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## Anger, racism, and anger management therapy with African American adolescents

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## Anger, racism, and anger management therapy with African American adolescents

### Abstract

Increasingly, much of the stress people in the United States experience is due to societal disorder and social pressures (Jenkins, 1982). Racial strife, violence, unemployment, hunger, and housing shortages among other problems, are examples of societal disorder" and are symptoms of the "sickness" of our society that contribute to the chronic anger that many people experience on a daily basis. The concept of social emotional process describes how a prolonged increase in social anxiety can result in a gradual lowering of the functional level of families (Nichols & Schwartz, 1995). Nichols & Schwartz (1995) cite the example of the high crime rate that results in communities with great social pressure and acknowledge that sexism and ethnic prejudice are examples of social pressures."

**ANGER, RACISM, AND ANGER MANAGEMENT THERAPY WITH  
AFRICAN AMERICAN ADOLESCENTS**

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**Presented to**

**The Department of Educational Leadership, Counseling,  
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**of the Requirements for the Degree**

**Master of Arts**

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**by**

**Rachel A. Dennis**

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Increasingly, much of the stress people in the United States experience is due to societal disorder and social pressures (Jenkins, 1982). Racial strife, violence, unemployment, hunger, and housing shortages among other problems, are examples of “societal disorder” and are symptoms of the “sickness” of our society that contribute to the chronic anger that many people experience on a daily basis. The concept of social emotional process describes how a prolonged increase in social anxiety can result in a gradual lowering of the functional level of families (Nichols & Schwartz, 1995). Nichols & Schwartz (1995) cite the example of the high crime rate that results in communities with great social pressure and acknowledge that sexism and ethnic prejudice are examples of “social pressures.”

According to Graham, Hudley & Williams (1992), “studies of childhood aggression reveal a social phenomenon rapidly emerging as a serious contemporary problem” (p. 731). Empirical literature has found childhood aggression to remain stable over time (Graham, 1992; Guerra, Huesmann, & Zelli, 1993; Hudley, 1993; Tedeschi, J. T., 1994) and predictive of negative outcomes such as low academic achievement (Guerra, Huesmann, Tolan, Van Acker & Eron, 1995; Hudley, 1993), school dropout in adolescence (Guerra, Huesmann, & Zelli, 1993; Graham, 1992), juvenile delinquency (Graham, Hudley & Williams, 1992; Guerra, Huesmann, & Zelli, 1993; Hudley, 1993), and adult criminality and psychopathology (Colder & Stice, 1998; Wilson & Herrnstein, 1985). The ramifications for African-American people become even more compelling with the realization that “many of the known correlates of childhood aggression are disproportionately prevalent among ethnic minorities, particularly African-American males” (Graham, Hudley, & Williams, 1992; p. 731).

In a society that historically has encouraged racial hatred, ambivalence toward the welfare of African-American people, and blatant discrimination, it is not surprising that African-American adolescents are becoming increasingly aggressive in voicing their anger. According to Stevenson (1997) and others (Colder & Stice, 1998; Houston, 1990), "the psychological effects of living in a racially hostile context are multiple. African-American adolescents who respond to racial intolerance with anger and depression are silenced and vulnerable to misinterpretation and misdiagnosis" (p. 197).

Although research has shown that general anger can be effectively reduced or managed (Abernethy, 1995; Graham, Hudley, & Williams, 1992; Kellner & Tutin, 1995), adequate attention has not been paid to counseling clients whose anger is rooted in the racism of others. Developing strategies to increase the success of counseling angry African-American youth requires a sensitivity to specific cultural aspects of African-American life. The dual purposes for this paper are to clarify and refine our understanding of anger, focusing on African-American adolescent anger that is due to racism, and to review research on anger management therapy to better understand how it can be adapted to best serve the African American adolescent population.

## Racism

### Racism Defined

Many definitions of racism have been proposed. In his book "Portraits of White Racism," Wellman (1977) defines racism as a "system of advantage based on race" (p. 7). As examples, he cites how Whites defend their racial advantage with access to better schools, housing, jobs. According to Tatum (1997), this

definition of racism is useful because it states that “racism, like other forms of oppression, is not only a personal ideology based on racial prejudice, but a system involving cultural messages and institutional policies and practices as well as the beliefs and actions of individuals” (p.7).

