 2006; Underwood & Washington, 2016). Meta-analyses

assessing the effectiveness of aggression focused CBT have found anger-focused therapies are often just as effective as any other type of psychotherapy for treating children and adolescents with conduct or other behavioral disorders (Ozabaci, 2011; Sukhodolsky, 2004). The improvements garnered from cognitive-behavioral therapies include improvement in problem solving skills, increased delay in initiating aggressive responses, and learning nonaggressive responsive strategies (Underwood & Washington, 2016; Ozabaci, 2011; Sukhodolsky et al., 2004; Henwood et al., 2015). Furthermore, research has indicated reduced rates of recidivism when juvenile offenders are taught CBT skills to effectively manage their anger and aggression (Henwood et al., 2015).

Theoretical Model

The case study described here was designed to assess the effects of treating a juvenile offender with the treatment strategies described as *Cognitive-Behavioral Therapy for Anger and Aggression in Children and Adolescents* (CBT-AAC) created by Sukhodolsky and Scahill (2012). CBT-AAC utilizes Lazarus' (1981 & 1990) multi-modal treatment approach, which dates back to 1981 and was created in an attempt to teach individuals coping skills and increase their self-efficacy in being able to manage their distressing emotions. The multi-modal approach for CBT-AAC integrates three foundational models: behavioral or learning model, social cognitive model, and emotional arousal model. Using these three models allows therapists to assess different perspectives and a variety of possible causes for an individual's aggressive behavior. Not only do the models have different perspectives, but each model also proposes using different approaches to manage an individual's aggressive behavior. Consideration of different models reflecting different perspectives provides a variety of ways to understand and manage aggressive behavior. This multi-modal approach allows therapists to

simultaneously apply multiple models and approaches, which provides the individual with more therapy skills and tools to be able to manage their symptoms effectively.

Behavioral or Learning Model

The behavioral or learning model describes aggression as being related to the three classic theories of learning: classical conditioning, operant conditioning, and observational learning. Sukhodolsky and Scahill propose (2012) classical conditioning occurs for aggressive behaviors when a conditioned stimulus such as a parent, sibling, or schoolmate becomes associated with the unconditioned stimulus of being threatened, with aggressive behaviors serving as both the unconditioned and conditioned response. Through associated learning, the unconditioned response, perceiving threat, becomes associated with aggressive behaviors and can become paired with a vast array of new stimuli, which leads the individual to react with the same aggressive behaviors in a large number of situations where they feel threatened.

Aggression reflects aspects of operant conditioning via the theoretical construct of negative reinforcement whereby the reduction of uncomfortable feelings and/or the removal or elimination of unwanted demands following an aggressive action serves to reward the aggressive action, thereby increasing the likelihood of that individual employing aggressive behaviors in future situations. When an individual responds with an aggressive behavior in a threatening situation and the threat ceases to exist, the individual learns aggressive behaviors can be used to decrease unwanted threats.

Lastly, observational learning influences how individuals not only learn about aggressive behavior and the consequences of aggressive behavior through direct experience, but also through indirect experiences and observing other's behavior. More specifically, individuals can learn to express aggressive behavior to decrease unwanted threats through: 1)

direct observational learning where they observe others acting aggressively; 2) modeling the behavior of respected authority figures or role models who act aggressively; and 3) vicarious reinforcement where they observe others securing respect or admiration or more tangible rewards such as material possessions after acting aggressively. Common across all three behavioral and learning models is an emphasis on how aggression stems from the specific situational experiences, which evoke a specific, learned reaction (Sukhodolsky & Scahill, 2012).

Based on the child's childhood behavioral learning, CBT-AAC aims to teach the child new ways of responding to previously conditioned situations and experiences (Sukhodolsky & Scahill, 2012). Using a model Lazarus labeled the "firing order," therapists can teach the juvenile to identify the sequence of cognitive-emotional-behavioral events preceding the expression of an aggressive behavior. This sequencing can be used to identify the transition points between the elements, which become the most obvious places to employ interventions. The therapist's task is to first help the client develop the self-awareness that allows for recognition of the recurring sequence that is likely to culminate in a physically aggressive act at an earlier point; and second to help the client develop skills which can be used to disrupt the predictable sequence. Eventually, through this combination of self-awareness and skill implementation, the individual becomes capable of disrupting, diverting or even ceasing their aggressive response. Another important element of CBT-AAC is the development of more adaptive social skills, which eventually replace previously learned aggressive behaviors with more socially acceptable behaviors (Sukhodolsky & Scahill, 2012).

Social Cognitive Model

Sukhodolsky and Scahill's (2012) CBT-AAC approach also employs aspects of the social-cognitive model, which is an outgrowth of social learning theory (Bandura, 1978). Within the social cognitive model, two factors have been identified to influence an individual's behavior (Luszczynska & Schwarzer, 2005). First, when an individual has higher self-efficacy and believes in one's ability to control anger, aggressive behavioral reactions become less likely to occur. This first premise suggests that the common assumption that aggressive behavior is the result of a need to dominate or control others may be misguided. Rather, the aggression serves the purpose of masking or counteracting a sense of inferiority, low self-esteem, or underdeveloped self-efficacy. Second, when an individual can reliably predict more negative and longer-term consequences associated with anger-induced aggressive behaviors, those types of behavior are less likely to be employed (Luszczynska & Schwarzer, 2005). The social cognitive model also provides a conceptual framework within which the problematic situations where the intensity of the emotion of anger disrupts the ability to adopt a more logical and rational perspective, which then inhibits the ability to view their situation in more objective terms, can be understood (Sukhodolsky & Scahill, 2012). The imbedded and ingrained distortions and dysfunctional thinking tend to encourage an individual to process an event through a distorted lens, which can lead individuals to over-react and use aggressive behaviors (Sukhodolsky & Scahill, 2012). Therefore, treatment must focus on modifying these dysfunctional distortions in thinking, toward the goal of replacing them with more adaptive thoughts and attributions.

CBT-AAC uses social problem-solving interventions in an attempt to teach individuals how to use more prosocial ways of reacting to a situation (Sukhodolsky & Scahill, 2012). The motivating factor for change within the social cognitive theory is the individual taking a

personal sense of control over their struggles with anger and aggression, as well as their ability to react to anger in a more adaptive and prosocial way (Luszcynska & Schwarzer, 2005).

Furthermore, one's ability to anticipate possible consequences when completing an action can have a positive influence on the individual's future behavior (Luszcynska & Schwarzer).

Emotional Arousal Model

The emotional arousal model builds on the notion that when an individual becomes physiologically aroused, they are likely to interpret their angry feelings as more intense, and therefore more serious, which promotes the expression of physical aggression (Sukhodolsky & Scahill, 2012). Deffenbacher (2011) further developed the model by suggesting the presence of a triggering event, which often cues the individual's physiological arousal. These triggers can be due to external stimuli such as peers or authority figures, internal stimuli such as physiological cues or cognitive distortions, or a combination of both. This conceptualization suggests when an individual becomes aroused, if they appraise their physiological arousal as more threatening, then they are more likely to become physically violent or act out their aggression. In other words, the individual's immediate reaction or cognition about their emotional-physiological state exerts a strong influence on their behavioral reaction. Research has revealed children who display more aggressive behaviors tend to show higher levels of physiological arousal when they are provoked in any way, and the level of physiological arousal is predictive of the severity of the subsequent violent action (Lochman, Whidby, & Fitzgerald, 2000).

Based on the emotional-arousal model, CBT-AAC begins by teaching specific skills to help individuals first notice their physiological arousal, and then to assess their cognitions and arousal in more objective terms. Taking a moment to intentionally recognize and consciously

contemplate their physiological arousal creates a buffer, which may allow individuals to more objectively appraise the situation and consider other non-aggressive behavioral alternatives (Sukhodolsky & Scahill, 2012). Therefore, this moment of conscious contemplation creates the opportunity to disrupt the connection between the situational trigger and what had evolved into an unmitigated and seemingly instinctual and automatic physically aggressive response. Furthermore, CBT-AAC involves teaching children relaxation skills in an attempt to help them target their physiological arousal and reduce the feelings associated with their anger before they act out using aggressive behaviors (Sukhodolsky & Scahill).

Working Model of Anger

When working from a multi-modal approach of understanding anger, there are some overlapping and similar concepts across the theoretical explanations. CBT-AAC poses a specific pattern of thoughts, feelings, and behaviors likely to occur when an individual experiences an anger-provoking trigger. According to the cognitive model (Beck, 2011), all underlying disturbances are due to some underlying dysfunctional thinking. When a situation or experience occurs, typically some constellations of thoughts that are associated with each trigger are present, which are frequently based off of previous learning and experiences. The sequence of environmental triggers followed by cognitions often creates a rather predictable sequence of reactions within the individual, which typically involves feelings of anger. The feelings then tend to predict specific aggressive behavioral actions and outcomes (Deffenbacher, 2011; Sukhodolsky & Scahill, 2012).

A rather unique element of CBT-AAC is the emphasis on how the individual appraises the situation based on the *intensity* of the trigger and feelings associated with it, along with

what they have learned during their past experiences (Deffenbacher, 2011; Sukhodolsky & Scahill, 2012). Lazarus's (1991) appraisal model identifies how different emotions are elicited and expressed based on how an individual chooses to understand or explain an event. Based on one's explanatory cognitions, motivations, and the triggers preceding an event, an individual appraises the situation and reacts accordingly. When the individual uses a behavioral theory-based primary appraisal approach, they assess whether the situation is benign, threatening, or irrelevant; as well as a social cognitive-based secondary appraisal approach when they assess whether or not they have the resources to cope with a specific situation. Lazarus' model illuminates how an individual appraises an event, not only based on the severity, but also based on whether the individual has the resources and self-efficacy needed to react in socially acceptable ways. In situations where it is not deemed possible, the person defaults to engaging in aggressive behavior.

The final theoretical component underlying CBT-AAC is an expansion of Lazarus' model. With Deffenbacher (2011) proposing how an individual appraises a situation is often delegated by their pre-anger state. The pre-anger state is influenced by what the individual may be experiencing or what their physiological arousal is in the moment right before they become aware of feelings of anger. The more anger experienced in the pre-anger state, the more likely an individual is to react in an aggressive manner (Sukhodolsky & Scahill, 2012; Deffenbacher). Many different aspects of the individual's life may effect pre-anger appraisals, including: importance of the situation and possible consequences to one's well-being (Schmidt, Tinti, & Levine, 2010). Lastly, the individual makes a behavioral choice about how to respond to the situation, typically using a conditioned or learned response (Sukhodolsky & Scahill). The

intersection between the individual's triggering event, pre-anger state, and appraisal of the triggering event is what creates the aggression response (Deffenbacher, 2011).

Treatment Overview

CBT-AAC has been evaluated through a number of empirical studies. As it is currently being promoted, CBT-AAC is a three-part treatment, which involves anger management training, development of problem solving skills, and social skills training (Sukhodolsky & Scahill, 2012). Each module is used to teach individuals' different skills and tools to manage and react to their anger and aggressive impulses in more socially acceptable ways (Sukhodolsky & Scahill, 2012). CBT-AAC has demonstrated efficacy across a variety of samples, including: youth rated as highly aggressive by teachers, youth with disruptive behaviors, youth with anger-related problems in schools, and youth with Tourette's Syndrome who exhibit disruptive behaviors (Lochman, Barry, & Pardini, 2003; Sukhodolsky et al., 2009; Sukhodolsky, Golub, Stone, & Orban, 2005; Sukhodolsky, Solomon, & Perine, 2000).

Anger Management

The first module within CBT-AAC therapy is anger management, which is used to educate the adolescent about what anger is, learn relaxation skills to use when physiological arousal is experienced, and employ emotion regulation strategies (Sukhodolsky & Scahill, 2012). These skills provide the initial foundation for helping individuals learn to control their anger more effectively. Only after anger is understood by identifying the factors which contribute to the sequence of events leading up to an aggressive action is therapy able to move forward and focus on how to implement more prosocial behaviors in the future (Sukhodolsky & Scahill). This strategy for developing anger management skills has been found to be an effective way to help individuals begin to more objectively assess, and eventually control, their

anger (Sukhodolsky & Scahill; Sukhodolsky, Kassinove, & Gorman, 2004; Sukhodolsky et al., 2000).

The anger management strategies used in the first module of CBT-AAC include: 1) teaching individuals how to stop and think before responding; 2) preventing exposure to anger-provoking situations; and 3) using a combination of distraction, verbal responses or cues, and relaxation training (i.e., deep breathing and progressive muscle relaxation). The ultimate goal of these strategies is to provide the individual with skills to help them manage their feelings of anger *before* these feelings result in them acting in an aggressive manner (Sukhodolsky & Scahill, 2012).

Problem Solving

The second module within CBT-AAC is used to teach individuals problem-solving skills. The problem-solving portion of therapy addresses dysfunctional cognitions (e.g., “Others are trying to hurt me,” “Everyone is out to get me,” “I have to protect myself”), which may contribute to an individual’s aggressive reaction when they experience anger (Sukhodolsky & Scahill, 2012). Problem solving skills are taught by helping individuals identify the link between their thoughts, emotions and problematic behaviors, and how these links disrupt adaptive growth. More specifically, the abilities to generate possible nonaggressive solutions to identified problems and to objectively evaluate the possible consequences associated with different actions are precluded (Sukhodolsky & Scahill). The problem-solving module of treatment is designed to help individuals redefine their typical responses to feelings of anger as the problem and to recognize how the anger is preventing them from achieving their personal goals. By first identifying anger related behaviors as a problem, the individual is then able to assess different situations likely to cause them to feel angry and create new responses to the

associated feelings of anger. By thinking through and assessing potential outcomes of different responses, individuals are able to choose a response associated with a more self-enhancing outcome.

Previous research has documented the therapeutic effectiveness of teaching problem solving skills (Hudley & Graham, 1993; Kazdin, Seigel, & Bass, 1992; Sukhodolsky et al., 2005). More specifically, when assessed as a stand-alone treatment, researchers found problem-solving skills to be relatively effective when used to correct an individual's hostile attribution bias (Sukhodolsky et al., 2005).

Social Skills

Social skills training is the third module within CBT-AAC and builds on the anger management/emotion-regulation and problem solving modules which precede it (Sukhodolsky & Scahill). The social skills training portion of therapy uses modeling, role-playing, and corrective feedback to reinforce individuals for performing socially acceptable behaviors (Merrel & Gimpel, 1998; Spence, 2003). Implementation of social skills training has been shown to improve individual's abilities to control their anger by employing proactive and intentional strategies for resolving conflicts in non-aggressive ways (Sukhodolsky & Scahill). When previously acquired problem-solving strategies are combined with social skills training, even greater improvements in anger-control have been reported (Sukhodolsky et al., 2005).

Although social skills training has demonstrated efficacy for individuals with conduct problems when used in isolation, research indicates an individual who has severe aggression or conduct problems is likely to show more significant improvements when using social skills training in conjunction with other treatment methods (Sukhodolsky & Scahill, 2012). Research has shown using social skills, anger management, and problem solving skills trainings in a

concurrent fashion when treating individuals with conduct disorder enhances the promotion of adaptive changes (Sukhodolsky & Scahill; Sukhodolsky et al., 2005; Lochman & Wells, 2004; Lochman, Wells, & Lenhart, 2008).