Another definition of racism is discussed as prejudice plus power (Tatum, 1997). Using this definition, racial prejudice when combined with social power leads to the institutionalization of racist policies and practices. This definition also captures the idea that racism is more than individual beliefs and attitudes. For some people, however, this definition has little relevance as they do not see themselves as prejudiced or powerful.

Sue & Sue (1990) talk about institutional racism as a “set of policies, priorities, and accepted normative patterns designed to subjugate, oppress, and force dependence of individuals and groups to a larger society” (p. 78).

Perhaps the clearest definition comes from Ridley who incorporates all of these points into his definition. According to Ridley (1995), racism is “any behavior or pattern of behavior that tends to systematically deny access to opportunities or privileges to members of one racial group while perpetuating access to opportunities and privileges to members of another racial group” (p. 28). His definition includes five features: “a variety of behaviors, systematic behavior, preferential treatment, inequitable outcomes, and nonrandom victimization” (p. 29). A discussion of each of these features is helpful in understanding racism.

### Features of Racism

Variety of behaviors. Racism is not always highlighted by blatant acts of bigotry. It is more than acts of violence, such as attacking civil rights

demonstrators or burning crosses. Racism involves a variety of behaviors, including those that are not typically thought of as racism. According to Ridley (1997), the “possibility for racism in the counseling profession is immense” (p. 29). Examples cited by Ridley include misinterpretations of client behavior by the counselor, refusing to accept minority clients because one believes them to be inferior, misdiagnosing pathology because of expectations about people of a certain ethnicity, setting fees above the affordable range of most ethnic minority clients with the hopes of excluding them from treatment, or using standardized psychological tests without consideration of subcultural group differences and biases in test construction and interpretation.

Systemic behavior. General systems theory is useful in demonstrating racism as a problem of social systems (Ridley, 1997). According to theory, a system is a pattern of relationships that prevails over time. Katz & Kahn (1978), describe social systems as:

All social systems, including organizations, consist of the patterned activities of a number of individuals. These patterned activities are complementary or interdependent with respect to some common output or outcome; they are repeated, relatively enduring, and bounded in space and time. If the activity pattern occurs only once or at unpredictable intervals, we could not speak of an organization. The stability or recurrence of activities can be examined in relation to the energetic input into the system, the transformation of energies within the system, and the resulting product or energetic output (p. 20).



If one depicts racism as social systems behavior, three characteristics of open systems are relevant to our understanding. Racism depends on: first, input such as money, personnel, and attitudes. Second, it involves a systemic transformation whereby behavior and patterns of behavior transform minority clients into victims. Third, it produces outputs. Katz & Kahn (1978) state that “racist outcomes are linked to a system’s input and transformation when minority clients leave counseling prematurely, unhelped, misdiagnosed, or disenchanting” (p. 32). These three characteristics suggest that racism is a function of social systems. According to Ridley (1997), “without the support and reinforcement from larger social systems, racism could not exist” (p. 31).

**Preferential treatment.** Racism is not a fair system where everyone has equal opportunity. Racism involves preferential treatment for members of the majority group. Ridley (1997) states that “in the mental health system, Whites have an advantage over minorities” (p. 32). This is especially true when a conflict in values contributes to the problem.

**Inequitable outcomes.** Benefits, whether they are social, psychological, economic, material, or political, are often given to Whites but not to African Americans. As a result, Whites consistently find themselves with more opportunities than African Americans and this is true in the mental health field as well as larger society. Ridley (1997) notes that the Diagnostic and Statistical Manual of Mental Disorders (4th ed.) gives little attention to the significance of culture. Since this “manual is used for classifying mental illnesses, diagnostic errors stemming from either the neglect of culture or misconceptions about culture may occur” (p. 33). Ridley further states that “since paradigms and models often

categorize people, favoring persons whose behaviors are consistent with traditional Western values, these paradigms may contribute to unintentional racist outcomes” (p. 33).

**Nonrandom victimization.** When members of a racial group are repeatedly victimized it is improbable that the recurring victimization is random (Ridley, 1997; Sue & Sue, 1990; Tatum, 1997). More plausible is that systematic influence - the systematic denial of access to opportunities and privileges - is occurring. The assumption of White entitlement in the United States is central in many narratives shared by African Americans (Watt, 1999). Watt states that “this unspoken assumption is subtly exemplified in statements in which there is a distinction made between “us” and “them” (p. 59). And it is exemplified anytime a White person uses “we” to speak for all White persons. Watt concluded that “there is a presumed sense of power that underlies the words of the White perspective and can be attributed in part to the unearned privilege of being White” (p. 59).

The dynamics of racism can be further clarified by considering its behavioral components. According to Ridley (1995), the two major behavioral categories are individual and institutional. An example of individual racism is the suspicious salesperson who follows every African American around a department store and automatically believes the person will shoplift. Institutional racism, however despite current rhetoric about affirmative action, involves the behavior of organizations that limits African American access to housing, better schools, or better jobs.

The two major categories of racism can be divided into the smaller components of overt and covert racism. Overt racism is always intentional and the

underlying motive is always prejudice. Overt racism is White men dragging an African American male behind a truck until he is ripped apart and dies. Covert racism, on the other hand, is more subtle and its motives are hidden. Some racists are skillful in hiding or masking their motives (Ridley, 1995). Covert acts of racism can be either intentional or unintentional. Covert intentional racism is illustrated as “a senior psychologist who assigns a minority client to an intern because of social discomfort but claims to have a schedule overload” (p. 37). Unintentional covert racism, as a last example, is illustrated as “a therapist, functioning under the illusion of color blindness, who erroneously diagnoses pathology” (p. 37).

As one can see, racism is a complex problem. Most people do not know how their behavior damages someone of another race, however, Ridley (1995) states that some of the greatest harm is done by individuals and institutions that unintentionally promote and engage in racism.

In this section, racism was defined and characterized by five features: many possible behaviors, systematic behavior, preferential treatment, inequitable outcomes, and nonrandom victimization. Racism was further categorized based on individual and institutional behaviors. Other components of racism were overt and covert, intentional and unintentional. Of all the forms of racism, unintentional racism is considered the most insidious (Ridley, 1995; Sue & Sue 1990; Locke, 1992). Unintentional racism often goes unnoticed but its effects are harmful to any minority culture. In the next section, the effects of racism on African American adolescents will be explored.

### Effects of Racism

Racism affects African American adolescents both psychologically and externally. According to Grier (1968), "racism constitutes a heavy psychological burden. Black men fight one another, do violence to property, do hurtful things to themselves while nursing growing hatred for the system which opposes and humiliates them. Their manhood is tested daily" (p. 71). Psychological harm has been documented in most literature that discusses racism. Sue & Sue (1990) list feeling powerless, hopeless, subordinated, deprived, inferior, inadequate, suspicious and mistrustful as effects of racism that are commonly experienced by African Americans. Ridley (1995) describe how African Americans often internalize stereotypes placed on them by Whites. African Americans may have a confused sense of self-identity (Watt, 1999). They may experience a strange mix of shame and pride (Sue & Sue, 1990). There is empirical evidence supporting the relationship between perceived discrimination and elevated depressive symptoms (Verkuyten, 1998). Perceived discrimination was also related to more reported aggression, sadness, anxiety, and egotism (Verkuyten, 1998). Outwardly, the effects of racism are manifested in behaviors that deny racial identity; "White" mannerisms, speech, dress, and goals may be mimicked (Sue & Sue, 1990). There may be the strong desire to assimilate and acculturate into White society in order to gain approval and advantage (Ridley, 1995). Typically, increased vigilance and sensitivity to Whites is displayed (Tatum, 1997). The guilt, shame, and anger felt internally is often directed outwardly toward oppression and racism. The person may occupy extreme positions that they to prove "how Black he or she is" (Sue & Sue, 1990).

The inferior status of African American people is constantly reinforced and perpetuated by institutional racism through the mass media of television, movies, newspapers, radio, books, and magazines (Locke, 1992). It contributes to widespread stereotypes that tend to trap African American individuals (Sue & Sue, 1990). It is displayed through public policies, political priorities, inequity in educational opportunity, normative patterns that do not consider cultural differences, unequal status and goals, unequal access to goods and services, selective law enforcement, blocked economic opportunities, forced acculturation, and forced ritualized accommodating-subordinating behaviors (Locke, 1992; Neighbors, 1990; Ridley, 1995; Sue & Sue, 1990).

The result of racism is that African American people, and children in particular, are taught to believe that deviations from the normative patterns of the White culture are indications that they are abnormal and that White culture, social, and institutional standards are superior (Locke, 1992). The result is identity crisis and self-hatred. Is it any wonder that African American adolescents are so angry?