Presenting Problem and Relevant History

Demographics and Psychosocial History

The offender is a 15-year-old African American male, currently incarcerated at a juvenile correctional facility. He is currently incarcerated for Aggravated Robbery and Attempted Aggravated Robbery, which he engaged in with his brother, and had resided at the facility for approximately two months when treatment began. His original sentence was 24 months with 6 months of aftercare, without considering any accumulation of “good time.” He is currently attending high school classes at the facility, although he has had multiple school problems due to displays of disrespect to teachers, inability to follow rules, and distracting other students in class.

The offender reported his parents are not married, and he was removed from his biological mother’s custody at a very young age due to her drug use and possible neglect. The offender’s biological parents’ parental rights have been terminated due to their inability to appropriately care for him and his siblings. He reported being in foster care with various placements for about two years before going to live with his grandparents. He described his grandparents as being supportive and reported he still has some contact with his mother. In regards to the offender’s father, the offender reported he has had sporadic contact with his father due to his father’s involvement in crime and being incarcerated. The offender reported he has had some contact with his siblings, although it has been inconsistent. It is assumed the

offender's family was lower in socioeconomic status. Throughout his life, the offender indicated he has made friends easily. He also reported all of his friends are involved with the legal system. He also reported having witnessed community or gang violence. When asked how this affected him, the offender denied the experiences having had any negative impact on his life.

During his initial diagnostic interview, the offender reported having been receiving mental health services since he was approximately five years old. He recalled receiving individual therapy to work on skills related to his anger and aggression, as well as receiving services to manage his psychiatric medications. According to records, the offender had been previously prescribed Seroquel and Adderall. Records also indicated the offender had been previously hospitalized due to his aggression and homicidal ideation., although the offender reported not being able to recall being hospitalized.

The offender reported using substances prior to his incarceration. He reportedly he began using marijuana around the age of 10 and has used the substance daily since he was 13 years old. Around the age of 11, the offender reportedly began using Xanax and began using it every other day until the age of 13. He reported symptoms consistent with cannabis use disorder and sedative, hypnotic, or anxiolytic use disorder, including: using first thing in the morning, experiencing cravings, increased tolerance, continued use despite problems caused by the use, and using during dangerous times. The offender also appeared to exhibit psychosocial problems related to his use, as he reported increased family arguments due to his use, testing positive for substances during community corrections, and attending school while under the influence.

Due to his incarceration, the offender was administered The Shipley Institute of Living Scale 2 (Shipley 2). This measure provides a brief measure of two aspects of cognition: crystallized knowledge and fluid reasoning. Scores on the Shipley 2 provide an estimate of the offender's current level of intellectual functioning. The offender's score of an 85 indicates his overall functioning is likely in the Low Average Range. Furthermore, the offender was administered an academic achievement test by his school. His academic achievement testing indicated he performed at a 5th grade reading level. Due to his scores on the intellectual and academic assessments, the offender was not referred for more comprehensive IQ testing.

Presenting Problem

The offender requested a behavioral health visit while he was placed in restrictive housing due to a physical altercation. At this time, he was seen by behavioral health staff to assess possible interventions from which he may benefit. The offender reported his psychiatric medications, Seroquel and Adderall, were decreased upon his entrance into the facility and were no longer helping him manage his symptoms of anxiety and anger. The psychiatrist had switched his medication upon his entrance into the facility and he was only taking Buspirone, 10 mg twice daily, at the time of this initial visit. During the initial visit with the therapist for treatment, he reported experiencing feelings of anger all the time, which he felt were uncontrollable. Reportedly, his struggles to effectively manage his anger markedly increased after the loss of his grandmother approximately two years ago. The offender described his anxiety as consisting of racing thoughts, which make it difficult for him to fall asleep at night. However, he denied knowing what he worried about and reported not feeling nervous at all.

Upon the conclusion of this initial visit, the offender was informed his medications would not be increased and he would be scheduled to see the psychiatrist within the next couple

weeks. The offender asked what other mental health services he could benefit from to help him manage his feelings of anger. In response to this request, this therapist provided psychoeducation on the use of CBT-AAC for adolescents struggling with anger and aggression. The offender agreed to participate in individual therapy and also provided formal informed consent to serve as the focus of the present case study.

Observations

The offender presented for treatment and was compliant and willing to work with the therapist. He reported willingness and motivation to complete interventions while in session. During the pretreatment assessment, his affect appeared flat and incongruent with his mood, as he often avoided eye contact and was reluctant to share personal information. As sessions progressed, his affect appeared more euthymic and mood congruent, as he would talk more often and for longer periods, make appropriate eye contact, and share personal information. He appeared open and honest throughout the assessments, as he would often admit to violent and criminal behaviors and his thoughts about harming others. Initially, the offender reported not wanting to complete homework outside of session. To gather compliance, the therapist offered incentives, pieces of candy or a bag of chips, for the offender completing his homework and he completed his homework before entering each session.

The offender reported symptoms consistent with anger control and anxiety in the pretreatment assessment. He reported feeling angry most of the day, nearly every day, which was evidenced in his previous physical altercations with other peers while at the facility. The offender did not appear to be angered during sessions and would often present with an appropriate range of affect. As for his anxiety, the offender reported experiencing racing thoughts that were uncontrollable at night, when he was trying to fall asleep. However, he not

only denied knowing what he worried about, he reported the worries did not interfere with anything in his life, aside from his sleep.

The offender showed some evidence of hyperactivity and inattention while in session, as he often fidgeted in his seat and looked around the room. He would regularly attempt to adjust the chair in the room and would attempt to remove the headrest. When redirected, he would often laugh and ask the therapist if she knew how to fix the chair. Often times, the offender would stand up and walk to the sink to wash his hands, grab a tissue, or look in the mirror. He would remain engaged and answer questions while moving around the room and appeared unconcerned that he had been instructed to remain seated throughout the session.

The offender showed some behaviors consistent with defiance during the pretreatment assessment and individual therapy sessions. During the pretreatment assessment, he would often complain about how long the assessment was taking and ask “Are we almost done yet?” The offender reported not liking to read and asked to have the items on the self-report assessment questionnaires read aloud to him. The therapist determined this would be appropriate as the offender was often times uncertain about the meanings of words included in the questionnaire items. The offender was resistant to this therapist’s attempts to teach and practice relaxation techniques, reporting they had not worked for him in the past. In fact, during the first two sessions, he refused to even initiate attempts to practice relaxation strategies. Only after this therapist provided him with an incentive, chips and candy, for completing relaxation strategies during the third session and as his homework did the offender comply and practiced the strategy over the next week.

Assessment

Diagnostic Measures

Mini International Neuropsychiatric Interview for Children and Adolescents

(MINI-KID). The MINI-KID (Appendix A) was created by Sheehan et al. in 1998. The MINI-KID is a standardized diagnostic interview designed to identify nine different mental health disorders a child or adolescent may be experiencing. The MINI-KID can be completed in approximately 30 minutes and the items are derived directly from DSM-5 criteria for each disorder (Duncan et al., 2017). The MINI-KID uses 25 diagnostic screening questions to identify nine psychological disorders commonly found in children and adolescents. Each screening question is initially answered using a forced choice “yes” or “no” response option. When one of the screening questions is answered affirmatively, the examiner pursues a more thorough investigation of the additional criteria for the disorder indicated. The more extensive investigation is not pursued when the examinee fails to endorse a screening question.

Once a screening question is endorsed, the examiner proceeds to administer the disorder specific subsections. Within each disorder specific subsection, questions are organized in a sequential, pre-determined order. If the examinee answers “no” to one of the earlier items in the subsection, the subsection is discontinued. After administering each disorder specific section, the examiner is asked to indicate whether the individual is likely to meet criteria for each specific DSM-5 diagnosis. To fully confirm a specific diagnosis, the MINI-KID instructs the clinician to reference the DSM-5 before officially assigning a diagnosis to the examinee.

The MINI-KID is normed for children ages 6 to 17 based on findings from two large-scale standardization samples (Duncan et al., 2017; Sheehan et al., 2010). Sheehan et al. assessed 231 American youth and Duncan et al. assessed 238 American youth. Both studies included youth identified as currently receiving mental health services and a comparison sample of youth from the general population. Test-retest reliability was assessed by

administering the MINI-KID initially and again 7 to 14 days after the initial administration. The range of test-retest reliability coefficients across the nine different diagnostic categories was reported to fall between $r = .33$ to $.79$), with the average test-retest reliability being $r = .52$ (Duncan et al.). Sheehan et al. examined test-retest reliabilities by assessing client's one to five days after the initial administration, a reported a range of test-retest reliabilities from $r = .41$ to 1.00 across the nine categories, with the average test-retest reliability being $r = .69$ and $r = .85$ for conduct disorder specifically. Sheehan et al. reported interrater reliability for identifying the presence of conduct disorder to be $k = 1.00$.

Assessments of convergent validity between the MINI-KID, the Brief Child and Family Phone Interview (BCFPI), and the Schedule for Affective Disorders and Schizophrenia for School Aged Children-Present and Lifetime Version (K-SADS-PL), which are used to diagnose children and adolescents in clinical settings, produced encouraging results (Duncan et al., 2017; Sheehan et al., 2010). More specifically, the MINI-KID has been shown to agree with the BCFPI, ranging from $r = .29$ to $r = .93$ (average $r = .62$) for the comparable subscales on the youth version and $r = .58$ for conduct disorder specifically (Duncan et al.). When compared to the K-SADS-PL convergent validity was found to be $k = .57$ for all behavior disorders and $k = .55$ for conduct disorder specifically.

In the present case study, the MINI-KID modules for ODD and CD were administered during the pretreatment assessment. These two modules were used to assess for an accurate diagnosis of CD, as compared to the differential diagnosis of ODD. After an accurate CD diagnosis was confirmed, the client was considered fit for completing the present case study.

Minnesota Multiphasic Personality Inventory-Adolescents (MMPI-A). The MMPI-A (Appendix B) was originally created and tested by Butcher et al. in 1992. The MMPI-A was

created by adapting the original MMPI for adults, created by Hathway and McKinley (1943), to become more language friendly for adolescents, to identify and assess adolescent relevant scales, and to be more representative of the adolescent population (Graham, 2012). The MMPI-A is designed to assess personality characteristics an adolescent may be experiencing (e.g., anxiety, depression, obsessiveness, self-esteem, etc.). The MMPI-A was used in the present study to gather information on the client's feelings of anger, aggressive behaviors, and symptoms consistent with conduct disorder. The standardization sample collected for the original creation of the MMPI-A was based on 1,620 adolescents (805 boys and 815 females) ranging in age from 14 to 18 years old. The wording of the MMPI-A reflects a fifth grade reading level, and the full test takes approximately one hour to complete.

The MMPI-A consists of 478 items, which are answered using a two-alternative, forced-choice response format. Clients receive a booklet, which provides the questions in written form, and they are asked to read each question and assign their answer of "True" or "False" by marking the answer sheet provided. When scoring, each of the items loads onto one or more of the ten clinical scales, the five PSY-5 scales, and a variety of other subscales (e.g., alcohol use, immaturity, introversion, etc.). For the purposes of the current case study, the content subscales of Anger (17 items), Conduct Problems (23 items), and Cynicism (23 items), as well as the PSY-5 scales of Aggressiveness and Disconstraint were specifically examined. The online scoring program, Q-Local, was used to score the MMPI-A. A cut-off t-score of 65 was used to warrant interpretation of each of the relevant subscales. Higher t-scores indicate the presence of higher levels of the dysfunctional personality trait being examined (e.g., anger, aggressiveness, conduct problems, etc.).

Previous research has established adequate internal consistency and temporal stability of the content subscales and PSY-5 scales used in the present study. When assessing internal reliability with an all-male clinical sample, Cronbach's alpha was found to be .75 for the Anger subscale, .74 for the Conduct Problems subscale, and .78 for the Cynicism subscale. Cronbach's alpha for the PSY-5 scales was found to be .79 for the Aggressiveness subscale and .74 for the Disconstraint subscale (Ben-Porath, Graham, Archer, Tellegen, & Kaemmer, 2006). To assess temporal stability, Stein, McClinton, & Graham (1998) re-administered the MMPI-A one week after the initial administration (short-term) and one year after the initial administration (long-term). Temporal stability for the short-term and long-term was found to be $r = .72$ and $.45$ for the Anger subscale, $.62$ and $.55$ for the Conduct Problems subscale, and $.73$ and $.51$ for the Cynicism subscale. Temporal stability was also assessed for the PSY-5 scales one year after the initial administration, and was reported as $r = .57$ for Aggressiveness and $.68$ for Disconstraint (Stein et al., 1998).

Convergent and divergent validity were assessed by Arita and Baer (1998) for the content subscales of Conduct Problems and Anger. The Conduct Problems subscale produced moderate but statistically significant correlations with the Trait Anger subscale ($r = .44$) of the State-Trait Anger Expression Inventory (STAXI), the Externalizing ($r = .57$), Delinquent Behavior ($r = .56$), and Aggressive ($r = .48$) subscales of the Youth Self-Report (YSR), and the Physiological Anxiety subscale ($r = .36$) of the Revised Children's Manifest Anxiety Scale (RCMAS). Divergent validity was assessed and weak correlations were found between the MMPI-A Conduct Problems subscale and the Reynolds Adolescent Depression Inventory (RADSI) ($r = .01$), the Anxiety-Depression subscale of the YSR ($r = .04$), and the Low-Energy Level subscale of the MDI ($r = -.07$).

Convergent validity for the Anger subscale of the MMPI-A was established through moderate but statistically significant positively correlations with the Irritability subscale ($r = .52$) of the Multiscore Depression Inventory (MDI), the Trait Anger subscale ($r = .59$) of the STAXI, the Externalizing ($r = .57$), Delinquent Behavior ($r = .37$), and Aggressive ($r = .62$) subscales of the YSR, and the Physiological Anxiety subscale ($r = .37$) of the RCMAS. When assessing divergent validity of the Anger subscale, weak correlations were found with the Low-Energy Level subscale ($r = -.03$) and the Irritability subscale ($r = .06$) of the MDI and with the Withdrawn subscale ($r = .07$) of the YSR. Overall, the Conduct Problems and Anger MMPI-A content subscales were markedly more strongly correlated with measures of externalizing behaviors in contrast to measures of internalizing behaviors, which produced weak correlations. Based on the current literature review, the content subscale of Cynicism and the PSY-5 subscales have not been adequately researched when assessing convergent and divergent validity.

To determine the validity of the MMPI-A, there are six validity scales designed to assess the veracity of the overall pattern of responses provided by an examinee on the MMPI-A. The Variable Response Inconsistency Scale (VRIN) is used to determine random response patterns, with T scores of 75 or more considered invalid. The True Response Inconsistency Scale (TRIN) was created to identify when individuals are answering without reading the question content and identifies a response bias toward either primarily “True” or primarily “False” responses, with a T score above 65 again considered invalid. The “Cannot Say” validity subscale is used to determine excessive numbers of items the client did not answer; if more than 10 items on this validity scale are omitted the assessment is considered invalid. On the Infrequency subscale, which is designed to assess for the over-reporting of symptoms, T scores

of 75 or more are considered invalid. The L and K scales are used to identify if the examinee responded to questions in a defensive manner, with T-scores of 65 or higher on the L or K scales are also considered invalid (Graham, 2012).

The MMPI-A was used during the pretreatment assessment to gather information on the client's feelings of anger, aggressive behaviors, and symptoms consistent with conduct disorder. Not only will the MMPI-A allow for the therapist to assess the client's scores on the relevant content subscales and PSY-5 scales, the therapist will also be able to examine the validity scales to determine the general test-taking attitude adopted by the client when responding to the MMPI-A items.

Behavior Assessment System for Children-2, Teacher Rating Scale for Adolescents (BASC-2 TRS-A). The BASC-2 TRS-A (Appendix C) will be used to assess the client's symptoms of aggression and conduct disorder within school and classroom settings. The BASC-2 TRS-A is important to include in the present study, as it provides valuable, objective data from the adolescent's teacher, which allowed this therapist to assess the client's risk for emotional and behavioral problems while the client is in school. The BASC-2 TRS-A was created by Reynolds and Kamphaus in 2004. The BASC-2 TRS-A is comprised of 139 items, and takes about 30 minutes to complete. Following factor analytic examination of how the items cluster, the 139 items produce scores on 15 different subscales. The 15 subscales are then combined to produce scores for five composite areas, including: externalizing problems, internalizing problems, school problems, behavioral symptoms index, and adaptive skills. For the purposes of the current study, the focus was on the subscales of Conduct Problems and Aggression, both of which fall under the Externalizing Problems composite score for the BASC-2 TRS-A.

The Conduct Problems subscale has been found to assess the tendency of individuals to behave in ways, which are considered to be antisocial and represent rule breaking and violations of common standards for age-appropriate behavior. The Conduct Problems subscale is derived by summing responses across 12 items, and includes items such as “breaks the rules,” disobeys,“ and “steals at school.” The Aggression subscale has been found to assess the tendency of individuals to act out using physically or verbally aggressive behaviors, which often times pose a threat to others. The Aggression subscale is derived by summing the responses to 10 items, and includes items such as “loses temper to easily, ”defies teachers,” and “threatens to hurt others.” All items on the BASC-2 TRS-A are answered using a frequency-based format; with each level of response options assigned a numerical value for the purposes of scoring (i.e., Always = 3, Often = 2, Sometimes = 1, Never = 0). Client’s scores are summed and then converted into T-Scores based on the tables from the *Behavior Assessment for Children: Second Edition Manual* (Reynolds & Kamphaus, 2004). T-Scores are then categorized along a continuum of severity or risk, with scores from 20 to 58 considered “average” or not-at-risk, and scores from 59 to 68 designated “at risk.” Scores between 69 and 120 on the clinical profile are considered clinically significant. The scoring of the BASC-2 TSR-A provides information on both a clinical profile, which assesses the clinically relevant subscales, and an adaptive profile, which assesses the client’s level of adaptive skills. For the purpose of the present case study, only the clinical profile was utilized.

Reynolds and Kamphaus (2004) collected psychometric data on the BASC-2 TRS-A measure using 1,800 teachers from across the United States. Boys and girls each made up 50% of the norms sample and teachers answered questions on children they had worked directly with ranging from ages 12-18. Composite score internal consistencies reported are quite

favorable, with Cronbach's alphas ranging from .91 to .97 for all four composite areas. More specifically, alphas of .96 to .97 have been reported for the Externalizing Problems composite. Test-retest reliability was assessed having teachers fill out the BASC-2 TRS-A again 8 to 65 days after the baseline administration. Coefficients across all five composites were strong, with alphas ranging from .87 to .91. Test-retest reliability for the Externalizing Problems composite was .91. Interrater reliability was acceptable across the five composites (ranging from $r = 0.55$ to .70), with the Externalizing Problems composite producing an $r = 0.66$.

Divergent validity for the Externalizing Problems composite was determined via intercorrelations calculated between it and the other four composite indices of the BASC-2-TRS. The intercorrelation with the Internalizing Problems Index was moderate in strength and reported to lie between $r = .44$ to .51). The intercorrelation with the Adaptive Skills Index was also of moderate strength but of an inverse direction with $r = -.54$ to -.56. The intercorrelation with the School Problems Index was stronger and in the range of $r = .66$ to .70), A strong, positive intercorrelation was found between the Externalizing Problems Index and the Behavioral Symptoms Index of $r = .86$ to .87.

Convergent validity was found by comparing the BASC-2 TSR-A to other similar measures. Comparisons between the various subscales from the Achenbach System of Empirically Based Assessment (ASEBA) Caregiver-Teacher Report form and the Externalizing Problems Index from the BASC-2 TSR-A, correlations across subscales ranged from $r = .75$ to .85. The Conners' Teacher Rating Scale-Revised was also used to assess convergent validity with the scale total score producing a correlation of $r = .78$ with the Externalizing Problems Index. The Conduct Problems and Aggression subscales from the BASC-2 TSR-A were also compared to each subscale within the ASEBA Caregiver-Teacher report form and the Conners'

Teacher Rating Scale-Revised. Conduct Problems was found to show favorable correlations with the ASEBA Caregiver-Teacher report form subscales for Rule-Breaking Behavior ($r = .83$) and Conduct Problems ($r = .76$), and with the Conners' Teacher Rating Scale-Revised Oppositional subscale ($r = .70$). The Aggression subscale was found to show a correlation with the ASEBA Caregiver-Teacher report form subscale of Aggressive Behavior ($r = .70$) and the Conners' Teacher Rating Scale-Revised Oppositional Subscale ($r = .94$).

The BASC-2 TRS-A provides objective evidence as to the client's behavior in the classroom, specifically aggression and conduct problems. The BASC-2 TRS-A shows acceptable reliability and validity and is considered to be an exceptional measure of adolescent's behavior in school when a teacher is present to complete the assessment. For the purpose of the present study, the BASC-2 TRS-A was used during the pretreatment and post-treatment assessments of the client. Having pre- and post-treatment data collected from the BASC-2 TRS-A allowed the therapist to determine how the client's conduct problems and anger were being expressed within the closely monitored and structured classroom setting. Information gleaned from the BASC-2 TRS-A was also useful therapeutically as it provided insights into possible anger-provoking triggers evident in the school setting. Comparisons of pre- to post-treatment ratings from the BASC-2 TRS-A allowed for objective measurement of outcomes indicating the client's successful implementation of treatment strategies to manage their conduct problems and anger within the school setting.

Progress on Treatment Goals

Disruptive Behavior Rating Scale (DBRS). The DBRS was created by Barkley in 1997. is an eight-item scale used to assess for the DSM-IV criteria of oppositional defiant disorder (ODD) (Appendix D). The DBRS has been used in previous CBT-AAC studies in

order to assess the symptoms related to the child's diagnosis that are relating to their anger and aggressive behaviors (Sukhodolsky & Scahill, 2012). The DBRS is a parent-rated scale where the parent responds to each question using a 4-point Likert scale. Each question asks about a different behavior and scores are assigned based on the frequency of each behavior throughout the past week. Scores range from 0 to 3 (0= rarely or never, 1= sometimes, 2= often, and 3= very often). Summing scores across all eight items produces total scale scores ranging from 0 to 24. Previous research has indicated scores of 12 or higher on the DBRS are considered clinically significant (Barkley, Edwards, Laneri, Fletcher, & Metevia, 2001). The internal consistency of the items on the DBRS has been found to range from alpha = .86 to .93 (Gomez, Burns, & Walsh, 2008). Psychometric information regarding convergent and divergent validity for the DBRS has not been published to date. The juvenile offender's unit core corrections officer was tasked with completing the DBRS, as they are responsible for the care of the offender and are most commonly interacting with the offender within the unit. Following the CBT-AAC treatment protocol, the DBRS will be completed during the pre-treatment and post-treatment assessments. The DBRS will be used to assess the child's behavior while they are on their living unit within the corrections complex, and can serve as a comparison to rating collected in the classroom.

Clinical Anger Scale (CAS). Unlike other measures used to assess anger, the CAS (Appendix E) was created in an attempt to distinguish clinical-level, and therefore more distressing or problematic anger, from minimal or average amounts of anger. Snell, Gum, Shuck, Mosley, and Hite (1995) created the first, and only, version of the CAS. The CAS is comprised of 21 sets of four related statements. Participants are asked to select the statement which best reflects what they typically experience (e.g., item 1; A = I do not feel angry, B = I

feel angry, C = I am angry most of the time now, D=I am so angry all of the time I can't stand it). A 4-point Likert scale is used to assign a numerical score to each item, with A = 0, B = 1, C = 2, and D = 3. Questions answered as D are considered to be the most clinically relevant. A total scale score is computed by summing scored responses, a range of possible scores from 0 to 63, with higher scores representing more clinical anger. Snell et al. have suggested total scores reflect different levels of impairment due to anger, including: 0 to 13 as minimal clinical anger, 14 to 19 as mild clinical anger, 20 to 28 as moderate clinical anger, and 29 to 63 as severe clinical anger (1995).

Snell et al. (1995) assessed the psychometric properties of the CAS using six different samples of participants from 1986 to 1991. Participants ranged from 21 to 24 years of age and consisted of 326 males, 804 females, and 40 participants who did not specify their gender. When assessing internal consistency, Cronbach's alpha was found to be .95 for men, .92 for women, and .94 overall. Test-retest reliability over a three-week time period was assessed and found to be .85 for males only, .77 for females only, and .78 for males and females together. Convergent validity was assessed and supported via a positive correlation with the STAS measure of state anger ($r = .56$ for the first sample to $r = .61$ for a second sample), and the STAS measure of trait anger ($r = .55$ for both samples). Divergent validity is evidenced by low to moderate correlations found between the CAS and the Anger Expression Scale (subscale coefficients ranging from $r = .23$ to $r = .45$), the Symptom Checklist 90-Revised (subscale coefficients ranging from $r = .30$ to $r = .68$), and Eysneck's Neuroticism subscale ($r = .28$). Given the CAS has been shown to be responsive to small fluctuations in anger, it was used to track the level of anger experienced by the client across the course of the present case study, and was administered during each individual therapy session.

Subjective and Objective Measures. Additional measures were also administered on a weekly basis to obtain more subjectively global assessments of the client's anger and aggression during weekly sessions (Appendix F). This subjective and objective measure contained four questions with each question assessed individually. Questions asked in the weekly measure are intended to directly monitor the client's mood over the past week by asking how often the client felt feelings of anger; how many times he acted out in an aggressive manner; and how many disciplinary reports (DRs) and verbal reprimands (VRs) he received over the past week. Client's was asked to rate his mood on a 7-point scale where 1 = not experiencing anger at all and 7 = experiencing anger at an intolerable level. All other questions were answered using the exact number of times the instances occurred over the past week. Once identified, the salience of the client's specific anger triggers were also be assessed during weekly measures. For these, the client responded using a 7-point rating scale, with 1 = never experiencing the trigger over the past week, and 7 = experiencing the trigger more than once a day almost every day during the past week.

Using subjective and objective measures during each session allowed the therapist to gain an understanding of how the client's experience of anger and aggression changed throughout treatment. Understanding how anger and aggression change from the client's own perspective, as well as based on the reported incidences, allowed the therapist to more accurately identify anger-related patterns the client experienced, and to gauge how he was benefitting from treatment on a weekly basis.

Diagnostic Assessment Results and Interpretation.

The therapist administered the MINI-KID modules for ODD and CD, MMPI-A, BASC-2 TRS-A, and DBRS to obtain information relevant to making an accurate diagnosis of CD,

offender's personality characteristics important for treatment, teacher's experience with the offender in school, and the corrections officer's experience while working with the offender.

MINI-KID. During the administration of the MINI-KID modules for ODD and CD, the offender reported he often experiences five symptoms consistent with ODD, including: losing his temper, being angry and resentful toward others, arguing with adults, refusing to follow rules, and being vengeful to others. The offender reported twelve criteria consistent with CD, including: bullying or threatening others, having fights with others, using a weapon to hurt others, hurting someone on purpose, has stolen things using force, destroying things that belong to others on purpose, breaking into someone's car, lying to get what he wants from other people, stealing items worth money, staying out later than allowed by parents, running away from home, and skipping school before the age of 13. Reportedly, offender's behaviors began causing problems for him at school, at home, and with his family around the age of 9.

Therefore, criteria were met for diagnoses of both ODD and CD. However a diagnosis of CD was deemed more appropriate due to the offender displaying behaviors more severe in nature and which are not associated with a diagnosis of ODD, including: more aggression toward other people, destruction of property, and a pattern of theft or deceit. This is evidenced by the offender reporting he starts fights and hurts others on purpose, destroys other's property on purpose, breaks into cars and homes, steals items worth money, and has frequently lied to get what he wants.

MMPI-A. After the interpretation of the MMPI-A content scales, the offender reported scores within the high end of the average range for the Anger (T=64) and Cynicism (T= 60) subscales. Both scores were found to be higher than his scores on the other content scales, with the exceptions being the Anxiety (T= 69) and School Problems (T=65) subscales. With the

Anger and Cynicism subscales being higher than many of the other subscales, this could indicate the offender still shows personality characteristics in these areas. This is evidenced by the offender's answers for the subscales, including: at times he feels like swearing and smashing things, easily becomes impatient with others, and is often called hotheaded by others for the Anger subscale. For the Cynicism subscale, he reported most people will use unfair means to get what they want, the way he does things is often misunderstood by others, and when people leave valuables unattended they are just as much to blame as the person who stole it. Answers reported by the offender, although not in the cut-off range, are still higher than other subscales and identify important features of his personality.

The offender reported a score well above the $T = 65$ cut-off range indicating strong endorsement of items that contribute to the Conduct Problems subscale ($T = 75$), and this score represents his highest score on the content scales. The offender reported personality characteristics consistent with those who experience conduct problems, including having done bad things he does not tell other people about, it has been impossible to not steal things at times, finding it easy to make other people afraid of him, and having ran away from home. High scores on the Conduct Problems subscale have been found to indicate an increased number of significant behavioral problems, which tend to be more clinically severe, including: lying, stealing, being disrespectful, having a troubled group of friends, taunting others, being entertained by criminal activity, taking advantage of others, and being involved in criminal activities they cannot tell others about (Graham, 2012).

The offender endorsed items that produced a moderate elevation for the PSY-5 subscale of Aggressiveness ($T = 65$), and a very high elevation on the Disconstraint ($T = 94$) subscale. In particular, the high scores on the Aggressiveness PSY-5 scale are interpreted as a person who is

verbally and physically aggressive, may enjoy intimidating and controlling others, has a history of behavioral problems in school, and may have histories of arrest. High scores on the Disconstraint PSY-5 scale are interpreted as a person who is impulsive and lacks self-control, seeks out excitement and takes risks, histories of school problems and arrests, and often have histories of substance abuse problems. Both of the interpretations for these scales have been found to be consistent with the experiences of the offender.

BASC-2 TRS-A. Offender's teacher completed the BASC-2 TRS-A to allow for the therapist to assess the offender's behavior while in a classroom setting. For the purpose of the present case study, the Externalizing Problems Composite was assessed, including the scales of Aggression and Conduct Problems. During the pretreatment assessments, the offender's teacher reported concerns regarding Externalizing Problems that were in the Clinically Significant range (T=89, 99%). The teacher also reported the offender had high levels of Aggression that were in the Clinically Significant range (T=78, 97%), including always losing his temper too easily, often annoying others on purpose, often defying his teachers, and often arguing when denied his way. The offender's teacher also endorsed Conduct Problems in the Clinically Significant range (T=81, 98%) at pre-testing, including always using foul language, often breaking the rules, often getting into trouble, and often disobeying.

DBRS. The offender's correction officer completed the DBRS prior to the first session of treatment. To enhance consistency, the core corrections officer on the offender's living unit was chosen to complete the DBRS assessment. At pretesting, the offender's behavior on the living unit was rated as a 4, indicating his anger on his living unit has not been evident to his corrections officer. The corrections officer provided only mild endorsement that the offender sometimes argued with adults, actively refused to comply with requests, was angry or resentful,

and was spiteful or vindictive. Reportedly, the offender's behavior had been improving over the past week and a half before the DBRS was administered.

DSM-5 Diagnoses

- F91.1 Conduct Disorder, Childhood-onset Type (primary)
- F12.20 Cannabis Use Disorder, Moderate
- F13.20 Sedative, Hypnotic, or Anxiolytic Use Disorder, Moderate
- F90.2 Attention-Deficit/Hyperactivity Disorder, Combined Presentation (provisional)

For the purpose of the present case study, the offender's diagnosis of Conduct Disorder was the primary focus of the interventions provided to him. The offender was also given a provisional diagnosis of ADHD, combined presentation due to interactions with him in session, as he was often impulsive and inattentive. He appeared to struggle when needing to remain seated and was easily distracted by other stimuli, including other chairs and noises outside of the room. Due to the inability to confirm ADHD symptoms meeting DSM-5 criteria before the age of 12, this diagnosis was not able to be confirmed. However, it should be considered if information is able to be gathered from his relatives or school teachers.

The offender also met criteria for two substance use disorders upon his entrance into the facility. The therapist agrees with these diagnoses, although the concerns regarding his drug use were not a factor during his time in the facility and were not a focus of the current treatment. The youth was referred for substance abuse treatment, which will be completed by a substance abuse counselor.

Case Conceptualization

The offender is a 15-year-old male, who is currently incarcerated at a juvenile corrections complex. He presented for individual therapy after being involved in two physical

altercations within the juvenile corrections complex. The offender reported having difficulties controlling his anger and feeling as if he was angry most of the day, nearly every day. The offender's anger can be understood using the three theories of anger previously discussed (Luszczyńska & Schwarzer, 2005; Beck, 2011; Sukhodolsky & Scahill, 2012). Additionally, the offender's pre-anger state and appraisals were also determined to be consistent with Deffenbacher's (2011) model and help explain his anger and frequent use of aggression.

When using the behavioral or learning model of anger, the use of aggression is due to the previously learned or conditioned responses the individual has used to cope with and decrease their stress associated with their anger. Several factors of behavioral learning may explain the offender's frequent aggressive behaviors. First, the offender has evidenced use of classical conditioning principals to explain his use of physical and verbal aggression. According to Sukhodolsky and Scahill (2012), it is likely the offender has previously learned when a threat is present he has no other option than to use aggression. Due to the offender's young age when he began using aggression to decrease threats, the strength of this relationship has become automatic for him. Over time the number of stimuli that serve as triggers for anger and aggressive acts has expanded through generalization. Second, operant conditioning has been evidenced due to the offender being negatively reinforced through his use of aggression. Research has indicated when an individual continues to use aggression to decrease threats, they are reinforced by the elimination of the presence of the threat (Sukhodolsky & Scahill). This is evident in the offender, as he reported having no other option than aggression when wanting to cease the presence of a threat. For example, in his past, as well as in the facility, the offender often started physical altercations with perceived threatening peers. The offender was able to show his strength and no longer felt threatened by his peer. As shown, the reinforcement

received by the offender has caused him to continue using aggression, even when it began causing other problems. Lastly, observational learning may explain the importance of aggression to the offender. It is likely the offender learned to use aggression from his peers. He reported his peers often engage in illegal behavior such as burglary along with him. Vicarious reinforcement may also be evidenced here as the offender may have begun using aggressive behaviors after watching other people benefit from having acted aggressively, such as obtaining material possessions via burglary.

When using the social cognitive model to explain the offender's aggression, the offender reported a low perceived ability to control his anger and, although he was able to predict short-term consequences, he was unable to predict the how those and other consequences would impact him longer term. Due to this distorted thinking, the offender may view his aggressive behaviors through a distorted lens. This lens is likely to make aggressive behaviors appear more beneficial than they actually are. This is evidenced in the offender, as he often reported wanting to fight others on his unit to show his strength although he was unable to recognize that fighting one person only caused more consequences in the long-term. Understanding the limitations this serves for the client, research indicates using CBT methods to increase the offender's ability to control his anger and predict accurate consequences could be beneficial in helping him reduce his use of aggressive behaviors.

The emotional arousal model of anger may explain the offender's use of aggressive behaviors as being related to his level of physiological responses. The offender reported small instances of annoyance as being likely to cause him to get into a physical altercation with another offender. Due to this, the offender may experience small triggers at a larger level and perceive them as more serious. Viewing minor situations as more serious becomes problematic

when the offender begins to experience an increased number of physiological responses, which make him more likely to react using aggressive behaviors. Awareness of physiological responses and triggers were assessed throughout treatment, in an attempt to increase the offender's ability to cope with his experiences before becoming aggressive.

Lastly, the offender reported experiencing anger throughout most of the day, nearly every day. This becomes problematic when addressing his physical aggression, as research suggests one's pre-anger state often influences their ability to appraise and react to situations appropriately (Deffenbacher, 2011; Sukhodolsky & Scahill, 2012). If the offender's pre-anger state is consistently high, the offender may report more primary appraisals suggesting minor events are always threatening, and if his secondary appraisal determines he has the resources to become physically aggressive with his peer, research suggests he may be much more likely to react to minor events using physical aggression (Deffenbacher; Sukhodolsky & Scahill). As previously mentioned, using treatment to address physiological, cognitive, and behavioral components of anger will attempt to address and decrease the offender's pre-anger state and alter his appraisals of events.

Treatment Plan

The therapist and offender met for a treatment planning session prior to the beginning of treatment. When asked to identify specific goals he would like to accomplish, he reported he wanted to "not feel angry all the time." With the help of the therapist, the offender was able to create of goal of: (1) Improving his ability to effectively cope with feelings of anger and rage in a prosocial manner, and (2) improving his interpersonal skills.

Problem: symptoms of anger and associated aggressive behaviors

Goal 1: Improve ability to effectively cope with feelings of anger and rage in a prosocial manner.

Objective 1: Youth will identify two specific negative thoughts attributing to his anger.

Objective 2: Youth will demonstrate having learned CBT-strategies to increase his awareness of anger-provoking triggers by applying them on 2 occasions outside of session.

Objective 3: Youth will demonstrate having learned problem-solving skills by describing in session multiple ways of approaching problematic situations he encounters outside of sessions.

Goal 2: Youth will improve his interpersonal skills.

Objective 1: Youth will demonstrate having learned skills designed to de-escalate situations by describing in session how he implemented prosocial assertive behaviors outside of sessions.

Objective 2: Youth will develop a coping template for coping with provocations and accusations from peers and others.

Objective 3: Youth will develop a coping template for coping with conflicts with adults

Objective 4: Youth will demonstrate having learned how to effectively manage conflicts with adults by describing in session interactions with authority figures that occurred outside of session in which he applied the coping template

Course of Treatment

The offender attended two pretreatment assessment sessions to complete the MMPI-A and the MINI-KID. He then attended 10 weekly individual therapy sessions to begin working on anger management, problem solving, and social skills training. The offender never missed a session and completed his homework for each session. Each sessions began with the offender completing the CAS. Next, the therapist and offender would review his homework and complete the four items of the weekly subjective and objective measure. Then, the therapist would educate the offender on the skills being discussed in the session and teach him the appropriate skills. The therapist and offender would complete the handouts and practice the skills learned in session. Role-plays were used when opportunities were presented to practice the offender's verbal skills when interacting with his teachers. Lastly, homework was assigned at the end of each session. A more detailed session-by-session overview can be found in Appendix J.

Evaluation of Treatment Outcomes

Module Performance

The offender responded well to the anger management module. Specifically, the offender reported using progressive muscle relaxation to manage the tension in his arms and fists when he became angry. Additionally, the offender reported using verbal reminders to remind himself of the goals he was trying to reach, including not wanting to lose good time and wanting to reach his levels. Lastly, he was able to use distraction effectively when he became angry, as he would attempt to engage in an activity he found pleasurable when he began to experience the physiological arousal and cognitions that were precursors to escalation of his anger. When asked near the end of treatment, the offender reported using these strategies more now than in the past.

During the problem-solving module, the offender identified the problem he was experiencing and was able to effectively evaluate different consequences for his actions. The offender reported these skills have been helpful for him when he was dealing with peer provocations on his unit. He reported caring more about the consequences of his actions near the end of treatment than he had at the outset. By thinking about consequences before acting, the offender was able to manage his anger responses and choose actions leading to positive outcomes.

The offender experienced some difficulties during the social skills module. Specifically, the offender struggled to apply the skills when he became angry with an authority figure. He often would react aggressively toward his teachers. The aggression often included cursing, yelling, and interrupting them. The offender most often got in trouble for being disrespectful in class. The therapist helped the offender identify the problem with his teacher and generate multiple solutions to dealing with his teacher when he became angry. The therapist also attempted to help the offender manage his anger in the school setting by role-playing how he could speak to his teacher and how she might respond. While the offender reported in session he had tried to use the skills practiced in session when talking to his teacher, it is unclear how effectively he performed the skills.

Outcome Assessment Results and Interpretation

BASC-2 TRS-A. During the post-treatment assessments, the offender's same teacher completed the BASC-2 TRS-A a second time. The teacher reported concerns regarding Externalizing Problems that were in the Clinically Significant range (T=108, 99%). His teacher reported concerns regarding Aggression in the Clinically Significant range (T=105, 99%), including annoying others on purpose, loses temper too easily, teasing others, and arguing

when denied his own way. Conduct Problems were also endorsed in the Clinically Significant range at post-testing (T=109, 99%) including breaks the rules, deceives others, sneaks around, lies, and using foul language.

When comparing the pre- and post-treatment assessment scores, the teacher indicated more significant symptoms during the post-treatment assessment phase on all subscales derived from the BASC-2 TSR-A. One possible explanation for this could be the amount of time the teacher had spent with the offender. During the pretreatment assessment, the offender had been attending school for less than a month, whereas the offender had been attending school for over 10 weeks at the post-treatment assessment phase. Due to the teacher having experienced limited interactions at the pretreatment assessment phase, she may have underestimated the frequency and severity of the offender's behavior. By the time post-testing occurred, the teacher was likely able to provide a more accurate report of the offender's behavior in the school setting. Also, given the offender acknowledged continued difficulty when interacting with authority figures throughout treatment, the increases in disruptive behavior reported by the teacher may be an accurate representation of his behavior in the school setting.

DBRS. The last assessment given during the pretreatment and post-treatment assessments was the, DBRS. The DBRS was completed again during the post-treatment assessment. Due to the offender being on a different unit, a different corrections officer completed the assessment. This difference could have affected the interrater reliability of the measure. The offender's score during the post-treatment assessment was a 3, which again indicates his anger on the unit has not been evident to the corrections officer. The officer reported the offender sometimes argues with adults, actively defies or refuses to comply with

requests or rules, and blames others for his mistakes or misbehavior. When compared to the pretreatment assessment, the offender's score on the DBRS remained consistently low.

The difference in scores on the BASC-2 TRS-A and DBRS may be explained by the differing roles and interactions of the corrections officer and teacher with the offender. The offender's teacher often asked him to complete assignments in school and behave appropriately in the classroom with other offenders. On the other hand, the corrections officer typically allowed him to choose what activity he wanted to do on his unit (i.e., play cards, watch TV, shower), as well as he is allowed to interact with the other offenders on his unit. Due to this, the offender's teacher is likely to witness more of the offender's defiant behaviors.

CAS. The CAS measure was given during the beginning of each session. The weekly scores are shown in Appendix G. The offender's initial CAS score was a 39, which indicates the offender's anger was in the severe clinical range. Throughout sessions, the offender's score ranged from 35 to 61. The offender's final CAS score was a 53, which indicates the offender's anger was in the severe clinical range at the end of treatment. Based on the CAS score, the offender's anger became more clinically significant at the end of treatment, when compared to the beginning. However, the CAS scores should be considered with caution. The offender began completing the measure much more quickly as sessions progressed. When asked in the eighth session, the offender reported he was no longer reading the statements because he "already knew what they said." The offender was encouraged to read the statements, although it is unclear if he fully read and carefully considered each statement to provide a valid rating of his experience of anger.

Subjective and Objective Measure. The subjective and objective measure was used to ask the offender about his experience of anger throughout the past week. The offender's weekly

responses can be seen in Appendix H. During the first session, the offender reported he experienced anger at a 5, indicating he experienced anger much of the day almost every day. Across the ten treatment sessions, the offender's score on the 1 to 7 scale, ranged from 4 to 7. At the final session, the offender reported he experienced anger at a 4, indicating he experienced anger at least once a day on most days. This indicates a small decrease in the offender's experience of anger from the beginning to the end of treatment.

The second subjective and objective question asked about the offender's use of aggressive behaviors. Across the ten treatment sessions, his score increased from a 2 to a 3, which indicates he was using one more aggressive behavior per week at the end of treatment than at the beginning. As for DRs and VRs, the offender received only two DRs throughout the entire 10 weeks of treatment, as compared to before treatment when he had received four DRs over the course of approximately four weeks, and minimal VRs, as compared to the beginning of treatment when he was routinely receiving, on average, 3 VRs per week. This indicates the offender likely reduced the amount of times he responded in a disrespectful or aggressive manner across treatment, and suggests he had effectively implemented the skills he had learned in sessions to manage his anger more effectively.

The last question from the subjective and objective measure asked the offender to rate how often he experienced his anger-provoking triggers. On a scale of 1 to 7, the offender rated his experience of triggers at a 7 during the first session, which indicates he experienced triggers every day multiple times a day. At the end of treatment, the offender rated his experience at a 6, which indicates he experienced triggers every day a few times a day. Although this reduction is minimal, the offender was able to evidence reductions in his anger, and more appropriately

manage his aggressive responses when compared to how often he reported experiencing his anger-provoking triggers at the outset of treatment.

Limitations

One limitation to the present case study was the offender's involvement in an anger management group. Due to the offender's DR history, after the second CBT-AAC session, the offender was placed in an anger management unit within the corrections facility. His treatment plan on the unit required him to participate in anger management groups each week, which focused on teaching similar skills as taught in his individual therapy. It is unclear whether his participation in anger management group influenced his ability to learn and apply the anger management skills taught in his individual therapy. However, the anger management group allowed the offender to practice the skills he learned in individual therapy while he was in group on his unit.

Another limitation was the offender's frustration with the weekly anger measure, the CAS. His scores consistently went up each week, which signify his anger was getting worse. In the seventh session, the offender marked almost all items as "D", which is the highest possible rating. This was a sign to the therapist he may not be reading each question and thinking about what statement best reflects his recent experiences with anger. During the eighth session, the offender took approximately two minutes to read all of the statements and answer the questions. The therapist asked him how he completed it so quickly and he reported he had completed the weekly measure so many times that he no longer needs to read the statements. It is expected the offender began only marking statements reflecting the most anger being present, without actually reading and accurately responding to the questions based on his recent experiences with anger.

Self-Evaluation

The transcript provided in Appendix I was of the 5th therapy session. Prior to this session, the offender had learned anger management strategies and was beginning to learn strategies focused on problem solving after having already been given the rationale for the purpose of using problem solving skills. During the fifth session, the offender was introduced to the PICC handout and was able to appropriately create multiple solutions to one problem. However, during the beginning of the session, the offender reported a current stressor that was causing him to worry about his safety on his housing unit. The transcript provided shows the discussion the therapist had with the offender and how the therapist attempted to relate the offender distress back to the skills taught in previous sessions and how he could use these skills, as well as problem solving skills, to effectively manage his current problem. The offender was able to identify the best way to solve his problem was to use his verbal skills and talk to his peers about the situation.

Therapist Strengths. The therapist demonstrated several strengths over the course of treatment. The first was building rapport with the offender. The offender was very reserved and reluctant to share information in beginning therapy sessions. The therapist was able to create a safe space that allowed the offender to be more comfortable with opening up and sharing his story, including: his struggles, frustrations, and anxieties. For example, the offender was willing to express his frustrations with his teacher and his inability to effectively communicate with her. He was willing to practice and role-play skills in session that would help him apply the skills he had learned in sessions. Furthermore, the offender was willing to talk about his

relationships with his grandmother, brother, and peers on his unit. The therapist encouraged the offender to share his personal stories as he felt comfortable, as the offender became more personal throughout sessions. When reflecting back to the offender, the therapist would use offender-specific language and use a relaxed posture. Treating the offender differently than correction's officers by being relaxed, empathetic, and respectful likely increased the rapport built between the therapist and offender.

Furthermore, rapport continued to be established as the therapist learned how to manage the offender's opposition and defiance. In the initial sessions, the therapist would often become flustered when the offender became oppositional. This often led to the offender trying to argue with the therapist. As sessions progressed, the therapist learned the importance of using reflections to over-emphasize the offender's oppositional statements. Reflecting back what he had said often helped him become more thoughtful and insightful in his responses. The therapist was able to reduce the offender's opposition which led to sessions being more focused on the CBT-AAC treatment and increased productivity. In reflection, using the offender's opposition to the therapist's advantage may have been beneficial in initial sessions and could have helped the offender continue to work on and restructure his thoughts.

Another strength the therapist displayed was the ability to create accurate and meaningful role-plays to provide the offender with effective feedback. During the beginning sessions, the offender was resistant to actively engage in role-play examples of how to use the skills taught in session. He would laugh and avoid eye contact when the therapist asked him to use his own words and apply the skills he had learned. The offender would often ask the therapist to give him an example before he would be willing to try role-playing. However, as the therapist continued to ask the offender to attempt to role-play situations, he became more

willing to make eye contact and use his own words to role-play what he would say in given situations. The therapist often gave him feedback about maintaining eye contact and using a calm tone of voice. Towards the end of therapy, the offender was able to effectively and appropriately role-play apologizing to his teacher for his misbehavior and disrespect in her class. After receiving feedback, he was able to practice the apology multiple times and apply feedback given about his eye contact and tone of voice.

The therapist also exhibited a strength when following the CBT-AAC sessions according to the manual. The CBT-AAC manual has specific guidelines for each session, in which there are homework reviews, learning of new skills, practicing new skills, and assigning homework. The therapist used outlines of the session material from the manual and was able to provide the offender with all of the skills described in all of the sessions. The treatment session reviews were used to ensure the therapist stayed on track and was able to spend an adequate amount of time on each topic or skill. Time management was used effectively and the offender was able to learn all of the skills outlined in the CBT-AAC manual for each session.

Areas of Improvement. There are also areas where the therapist could improve. First, the difference in cultural backgrounds between the offender and the therapist likely influenced the treatment outcomes. However, it was not assessed for or discussed during any of the sessions. The offender was an African American male who was raised in the inner city and currently incarcerated at a juvenile corrections facility. Whereas, the therapist was a European American female who was raised in a farming town and currently working as a therapist in the facility. Research has demonstrated patterns of responding, eye contact, and emotionality (Sue & Sue, 2008). African Americans are more likely to speak with affect, interrupt while the other person is talking, and use prolonged eye contact when speaking with less eye contact when

listening. On the other hand, European Americans are more likely to speak loudly and quickly to control the listener, use more eye contact while listening, and increase head nods and nonverbal communication (Sue & Sue). There are some striking differences in the communication styles exhibited by the therapist and offender. Communication style differences may have influenced treatment outcomes, especially if the offender felt uncomfortable with the therapist's nonverbal or felt unable to interrupt or disagree with the therapist. It may have been more beneficial for the therapist to adopt a style of communication similar to the offender's style, as research has shown this to be effective (Sue & Sue).

The second area was providing incentives for the offender to practice deep breathing between sessions. Due to the offender's resistance during the beginning of therapy and reporting he had tried deep breathing before and did not like it, the therapist decided to focus more on other skills. However, deep breathing could have been beneficial for the offender to effectively prevent anger situations from occurring. The therapist should have provided the offender with an incentive for completing the deep breathing between sessions. This would have allowed him to get extra practice and the skill may have worked better for him than it had in the past. For example, the therapist could have gone to the offender's living unit and practiced with him each afternoon. This would have given the therapist to provide the offender with a piece of candy upon completion of the exercise.

Also, the therapist often struggled to correct the offender's homework. The offender would often complete his homework while doing the minimum amount of work. For example, when he was given multiple sheets of homework, he would complete both sheets over the same situation. He also never fully answered the questions on his homework handouts, and would provide very short answers of only two to three words. It is unclear how the offender's ability

to read and write may have effected his ability to complete the homework assignments. According to initial, brief measures of intellectual functioning, the offender appeared to have an IQ in the Low Average Range, although he was not referred for a comprehensive IQ assessment. Due to this, rather than criticizing the offender's efforts, the therapist elected to elicit an elaboration of the offender's homework via verbal discussions during each session. However, a comprehensive IQ assessment may be beneficial for those working with the offender in the future.

Another area the therapist could improve was the ability to engage the offender while in session. As shown in Appendix I, the therapist often spoke more often and for longer durations than the offender. The therapist often struggled when attempting to get the offender to talk, as he often used short and fragmented sentences. As well as, the offender was consistently hyperactive and inattentive in sessions. He frequently played with the extra chair in the room, drew with his finger on the wall, and would get out of his seat when he was supposed to remain seated. The therapist would redirect his behavior and remind him to leave the chair alone, although some behaviors were ignored in an attempt to not reinforce the behaviors by providing him with attention. In reflection, the therapist could have used incentives to increase the offender's motivation to participate and remain engaged. The therapist should have attempted to track the pattern of speaking and asked the offender open-ended questions to encourage his participation when the pattern was not even.

The last challenge the therapist struggled with were the restrictions of the facility. Due to the offender being in the juvenile prison, confidentiality is difficult to maintain. Sessions were held in a confidential room, however corrections officers were aware of his participation in therapy, as the corrections officers escort the offender to and from the health services area.

As well as, the offender's peers may have been aware of his participation in therapy due to him being escorted to health services each week at the same time. Furthermore, providing consistent incentives for the offender applying therapy skills in his daily life were not provided. The facility restrictions and number of youth per each corrections officer made it difficult to enlist the officers in providing incentives. Also, having an incentive program for one youth and not others is not considered acceptable. Due to these restrictions, the offender was not able to receive consistent positive reinforcement for his use of skills taught between sessions beyond the praise and encouragement offered by the therapist during sessions.

References

- Aebi, M., Barra, S., Bessler, C., Steinhausen, H., Walitza, S., & Plattner, B. (2016). Oppositional defiant disorder dimensions and subtypes among detained male adolescent offenders. *Journal of Child Psychology and Psychiatry*, *57*(6), 729-736.
- American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition. Arlington, VA, American Psychiatric Association, 2013.
- Arita, A. A. & Baer, R. A. (1998). Validity of selected MMPI-A content scales. *Psychological Assessments*, *10*(1), 59-63.
- Bandura, A. (1978). Social learning theory of aggression. *Journal of Communication*, *28*(3), 12-29.
- Barkley, R. A. (1997). *Defiant children: A clinician's manual for assessment and parent training (2nd ed.)*. New York: Guilford Press.
- Barkley, R. A., Edwards, G., Laneri, M., Fletcher, K., & Metevia, L. (2001). The efficacy of problem-solving communication training alone, behavior management training alone, and their combination for parent-adolescent conflict in teenagers with ADHD and ODD. *Journal of Consulting and Clinical Psychology*, *69*(6), 926-941.
- Barkley, R. A. (2013). *Defiant children: A clinician's manual for assessment and parent training*. New York, NY: The Guilford Press.
- Beck, J. S. (2011). *Cognitive behavioral therapy: The basics and beyond*. New York: The Guilford Press.
- Ben-Porath, Y. S., Graham, J. R., Archer, R. P., Tellegen, A. J., & Kaemmer, B. (2006). *Supplement to the MMPI-A manual for administration, scoring, and interpretation*. Minneapolis, MN: University of Minnesota Press.

- Burke, J. D., Mulvey, E. P., & Schubert, C. S. (2015). Prevalence of mental health problems and service use among first-time juvenile offenders. *Journal of Child and Family Studies, 24*(12), 3774-3781.
- Butcher, J. N., Williams, C. L., Graham, J. R., Archer, R. P., Tellegan, A., Ben-Porath, Y. S., & Kaemmer, B. (1992). *Minnesota Multiphasic Personality Inventory-Adolescent (MMPI-A): Manual for administration, scoring and interpretation*. Minneapolis, MN: University of Minnesota Press.
- Byrd, A. L., Loeber, R., & Pardini, D. A. (2012). Understanding desisting and persisting forms of delinquency: The unique contributions of disruptive behavior disorders and interpersonal callousness. *Journal of Child Psychology and Psychiatry, 53*(4), 371-380.
- Deffenbacher, J. L. (2011). Cognitive-behavioral conceptualization and treatment of anger. *Cognitive and Behavioral Practice, 18*(2), 212-221.
- Duncan, L., Georgiades, K., Wang, L., Van Lieshout, R. J., MacMillan, H. L., Ferro, M. A., . . . Boyle, M. H. (2017). Psychometric evaluation of the Mini International Neuropsychiatric Interview for Children and Adolescents (MINI-KID). *Psychological Assessment, 1*-14.
- Fazel, S., Doll, H., & Langstrom, N. (2008). Mental disorders among adolescents in juvenile detention and correctional facilities: A systematic review and metaregression analysis of 25 surveys. *Journal of the American Academy of Child and Adolescent Psychiatry, 47*(9), 1010-1019.
- Fisher, W. H., Hartwell, S. W., Deng, X., Pinals, D. A., Fulwiler, C., & Roy-Bujnowski, K. (2014). Recidivism among released state prison inmates who received mental health treatment while incarcerated. *Crime and Delinquency, 60*(6), 811-832.

Gomez, R., Burns, G. L., & Walsh, J. A. (2008). Parent ratings of the oppositional defiant disorder symptoms: Item response theory analyses of cross-national and cross-racial invariance. *Journal of Psychopathology and Behavioral Assessment, 30*, 10-19.

Gottzman, D. & Schwarz, S. *Juvenile Justice in the U.S.: Facts for Policymakers*; National Center for Children in Poverty: New York, NY, 2011.

Graham, J. R. (2012). *MMPI-2: Assessing personality and psychopathology*. New York, NY: Oxford University Press.

Grisso, T. (2008). Adolescent offenders with mental disorders. *Future Child, 18*(2), 143–164.

Henggeler, S. W., & Sheidow, A. J. (2012). Empirically supported family-based treatments for conduct disorder and delinquency in adolescents. *Journal of Marital and Family Therapy, 38*(1), 30–58.

Henwood, K. S., Chou, S., & Browne, K. D. (2015) A systematic review and meta-analysis on the effectiveness of CBT informed anger management. *Aggression and Violent Behavior, 25*, 280-292.

Howells, K., Daffern, M., & Day, A. (2008). Aggression and violence. In K. Soothill, M. Dolan, & P. Rogers (Eds.), *Handbook of forensic mental health* (pp. 351-374). Devon, UK: Willan.

Hudley, C. & Graham, S. (1993). An attributional intervention to reduce peer-directed aggression among African-American boys. *Child Development, 64*(1), 124-138.

Kazdin, A. E., Seigel, T. C., & Bass, D. (1992). Cognitive problem-solving skills training and parent management training in the treatment of antisocial behavior in children. *Journal of Consulting and Clinical Psychology, 60*(5), 733-747.

- Lazarus, A. A. (1981). *The practice of multimodal therapy*. New York, NY: McGraw-Guilford.
- Lazarus, A. A. (1990). Assessment models: multimodal therapy. In J. K. Zeig & W. M. Munion (Eds.), *What is psychotherapy?: contemporary perspectives* (221-225). San Francisco: Oxford.
- Lazarus, R. S. (1991). *Emotion and adaptation*. New York, NY: Oxford University Press.
- Lochman, J. E., Barry, T. D., & Pardini, D. A. (2003). Anger control training for aggressive youth. In A. E. Kazdin & J. R. Weisz (Eds.), *Evidenced-based psychotherapies for children and adolescents* (pp. 263-281). New York: Guilford Press.
- Lochman, J. E., & Wells, K. C. (2004). The coping power program for preadolescent aggressive boys and their parents: Outcome effects at the 1-year follow-up. *Journal of Consulting and Clinical Psychology, 72*(4), 571-578.
- Lochman, J. E., Wells, K. C., & Lenhart, L. A. (2008). *Coping power: Child group program*. New York: Oxford University Press.
- Lochman, J. E., Whidby, J. M., & Fitzgerald, D. P. (2000). Cognitive-behavioral assessment and treatment with aggressive children. In P. C. Kendall (Ed.), *Child and adolescent therapy: Cognitive behavioral procedures* (2nd ed., pp. 31-87). New York: Guilford Press.
- Luszczynska, A. & Schwarzer, R. (2005). Social cognitive theory. In Conner, M. & Norman, P. (Eds.), *Predicting Healthy Behavior* (127-169). New York: Open University Press.
- Mental Health Division. (2006). *Children's evidence based practices expert panel-update*. Retrieved from https://www.dshs.wa.gov/sites/default/files/BHSIA/dbh/documents/childrens_ebp_expert_panel_report_final_2%5B1%5D.pdf
- Ozabaci, N. (2011). Cognitive behavioral therapy for violent behavior in children and

- adolescents: A meta-analysis. *Children and Youth Services Review*, 33(10), 1989-1993.
- Reynolds, C. R. & Kamphaus, R. W. (2004). *Behavior Assessment for Children: Second Edition Manual*. Circle Pines, MN: AGS Publishing.
- Sakai, J. T., Mikulich-Gilbertson, S. K., Young, S. E., Rhee, S. H., McWilliams, S. K., Dunn, R., ... Hopfer, C. J. (2016). Adolescent male conduct-disordered patients in substance use disorder treatment: Examining the 'limited prosocial emotions' specifier. *Journal of Child & Adolescent Substance Abuse*, 25(6), 613-625.
- Schamborg, S., Tully, R. J., & Browne, K. D. (2015). The use of the State-Trait Anger Expression Inventory-II with forensic populations: A psychometric critique. *International Journal of Offender Therapy and Comparative Criminology*, 60(11), 1239-1256.
- Schmidt, S., Tinti, C., & Levine, L. J. (2010). Appraisals, emotions and emotion regulation: An integrative approach. *Motivation and Emotion*, 34(1), 63-72.
- Sheehan, D. V., Lecrubier, Y., Sheehan, K. H., Anorim, P., Janavs, J., Weiller, E., . . . Dunbar, G. C. (1998). The MINI-International Neuropsychiatric Interview (M.I.N.I.): The development and validation of a structured diagnostic psychiatric interview for DSM-IV and ICD-10. *Journal of Clinical Psychiatry*, 59(20), 22-33.
- Sheehan, D. V., Sheehan, K. H., Shytle, R. D., Janavs, J., Bannon, Y., Rogers, J. E., . . . Wilkinson, B. (2010). Reliability and validity of the Mini International Neuropsychiatric Interview for Children and Adolescents (MINI-KID). *Journal of Clinical Psychiatry*, 71(3), 313-326.

- Snell, W. E., Gum, C., Shuck, R. L., Mosley, J. A., & Hite T. L. (1995) The Clinical Anger Scale: Preliminary reliability and validity. *Journal of Clinical Psychology, 51*(2), 215-226.
- Stein, L. A. R., McClinton, B. K., & Graham, J. R. (1998). Long-term stability of MMPI-A scales. *Journal of Personality Assessment, 70*(1), 103-108.
- Sue, D. W. & Sue, D. (2008). *Counseling the culturally diverse: Theory and practice* (5th ed.). Hoboken, NJ: John Wiley & Sons, Inc.
- Sukhodolsky, D. G., Golub, A., Stone, E. C., & Orban, L. (2005). Dismantling anger control training for children: A randomized pilot study of social problem-solving versus social skills training components. *Behavior Therapy, 9*(3), 247-269.
- Sukhodolsky, D. G., Kassinove, H., & Gorman, B. S. (2004). Cognitive-behavioral therapy for anger in children and adolescents: A meta-analysis. *Aggression and Violent Behavior, 9*(3), 247-269.
- Sukhodolsky, D. G. & Scahill, L. (2012). *Cognitive behavioral therapy for anger and aggression in children*. New York: The Guilford Press.
- Sukhodolsky, D. G., Solomon, R. M., & Perine, J. (2000). Cognitive-behavioral, anger-control intervention for elementary school children: A treatment outcome study. *Journal of Child and Adolescent Group Therapy, 10*(3), 159-170.
- Sukhodolsky, D. G., Vitulano, L. A., Carroll, D. H., McGuire, J., Leckman, J. F., & Scahill, L. (2009). Randomized trial of anger control training for adolescents with Tourette's Syndrome and disruptive behavior. *Journal of the American Academy of Child and Adolescent Psychiatry, 48*(4), 413-421.

Teplin, L. A., Abram, K. M., McClelland, G. M., Dulcan, M. K., & Merical, A. A. (2002).

Psychiatric disorders in youth juvenile detention. *Archives of General Psychiatry*, 59(12), 1133-1143.

Underwood, L. A., Phillips, A., von Dresner, K., & Knight, P. D. (2006). Critical factors in mental health programming for juveniles in corrections facilities. *International Journal of Behavioral Consultation and Therapy*, 2(1), 107-140.

Underwood, L. A., & Washington, A. (2016). Mental illness and juvenile offenders.

International Journal of Environmental Research and Public Health, 13(2), 228-242.

Appendix A

Mini International Neuropsychiatric Interview for Children and Adolescents

The Mini International Neuropsychiatric Interview for Children and Adolescents (MINI-KID) is a copyrighted measure that cannot be reproduced. A detailed description of the measure including information for obtaining copies of the specific items can be accessed using the information provided below.

Sheehan, D. V., Lecrubier, Y., Sheehan, K. H., Anorim, P., Janavs, J., Weiller, E., . . . Dunbar, G. C. (1998). The MINI-International Neuropsychiatric Interview (M.I.N.I.). Copyright 2016 Sheehan, D. V.

Appendix B

Minnesota Multiphasic Personality Inventory- Adolescent

The Minnesota Multiphasic Personality Inventory-Adolescent (MMPI-A) is a copyrighted measure that cannot be reproduced. A detailed description of the measure including information for obtaining copies of the specific items can be accessed using the information provided below.

Butcher, J. N., Williams, C. L., Graham, J. R., Archer, R. P., Tellegen, A., Ben-Porath, Y. S., & Kaemmer, B. (1992). *Minnesota Multiphasic Personality Inventory-Adolescent (MMPI-A)*. Minneapolis, MN: University of Minnesota Press. Copyright 2018 Pearson Education, Inc.

Appendix C

Behavior Assessment for Children: Second Edition

The Behavior Assessment for Children: Second Edition (BASC-2) is a copyrighted measure that cannot be reproduced. A detailed description of the measure including information for obtaining copies of the specific items can be accessed using the information provided below.

Reynolds, C. R. & Kamphaus, R. W. (2004). Behavior Assessment for Children: Second Edition (BASC-2). Circle Pines, MN: AGS Publishing. Copyright 2018 Pearson Education, Inc.

Appendix D

Disruptive Behavior Rating Scale

Instructions: Please circle the number next to each item that best describes the behavior of this child during the past week.

	Never or rarely (once a week or less)	Sometimes (2-3 times a week)	Often (almost every day)	Very often (every day or several times s day)
Loses temper	0	1	2	3
Argues with adults	0	1	2	3
Actively defies or refuses to comply with adult's requests or rules	0	1	2	3
Deliberately annoys people	0	1	2	3
Blames others for his mistakes or misbehaviors	0	1	2	3
Is touchy or easily annoyed by others	0	1	2	3
Is angry or resentful	0	1	2	3
Is spiteful or vindictive	0	1	2	3

Appendix E

Clinical Anger Scale

FEELINGS INVENTORY INSTRUCTIONS: The group of items below inquire about the types of feelings you have. Each of the 21 groups of items has four options.

- For example, ITEM 99 _____
- A. I feel fine.
 - B. I don't feel all that well.
 - C. I feel somewhat miserable.
 - D. I feel completely miserable.

For each cluster of items, read and identify the statement that best reflects how you feel. For example, you might choose A in the above example. If so, then you would darken in the letter (A) on the answer sheet next to the item number associated with that group of statements. In this example, that item number would have been "99."

Now go ahead and answer the questions on the answer sheet. Be sure to answer every question, even if you're not sure. Make sure you select only one statement from each of the 21 clusters of statements.

PLEASE BE HONEST IN RESPONDING TO THE STATEMENTS.

1. _____
 - A. I do not feel angry.
 - B. I feel angry.
 - C. I am angry most of the time now.
 - D. I am so angry and hostile all the time that I can't stand it.

2. _____
 - A. I am not particularly angry about my future.
 - B. When I think about my future, I feel angry.
 - C. I feel angry about what I have to look forward to.
 - D. I feel intensely angry about my future, since it cannot be improved.

3. _____
 - A. It makes me angry that I feel like such a failure.
 - B. It makes me angry that I have failed more than the average person.
 - C. As I look back on my life, I feel angry about my failures.
 - D. It makes me angry to feel like a complete failure as a person.

4. _____
 - A. I am not all that angry about things.
 - B. I am becoming more hostile about things than I used to be.
 - C. I am pretty angry about things these days.
 - D. I am angry and hostile about everything.

5. _____
 - A. I don't feel particularly hostile at others.
 - B. I feel hostile a good deal of the time.

- C. I feel quite hostile most of the time.
D. I feel hostile all of the time.
6. ____A. I don't feel that others are trying to annoy me.
B. At times I think people are trying to annoy me.
C. More people than usual are beginning to make me feel angry.
D. I feel that others are constantly and intentionally making me angry.
7. ____A. I don't feel angry when I think about myself.
B. I feel more angry about myself these days than I used to.
C. I feel angry about myself a good deal of the time.
D. When I think about myself, I feel intense anger.
8. ____A. I don't have angry feelings about others having screwed up my life.
B. It's beginning to make me angry that others are screwing up my life.
C. I feel angry that others prevent me from having a good life.
D. I am constantly angry because others have made my life totally miserable.
9. ____A. I don't feel angry enough to hurt someone.
B. Sometimes I am so angry that I feel like hurting others, but I would not really do it.
C. My anger is so intense that I sometimes feel like hurting others.
D. I'm so angry that I would like to hurt someone.
10. ____A. I don't shout at people any more than usual.
B. I shout at others more now than I used to.
C. I shout at people all the time now.
D. I shout at others so often that sometimes I just can't stop.
11. ____A. Things are not more irritating to me now than usual.
B. I feel slightly more irritated now than usual.
C. I feel irritated a good deal of the time.
D. I'm irritated all the time now.
12. ____A. My anger does not interfere with my interest in other people.
B. My anger sometimes interferes with my interest in others.
C. I am becoming so angry that I don't want to be around others.
D. I'm so angry that I can't stand being around people.
13. ____A. I don't have any persistent angry feelings that influence my ability to make decisions.
B. My feelings of anger occasionally undermine my ability to make decisions.
C. I am angry to the extent that it interferes with my making good decisions.
D. I'm so angry that I can't make good decisions anymore.
14. ____A. I'm not so angry and hostile that others dislike me.
B. People sometimes dislike being around me since I become angry.

- C. More often than not, people stay away from me because I'm so hostile and angry.
D. People don't like me anymore because I'm constantly angry all the time.
15. ____ A. My feelings of anger do not interfere with my work.
B. From time to time my feelings of anger interfere with my work.
C. I feel so angry that it interferes with my capacity to work.
D. My feelings of anger prevent me from doing any work at all.
16. ____ A. My anger does not interfere with my sleep.
B. Sometimes I don't sleep very well because I'm feeling angry.
C. My anger is so great that I stay awake 1—2 hours later than usual.
D. I am so intensely angry that I can't get much sleep during the night.
17. ____ A. My anger does not make me feel anymore tired than usual.
B. My feelings of anger are beginning to tire me out.
C. My anger is intense enough that it makes me feel very tired.
D. My feelings of anger leave me too tired to do anything.
18. ____ A. My appetite does not suffer because of my feelings of anger.
B. My feelings of anger are beginning to affect my appetite.
C. My feelings of anger leave me without much of an appetite.
D. My anger is so intense that it has taken away my appetite.
19. ____ A. My feelings of anger don't interfere with my health.
B. My feelings of anger are beginning to interfere with my health.
C. My anger prevents me from devoting much time and attention to my health.
D. I'm so angry at everything these days that I pay no attention to my health and well-being.
20. ____ A. My ability to think clearly is unaffected by my feelings of anger.
B. Sometimes my feelings of anger prevent me from thinking in a clear-headed way.
C. My anger makes it hard for me to think of anything else.
D. I'm so intensely angry and hostile that it completely interferes with my thinking.
21. ____ A. I don't feel so angry that it interferes with my interest in sex.
B. My feelings of anger leave me less interested in sex than I used to be.
C. My current feelings of anger undermine my interest in sex.
D. I'm so angry about my life that I've completely lost interest in sex.

Appendix F

Subjective and Objective Measures

Instructions: Please answer the following questions based on your experienced over the past week. Remember, please be honest when responding to the following questions.

1. How often did you experience feelings of anger?

1 Never experienced anger	2	3	4	5	6	7 Experienced anger at an intolerable level every day
---------------------------------	---	---	---	---	---	---

2. How many times did you react to your feelings of anger using aggressive behaviors?

3. How many disciplinary reports or verbal reprimands did you receive over the past week?

Triggers

1. How often did you experience the trigger of ____ (i.e., identified in session by the client) over the past week?

1 Never experienced the trigger	2	3	4	5	6	7 Experienced the trigger more than once a day, every day of the week
---------------------------------------	---	---	---	---	---	--

Appendix G**Clinical Anger Scale Scores**

Weekly CAS Scores	
Week 1	39
Week 2	35
Week 3	37
Week 4	38
Week 5	44
Week 6	47
Week 7	59
Week 8	61
Week 9	51
Week 10	53

Table 1: Weekly Clinical Anger Scale (CAS) scores for anger symptoms

Appendix H

Subjective and Objective Measure Ratings

Subjective and Objective Measure Ratings					
	Experience of Anger	Aggressive Behaviors	Disciplinary Reports	Verbal Reprimands	Trigger Frequency
Prior to Treatment	N/A	N/A	4	N/A	N/A
Week 1	5	2	0	5	N/A
Week 2	4	2	0	3	7
Week 3	7	5	0	1	6
Week 4	7	2	0	5	6
Week 5	5	1	0	2	7
Week 6	7	1	1	4	7
Week 7	7	4	0	2	6
Week 8	7	4	0	1	5
Week 9	5	4	0	2	5
Week 10	4	3	1	2	6

Table 2: Weekly subjective and objective measures assessing for the occurrences of anger, number aggressive responses, disciplinary reports and verbal reprimands received, and experience of anger triggers.

Appendix I

Session 5 Transcript: Session Two of the Problem Solving Module

The offender completed the CAS prior to the beginning of the transcript.

Therapist: Over the past week, on average, on a scale of 1 to 7, how often did you experience feelings of anger?

Offender: Most of the time.

Therapist: Every day at an intolerable level and you couldn't handle it?

Offender: I can handle it.

Therapist: Where would you put it?

Offender: Five.

Therapist: Five, okay. How many times did you react using aggressive behaviors this past week?

Offender: Disrespect.

Therapist: Well it can be disrespect, as verbal aggression. But did you ever act out physically?

Offender: Like try and get restrained? Yeah.

Therapist: Did you fight?

Offender: No

Therapist: Okay. How many times would you say that you did that?

Offender: Once.

Therapist: How many DRs did you get?

Offender: One.

Therapist: For what?

Offender: She's trying to give me a DR for standing in class, but I am going to beat that so it doesn't matter.

Therapist: So, help me understand what this is? You've had about five VRs in the school and now you are getting a DR?

Offender: Yep.

Therapist: If you get a certain number of VRs, do you start to get DRs?

Offender: It's a summary judgment. That's supposed to be an SJ.

Therapist: It's not quite a DR yet.

Offender: Yeah.

Therapist: You said you got five VRs for getting out of your seat in class. Were all of them getting out of your seat or was there others?

Offender: Other stuff.

Therapist: Like what? Not following orders? Being disrespectful?

Offender: Yep.

Therapist: On a scale of 1 to 7, we've identified a lot of different triggers that you experience, right? Like the one teacher in your class, your peers, sometimes the officers. How often would you say they triggered you or made you angry? With 7 being every single day, multiple times a day.

Offender: Multiple times a day. Every day. 7.

Therapist: Walk me through how you completed your homework.

Offender: They tried to give me 15 minutes in my room.

Therapist: The officer did? Okay, so that made you angry. Why was he trying to give you 15 minutes in your room?

Offender: Because I asked to get up and wash my hands and then he gonna say no.

Therapist: So you were watching TV and you asked to get up and wash your hands and the officer said no.

Comments: At this point, it may have been helpful to use a role play when talking about the offender's behavior in school. A role play would have allowed the offender to act out what happened in the school, with the therapist as the teacher. Then, roles would have been reversed and the offender would have been given the opportunity to role play his teacher. This would have allowed the offender to take the teacher's perspective, which could have helped him take more responsibility for his actions.

Offender: Yup.

Therapist: Then what did you do?

Offender: Got up any damn way. Then, he tried to make me go to my room. I was not. I was not going to my room. So then, he called a sergeant down to the unit and they said go to your room for 15 minutes and she talked me through it.

Therapist: Okay, so they were able to talk you through it.

Offender: It wasn't that. He said I had to go to my room. So I went and shut the door. When I came out of my room, I knew I was going to get restrained.

Therapist: You said the problem in the situation was him trying to lock you in your room. His problem was that he wanted you to secure and you weren't. Right?

Offender: Yup.

Therapist: Do you think that by trying to refuse, you would get in more trouble or less trouble?

Offender: More.

Therapist: More. Yeah. What are some other reasons for why he wanted you to secure? You wrote on here that it was because you were walking across the unit, which is probably one right?

Offender: Yeah. To wash my hands.

Therapist: Maybe you were also not following directives?

Comment: In reflection, this close-ended question likely influenced the offender's one-word answer. A reflection could have been used to amplify the offender's behavior. For example, saying "you were not following directives" would have allowed the offender to reflect and then correct or elaborate on this reflection.

Offender: Yes.

Therapist: Yeah. What makes you not want to follow his directives?

Offender: He is always getting on my damn nerves, every time he is on the unit.

Therapist: You've had problems with this officer in the past.

Offender: Yeah.

Therapist: Is it common that you don't want to follow his orders. We talked last time about how we can take other people's perspectives, right? You've had problems with this guy in the past, it's likely he has had problems with you in the past, right?

Offender: Yup.

Therapist: Do you think he looks at you in a more positive light?

Offender: No.

Comment: The previous reflection was well placed, although it did not elicit an open-ended response from the client. At this point, it may have been more helpful to address the offender's resistance. Using a process comment like, "I am noticing I am doing most

of the talking and you are often responding with one-word answers. What does this say about our conversation?" A process comment on the pattern of speech could have helped the offender be more aware of the pattern of speech and encourage him to talk more often and for longer durations.

Therapist: How do you think this situation may influence his view of you?

Offender: He sent me to the room to just get me out of the way.

Therapist: Yeah. So, maybe he didn't want to deal with you. That could have been one option.

Did you spend the 15 minutes in your room?

Offender: Yeah, because he closed the door.

Therapist: But you were able to tell yourself that you are trying to get to a level two. When are you supposed to get your level two?

Comment: The previous comment was used to review past material covered in sessions. Using verbal reminders was helpful for the offender to remember his goals and his motivation for wanting to manage his anger and aggression more effectively. The therapist attempted to address this in session to remind him of his goals, as well as gauging if his past goals were still motivators for him to manage his anger.

Offender: On Monday.

Therapist: How do you think refusing to do what officers tell you to do is influencing you getting your level two?

Offender: Refusing?

Therapist: Yeah. Do you think that makes you more likely to get your level two or less likely?

Offender: They can't give me a DR. They can give me an SJ, but that ain't going to do shit.

Therapist: Yes. But do you think when people get DRs, are they more or less likely to get their level?

Offender: Less likely.

Therapist: Probably less likely. So we are really working for your level two. Last week, we talked a lot about how when we get angry it's usually because we have a goal and something is in the way of us reaching our goal. Do you remember that?

Offender: Head nodding yes.

Therapist: And how we can take other people's perspectives. We talked about your teacher and how you can take her perspective when you are in the classroom. Right?

Comment: Again, the previous comment was used to discuss past concepts discussed in sessions. Perspective taking was often difficult for the offender, as he was often able to reflect and identify what other's may be thinking. However, he struggled to take other's perspectives when his anger began to increase. The therapist consistently used the examples the offender brought to session as practice for perspective taking.

Offender: Yeah.

Therapist: How did that go this week? Did you get your VRs in the same class that you normally do? Or a different class?

Offender: No. It's all of them, except for one.

Therapist: It sounds like you still had problems following their directives. And we are going to talk about that a little today, too. So we talked a lot about anger management skills and goals and other people's perspectives. But once we are able to do all of this stuff, we have to take the next step in figuring out how we react differently. We know problems are happening, we know we are angry in the situation, but what do I do differently to not cause me to get in trouble?

This is going to be like riding a bike and it's going to take some time to practice. The first time you ride a bike, are you usually really good or do you tend to fall a couple times?

Offender: I ain't failed.

Therapist: You never failed at a riding a bike.

Offender: Nope.

Therapist: Well I definitely did. It took me a couple times before I got the hang of it and got good at it. Now, I can jump on a bike, I can ride it and I never forget. Have you heard the saying?

Offender: Yeah. You can never forget how to ride a bike.

Therapist: It's the same thing when we are trying to behave in a different way. The first time you try to do something new and different, it is probably going to be pretty challenging. Right? You have learned to react in ways that make sense for you and so reacting differently may be pretty difficult. With that being said, if we practice and we are able to think of different ways to react when we are not angry, then it makes it more likely we are going to be able to react appropriately when we are angry. Does that make sense? What questions do you have?

Offender: Head nodding no.

Therapist: We are going to walk through this handout and its called the problem identification, choices, and consequences handout. It's the PICC handout. What we are really going to talk about is coming up with as many solutions as we can to a problem. As many different ways that we could react as possible. These don't have to be things that you do now and it can be things that right now you think you would never do, you may think this doesn't fit with me. But we are just trying to come up with as many solutions as we can and then we will narrow them

down to what you might be able to do. Let's pick a situation that we can walk through this handout with. What problem do you want to come up with solutions for?

Comment: In reflection, the previous paragraph should have been broken into multiple sections. The therapist was using a handout from the CBT-AAC treatment manual to help the offender identify the problem, his choices of behaviors to react with, and consequences for each of his choices. Due to the offender's pattern of speech often being short in duration, the therapist should have taken this into consideration when educating the offender on new concepts in sessions. Breaking concepts into smaller pieces may have allowed the offender to be more thoughtful in his responses and understand the concepts more fully.

Offender: Fighting with the officers and peers.

Therapist: What makes you want to fight or what causes you to want to fight?

Offender: They are just annoying.

Therapist: People being annoying. What's it look like when they are annoying you?

Offender: I don't even know. Just talking. It can be anything.

Therapist: When they start saying things to you, what do you do? Do you say something back?

Stand up? Tighten your shoes?

Offender: What do I do? Tighten my shoes.

Therapist: What does the other person do?

Offender: Tightens his shoes too. Then I'm gonna get to beatin' his ass.

Therapist: At that point, it's going to escalate. The next part is answering what you could do in this situation. You said the first one is that you could have fought. We are going to come up with five different things we could do in this situation. What's another thing you could do?

Offender: Walk away. Ignore him. Go to rec.

Therapist: Could you take deep breaths?

Offender: Yeah.

Therapist: Now remember these aren't necessarily things you want to do or think you would do. These are all of the possible solutions to the problem. Could you ask your officer to put you in your room?

Offender: No.

Therapist: Couldn't do that or you wouldn't want to do that?

Offender: I wouldn't want to do that.

Therapist: So you could do it. You might not do it, but it is still an option. Let's come up with one more thing that we can do.

Offender: All I know is that I'm gonna fight him.

Therapist: That is what you do in this situation right now, right? It's hard to think of new ways to react. Could you talk to him instead of immediately fighting?

Comment: Validating the offender's current response was likely helpful here. It allowed the offender to feel heard and know his responses are important.

Offender: Yeah.

Therapist: Now I want us to think of the possible consequences that each one of these actions are going to have for us. If you fought him, what's that consequence going to be?

Offender: He gonna be in HSO.

Therapist: And where are you going to be?

Offender: In seg.

Therapist: Yeah. You are likely going to be in RH. Is that a positive thing or is that more of a negative thing?

Offender: Negative.

Therapist: What if you walked away? What are the consequences for that?

Offender: There ain't no consequences.

Therapist: Right. The situation is going to de-escalate and may end.

Offender: What if he run up on me first?

Therapist: That could be a consequence. Let's say you walk away first and he runs up on you.

Offender: Yeah. What if he starts punching me and if I hit back, do I still get a DR?

Therapist: Well it kind of depends. In this facility, if you are targeted or you become a victim, let's say someone runs up behind you and starts punching you. If you immediately start punching them back and they fall down on the ground and you're still punching them. You are going to get in trouble.

Offender: Alright. What if I stop punching him when he falls on the ground?

Therapist: Then it is looked at more highly. If you get him off of you and then you back up and get ready to secure when the A-Team gets there, then it is looked at more highly on you.

Offender: Ah hell no. I am getting up and beating his ass.

Therapist: Then you are not going to look at as the victim, right?

Offender: No, somebody told me somebody is supposed to run up on me on the 30th, so tomorrow.

Therapist: This is an interesting point you bring up. What? You are supposed to get jumped tomorrow?

Offender: Yeah. I don't know who by, but if they run up on me, I'm gonna get to stealin' on 'em. So how do I get a self-defense and still get my level? I'm not fixin' to let them beat my ass.

Therapist: This is an important point that you bring up. Right?

Comment: Again, validating the offender's comments and reminding him what he brings to sessions is important can be extremely validating for him. Specifically for this example, the therapist wanted the offender to know he was cared for and his safety was important. The offender trusted the therapist enough to tell her this information, which likely led to a boost in rapport building.

Offender: Uh-huh.

Therapist: In here, for it to be self-defense you have to not use as much force as them. If he runs up and jumps you, if you start fighting back that is going to be a problem. They are not going to view that as self-defense. Does that make sense?

Offender: Yeah.

Therapist: Why do you think they don't view it as self-defense?

Offender: Fighting back?

Therapist: Yes. If you are fighting back.

Offender: Alright. So what if I just. What if they just hit me when I'm not looking?

Therapist: If they hit you while you aren't looking, and it doesn't escalate from there, then..

Offender: But what if it does escalate?

Therapist: What does escalate look like to you?

Offender: Me getting back up and fighting. I'll hit him, but what if I hit him three times and the A-team already there, and I back off of him.

Therapist: I don't think there are a certain number of punches, per say, that I can tell you. Three punches is self-defense. Doesn't quite work that way. Let's say they hit you one time and you hit them back and they fall on the ground, you need to stop. But what is the goal here?

Offender: What if they hit me more than one time?

Therapist: The goal here is that we don't hit back at all. That's the real goal. If you really want this to be self-defense because someone is running up on you, you have to not do anything.

Offender: They gonna think I dodge that shit. Nah. Cause then if I'm dodging him then I'm gonna be on the ground in the corner lookin' shitty and he still gonna get to takin' off on me.

Therapist: If he hits you, you are going to take off on him. What sorts of consequences is that going to have?

Offender: Seg. And after that, when I get sent to seg, I ain't gonna give a shit. I'm going to go right to K. From that point on, I am getting restrained every time I get out of the fuckin' cell.

Therapist: If you go to seg, every time you get back in GP, you are just going to try to get restrained to go to K. I'm just not gonna give a shit. If they tryin' to lower my levels and then messin' up on me there's no point. I'm just gonna get restrained every time.

Therapist: Losing your level means that you have lost everything then. You could never get your level back.

Comment: These reflections were used to amplify the offender's previous statements. However, it may have been more beneficial if the therapist had only used the first reflection and then paused for the offender to respond. As shown, the offender only responded to the second reflection, which was not as exaggerated as the first. By only saying the first reflection, the therapist may have been able to elicit a more thoughtful response from the offender.

Offender: I can, but I am not going to try. I am just going to keep getting into trouble.

Therapist: What makes you not want to try?

Offender: Cause that shit retarded. If he hit me and I hit him back for self-defense.

Therapist: I told you. What I have seen since I have been here, this happened recently.

Someone did get jumped, people ran up on him. He hit them both and when they fell on the ground, he cuffed up. He was like, "I'm done."

Offender: Did this happen in intake?

Therapist: I'm not going to tell you who it is.

Offender: I know who it is. (*laughing*)

Therapist: Stuff like this happens all the time here. What I'm telling you is, you can't use force against this other person and think that nothing is going to happen. You have to use these strategies we've been talking about in here and make them worth your while out there.

Comment: In reflection, this comment appears to be somewhat argumentative. It may have been more helpful to use a process comment here to say, "I'm noticing that we are getting a little off topic here. How could we use the skills we have talked about in this situation?" It is believed this comment would have helped the offender remember the skills learned and identify how to apply them appropriately.

Offender: Shit. I'm gonna keep gettin' into more fights then.

Therapist: How can you use the stuff we've talked, in here, about?

Offender: Can't go to my room. I can't go to rec.

Therapist: You can't go to your room, you can't go to rec, what's something else you could do?

Offender: Just take off on his ass.

Therapist: I think we have come up with some other things that you could do. And that's also what we are going to do today, is come up with more solutions. Right?

Offender: Nah. I just hit him. That's the only thing I could do. Well I know he can't beat my ass, I'm just gonna hit that nigga one time.

Therapist: Okay. Let's say he does go off on you and you do hit him one time. Then he falls to the ground. What is the consequence for stopping there?

Offender: I am gonna stop.

Therapist: You are gonna stop.

Offender: Yeah. But he gonna have to cuff up first.

Therapist: I can't tell you who is going to cuff up first.

Offender: Cause if I cuff up then he's gonna hit me and the next time I see him I'm gonna be on his ass.

Therapist: Typically enough officers come in to where the two of you are separated, right?

Offender: Yeah. But they be taking they sweet ass time.

Therapist: I think it takes a little more time then you think for the officers to get down there and get you guys cuffed up.

Offender: By that time I'm gonna have like two or three hits off his ass and it's gonna be over and I am gonna have a DR.

Comment: Towards the end of the session, the pattern of speech between the offender and therapist became more even. Had the therapist used a process comment about the pattern of speech earlier in the session, it is likely this pattern would have been more equal earlier on in session.

Therapist: Yeah. Do you wanna get a DR?

Offender: No.

Therapist: Then your level 2 is pretty much gone, right? If you beat the crap out of this guy, I can almost guarantee you, you are not going to be getting your level 2.

Offender: I already know.

Therapist: So, it's important that you don't do that. That you use the strategies that we are talking about today, if that happens. Let's come up with more solutions. What happens if you ignore him? What's your consequence for ignoring him?

Offender: Walk away.

Therapist: What's the consequence for that?

Offender: Nothin'.

The offender identified the best way to solve this problem would be to walk away from the other youth or talk to him about the problem. The session concluded by discussing how the best way to manage a problem with another person is to use verbal strategies. A role-play was used to help the offender practice what it would be like to verbally discuss with his teacher the problems he has been having in class. The offender was able to appropriately verbalize his frustrations with the therapist and receive feedback, regarding the words he used and his tone of voice. The offender was able to role-play a second time, and incorporate the therapist's language examples and feedback. The therapist then assigned the offender homework to complete over the next week.

Appendix J

Session Performance

The offender was seen once a week for 10 weeks. The first three sessions of CBT-AAC comprised the first module and were used as a basis for teaching the client skills regarding anger management. During the first session, the therapist presented the rationale for treatment and used motivational interviewing skills to increase the client's motivation for treatment. The offender reported he wanted to learn how to manage his anger more effectively, while simultaneously sharing his belief that decreasing the amount of anger he currently feels is not possible. The therapist educated the client on the usefulness of anger and the elements of an anger episode. The offender was able to identify five triggers of anger he experiences daily that are likely to culminate an aggressive response, including: liars, being disrespected by others, being told what to do, when others think they can beat him up, and when he is arguing with someone. Therapist provided psychoeducation on the use of distraction to decrease aggressive behaviors. The offender reported he could read a book, talk to his brother, go to recreation, go to sleep, or talk to his grandpa. According to CBT-AAC the offender should have practiced deep breathing during this session. However, the offender refused to participate in practicing this skill as he reported having done it in the past and not wanting to try it again. The offender reported feeling confident to use his distraction strategies to decrease his physical aggression over the next week, and the therapist assigned the offender to complete the anger management log one for homework.

The second session began with reviewing the offender's homework and praising him for his ability to complete the activity and manage his anger in a more prosocial manner. Therapist provided psychoeducation on anger intensity and monitoring anger intensity throughout the day

to increase one's ability to manage anger when it's intensity is lower. Therapist and offender worked together to create verbal reminders he can use to help manage his anger when the intensity is at a lower level. The offender identified several verbal reminders, including: "chill out," "calm down," "take it easy," and "you want your level 2." The offender often referred back to information from the first session and reported he felt very comfortable to read a book or use distraction to manage his anger. Therapist encouraged the offender to also practice using verbal reminders, in addition to his distraction techniques. The offender was also educated on how one's labeling of anger often influences their experience of anger and he reported using words like "annoyed" and "frustrated" would be less anger provoking for him. The therapist and offender practiced client specific examples when checking in with his feelings of anger, labeling his feelings, and using nonverbal reminders to manage his level of anger effectively. Lastly, although the offender still reported being reluctant to engage in deep breathing to achieve relaxation, the therapist and offender agreed he would try taking three deep breaths before bed each night while visualizing something positive. The offender also agreed to keep his verbal reminder notecard in his room and complete the anger management-log two as part of his homework.

During the third session, the offender was able to complete his anger management log. He reported becoming angered when another youth on his unit was provoking him. The offender reportedly refrained from getting into a physical altercation, and instead having gone into his room to read a book and distract himself from his anger. Therapist provided psychoeducation on the prevention of anger-provoking situations by using the techniques previously taught in therapy. The offender identified he could avoid specific youth on his unit that are particularly triggering for him by moving away from them or using his distraction

techniques. Then, therapist and offender identified physiological cues associated with the offender's anger and he was able to identify several physiological cues he experiences, including feeling his heart race, tensing his muscles, experiencing no pain, and having racing thoughts. Lastly, the therapist educated the offender on the use of progressive muscle relaxation (PMR) and practiced tensing and relaxing different muscle groups with him. The offender was resistant to trying PMR, but allowed the therapist to walk him through the exercise. After completing PMR, he reported being able to feel the difference between tense and relaxed muscles, and agreed that having tense muscles could increase his anger intensity. The offender agreed to complete another anger management log focusing on using strategies to prevent anger-provoking situation, and also a relaxation practice log for homework before next session.

The fourth session is the first session in the second module of CBT-AAC called problem solving. The session began by reviewing the offender's homework from the past session. The offender was able to complete his PMR practice and he reported he would feel calm for about 10 minutes after completing PMR. The offender completed his anger management log over a situation he experienced regarding a disagreement with a correctional officer. Reportedly, the offender was able to manage his anger by returning to his room and taking deep breaths before talking with a different corrections officer. The therapist provided psychoeducation on the importance of the connection between one's thinking and their emotions. The offender was able to create three different calming thoughts he could say to himself when he gets angry, including "ignore her" when his teacher frustrates him, "go to the weight room" when his peers push him while playing basketball, and "just do it" when the corrections officers ask him to do something. Next, the therapist and client discussed problem identification and perspective taking. When evaluating client specific examples, the offender

was able to accurately and appropriately identify his and the other person's goals and perspectives when they are in a disagreement. Lastly, the therapist provided psychoeducation on using a hostile attribution bias and how this may affect the offender's anger. The offender reported feeling others are out to get him and intentionally try to get him in trouble frequently. He identified how his hostile attribution bias may influence how he views situations. The offender agreed to complete another anger management log, specifically focusing on identifying other's goals and perspectives in the situation, before next session.

The fifth session was focused on the ability to generate multiple solutions for a problem and then identifying which solution would lead to the most positive outcome by maintaining relationships with others and staying out of trouble. A transcript of the fifth session is provided in Appendix I. At the beginning of the fifth session, the therapist and offender reviewed his anger management log. He was able to effectively manage his anger during a situation where his corrections officer told him he had to secure in his room for not following directives. The offender felt wronged and did not want to secure. Reportedly, the officer called a sergeant and the sergeant was able to de-escalate the situation by allowing the offender to remember he wants to earn his level two in the next couple weeks. The offender was able to effectively manage his feelings of anger and secure before getting into further trouble. The offender identified that his goals and the corrections officer's goals were different and this likely led to the disagreement between the two. Next, the therapist educated the offender on the importance of identifying and practicing new ways of behaving to solve problems. The Problem Identification, Choices, and Consequences (PICC) handout was used to allow the offender to generate multiple solutions to the problem of being annoyed by others on his unit. He was able to generate multiple possible solutions, including: fighting, walking away, ignoring the other

person, going to recreation, taking deep breaths, locking down, and talking to the other offender. When asked, he identified the most positive solution would be to talk to the other offender, although he reported being most likely to walk away and avoid the situation. During this discussion, the offender reported he was told he was going to “get jumped” the day after this session, which could explain the increase in the offender’s CAS score during this session. The therapist and offender worked together to discuss ways in which he could appropriately respond if he was jumped, by applying skills taught during his sessions including: protecting himself using self-defense, not fighting back, and remembering he wants to earn his level two in the next couple weeks. The offender reported he does not want “getting jumped” to interfere with the progress he has made and the possibility of receiving his Level 2 treatment status in the next couple of weeks. Then, the therapist and offender discussed the effect anger has on one’s ability to generate multiple solutions. The offender reported it is hard for him to think differently when he becomes angry and he is not able to think of any other solutions besides fighting. The therapist educated the offender on the importance of practicing generating solutions when he is calm, in order to be able to effectively generate and use them when he is angry. The Managing Anger before Problem Solving (MAPS) worksheet was used to allow the offender to visually process how one can manage their anger to effectively solve a problem. Lastly, the offender recognized the best way to manage a problem with another person is to use verbal strategies. In particular, the offender and therapist role-played what it would be like if the offender used his verbal skills to express his anger to his teacher. The therapist acted as the teacher and the offender was able to receive corrective feedback about his tone, use of sarcasm, and put-downs when role-playing this discussion with his teacher. After the role-play, the offender reported wanting to express his anger to his teacher using polite and calm language

during the next week. In addition to this, the offender was assigned the completion of the anger management log 5, which focuses on generating multiple solutions to an anger-provoking situation as homework. Furthermore, the offender elected to do extra homework by completing the PICC and MAPS worksheets on his own over the next week.

The sixth session began with a review of the offender's completed homework. He completed an anger management log over a situation he experienced on his unit. The offender reported he received a DR for having a pen in his room and he felt it should not have been a DR. The youth reported using his verbal reminders to calm himself and then verbally solve the problem by talking to his officer. The offender reported three other anger-provoking situations he experiences where he was able to effectively use the skills he has learned to manage his anger without using aggression. He also completed two extra worksheets, the PICC and MAPS handouts. After discussing his worksheets and his ability to manage his anger effectively, the therapist concretized the changes the offender has made. The offender reported behaving in a new ways and recognized his ability to manage his anger without becoming aggressive. The therapist introduced the concept of consequential thinking by explaining how the choices one makes influences other people and it is important to consider how one's decisions may affect their relationships with others. The offender completed the fishing boat handout and identified the consequences of selecting each item he planned to keep. He quickly identified how the handout related to the solutions available to him when he becomes angry. In regards to his teacher, the offender reported understanding her views on him and how he influences her view of him. Reportedly, he was able to talk to his teacher and build a relationship with her, instead of being disrespectful. The offender identified he causes problems with his teacher because he is disrespectful and talks to other youth in his class. The therapist and offender created a

behavior contract to work on his behavior in class. The offender agreed he will not receive any VRs over the next week. To increase his ability to complete his behavior contract, he reported he will have to say “okay” when his teacher asks him to do something and ignore other youth when they talk to him. For homework, the offender agreed to complete the sixth anger management log by writing about a situation in which he was able to effectively manage a problem by thinking about the consequences of his actions.

The seventh session was the first session in the social skills module. The focus of this module is to allow the offender to practice the anger management and problem solving skills he has learned to allow the skills to become more automatic. When the offender arrived for the session, he was particularly quiet, avoided eye contact, and appeared less engaged than in previous sessions. The offender completed his homework over a situation where he became angry with his teacher. He reported he could have gotten restrained, but decided to follow directives and secure in his room. Therefore, the offender was not able to complete his behavior contract agreed to in the previous session. His goal was to receive no VRs and he reported receiving six, although records indicate he received three. The offender reported becoming angry with his teacher, receiving one VR, and then deciding it was not worth it to behave appropriately while in school. The therapist educated the offender on the use of assertive behaviors to de-escalate and directly communicate one’s needs and the use of role-plays to practice using assertive behaviors. The three ways of acting handout was used to allow the offender to express his thoughts on being passive, aggressive, and assertive in anger-provoking situations. He reported becoming aggressive is the easiest for him, although he reported being willing to try using assertive behaviors. The offender created a list of triggers he experiences on his unit and categorized them as can be ignored, cannot be ignored, and can be responded to

assertively. The therapist and offender role-played responding to the triggers in assertive ways and the offender identified one assertive response he could use to address his peers when they provoke his anger. Lastly, nonverbal communication was discussed and the offender was able to recognize the therapist's nonverbal behaviors which may influence and escalate a situation. The offender was assigned to complete anger management logs 7a and 7b, which are designed to help him practice ignoring triggers that can be ignored and using assertive communication when triggers cannot be ignored. When asked if he would like a second chance to achieve his behavior contract, the offender reported feeling like getting no VRs was too high of an expectation. He revised his behavior contract and decided he wanted to work on not receiving a summary judgment (an infraction higher than a VR, but lower than a DR) before next session.

During the eighth session, the offender completed two anger management logs for homework. He reported experiencing one anger-provoking situation with his peer and one with his corrections officer in which he was able to effectively manage his anger using skills practiced in sessions. The offender was not able to reach his goal of receiving no summary judgments at school and the therapist determined teaching the social skills of this session may influence his ability to be able to talk with his teacher and manage his anger in future weeks. The therapist used psychoeducation to discuss the difference between fairness and rights. The Bill of Rights handout was used to illustrate the five rights each person has, including: to be listened to, to explain one's side of the story, to own property, to not be insulted, and to not be hurt. The offender shared some examples where he felt like his rights were violated and an example was used to identify violated rights. Next, the therapist educated the offender on active listening. The offender reported often being wrongfully accused by his teacher of talking in class. The therapist role-played and created a coping template with the offender on how he

could effectively use active listening skills to talk to his teacher and advocate for his rights. He identified he could say, "I was not talking. I think it was someone else," while making eye contact and using a soft tone of voice. He reported this statement wouldn't make him feel weak and he thought his teacher would respond positively to him using this statement. Lastly, the therapist educated the offender on the use of apologies to recognize when another's rights have been violated. The offender reported a situation that happened on his unit where he was teasing another youth by calling him names. He reported he apologized for his behavior by saying, "I'm sorry for doing that to you." The therapist validated the offender's current use of apologies and educated him on using eye contact and a soft tone of voice while apologizing. Before next session, the offender agreed to complete anger management logs 8a and 8b as homework.

The offender was able to complete his homework for the ninth session. He wrote about two different anger-provoking situations he had over the past week, including a situation with an officer and his teacher. He reported attempting to use the skills previously talked about in session to manage his anger appropriately. Therapist attempted to role-play the situations with the offender, however he reported he could not remember exactly what happened. The therapist continued psychoeducation on how to resolve conflicts with adults. The offender was able to appropriately role-play different anger-provoking situations he has with adults. He reported having tried to talk with his teacher before, but felt like she didn't listen to him. Therapist provided corrective feedback and educated the offender on the importance of making eye contact when talking to his teacher. Therapist used the poor communication habits handout to allow the offender to identify what communication habits he uses, including insulting, interrupting, getting defensive, going silent, looking away, and using sarcasm; as well as,

identifying how he could behave differently. He identified wanting to state the issue clearly, make eye contact, take turns when talking, and calmly disagree. Lastly, the therapist and offender discussed the importance of admitting to one's faults in any problem situation. The offender reported often blaming others but reported being willing to try apologizing for his behavior in class. The therapist and offender role-played an appropriate apology and the therapist provided the offender with corrective feedback. The offender practiced his apology two more times. For homework, the offender agreed to complete the final anger management log and the daily anger-monitoring log.

The final session included a review of the offender's homework, anger management skills, problem solving skills, and social skills. The offender completed the anger management log by writing about a situation with his teacher. He reported she asked him to stop talking and he attempted to use verbal skills to tell her he was not talking. Reportedly, the offender felt like the teacher did not listen to him, although he admitted he did not maintain appropriate eye contact and interrupted her when she was talking. Therapist helped the offender determine what would have been more effective when talking with his teacher. Next, the therapist used the anger management skills handout to determine what skills the offender found to be helpful. When assessing anger management skills, he reported always using progressive muscle relaxation, calming verbal reminders, and engaging in pleasant activities when he becomes angry. Specifically, he reported reminding himself of his goals and not wanting to lose good time provided him with continued encouragement to manage his anger appropriately. For the problem solving skills module, the offender reported always thinking about why there is a problem when he is mad and evaluating different consequences. He reported using these skills more now than he did before treatment. Lastly, the offender reported always trying to explain

his side of the story when he is angry. Although, he did admit to not always making eye contact and often times interrupting the other person when he tries to tell his side of the story. The offender appeared pleased with himself and his ability to complete the treatment. Although this tenth session served as the completion of the CBT-AAC modules, as well as the conclusion of this EST Case Study, the therapist plans to check-in with the offender in the coming weeks to ensure he continues to practice the skills he has learned.