### Anger

According to Abernethy (1995), "special attention to the experience of anger is vital because cross-racial interactions are often embedded with anger or the anger is avoided or ignored, and skills in managing anger are an effective tool for working with culturally different clients" (p. 96). African American clients may come to therapy with anger as a presenting complaint. The anger may be related to racism, discrimination, or socioeconomic status (Abernethy, 1995). This section of the paper defines anger, studies its causes, and delineates its consequences.

## Anger Defined

Anger is an emotional state that comprises feelings ranging from mild annoyance to rage (Spielberger, 1988). It has been associated with the experience of injustice and with the attribution of responsibility and blame to others (Tedeschi & Felson, 1994).

## Causes of Anger

Historically, anger has been misunderstood (McKay, Rogers, & McKay, 1989). Anger and aggression have been studied in many scientific disciplines and each discipline develops its own set of theories and methods to explain aggression.

“Biologists focus on evolutionary principles, genetic codes, biochemical factors, or central nervous system activity” (Tedeschi & Felson, 1994, p. 3). Scientists have examined instincts, hormones, genetic abnormalities, heritability of aggression, and brain centers (McKay, Rogers, & McKay, 1989). The research, however, was done with lower organisms and generalizing such findings to explain human aggression has not been corroborated (Tedeschi & Felson, 1994).

Freud’s classic frustration-aggression theory was a landmark study of aggression because it led to laboratory research on aggression by psychologists (Tedeschi & Felson, 1994). The theory tried to combine built-in biological factors with learning to explain aggression. According to Tedeschi & Felson (1994), “research does not consistently support frustration-aggression theory” (p. 5). Berkowitz revised the theory in 1993 by proposing two systems of aggression: angry aggression - based on anger and aimed at inflicting pain, and instrumental aggression - aggression as a means to some goal other than causing pain (Tedeschi & Felson, 1994). According to Berkowitz, a biological structure is activated to

create a desire to hurt others (Tedeschi & Felson, 1994). Evidence has supported these processes only inconsistently and there remains some question about misinterpretations by Berkowitz (Tedeschi & Felson, 1994).

Physiological arousal and its effects on aggressive behavior were proposed in Zillmann's 1971 theory of excitation transfer (Tedeschi & Felson, 1994). According to Zillmann (as cited in Tedeschi & Felson, 1994), anger causes aggressive behavior. Arousal due to anger is heightened by residual arousal so that the individual retaliates at a higher level of aggression. He stated that when arousal is heightened, cognitive controls are bypassed so that habitual and impulsive aggression may occur (Tedeschi & Felson, 1994). Tedeschi & Felson (1994) state that "research has indicated the physiological arousal facilitates aggression but does not instigate it" (p. 5). Another area of public interest has been the effects of sexual arousal on aggressive behavior. Tedeschi & Felson (1994), concluded that "erotic stimuli and pornography do not instigate or facilitate aggressive behavior specifically directed toward women" (p. 5).

Social learning theories assume that aggression is learned like other behaviors and is a means to achieving goals (Bandura, 1983). According to Bandura, learning any behavior, including aggression, is a function of rewards and punishments, association of stimuli and responses, and extinction processes. In addition to the behavioral aspect, learning is a function of cognitive processes (Bandura, 1983) with the central idea being that people learn not only by doing, but by observing the behavior of others. According to Tedeschi & Felson (1994), studies have shown that "the impact of watching violence on television is very

small” (p. 6). They state that “while learning is important, the relationship between observation and aggression is not strong” (p. 6).

Sociological theories of violence and crime have been used to explain sociodemographic variation in criminal behavior (Tedeschi & Felson, 1994). These theories focus on variation across groups in values conducive to violence and delinquency; interpreting crime as an alternative form of achievement; or as a way of handling grievances when legitimate opportunities are blocked (Tedeschi & Felson, 1994). Other theories assume that the incentives for crime are constant but costs and inhibitions vary. Still others state that aggression is likely to occur when internal and external controls are weak and when there are opportunities to commit crime with impunity (Tedeschi & Felson, 1994).

Finally, the social interactionist approach, put forth by Tedeschi & Felson (1994), assumes that “harmdoing is goal-oriented behavior that develops out of social interactionist processes” (p. 155). This theory interprets coercive actions as a form of social influence. The aggressor is viewed as “a decision maker who imposes harms or forces compliance to achieve valued outcomes” (Tedeschi & Felson, 1994, p. 176). The theorists suggest three primary social motives for using coercion: to influence others to obtain some benefit; to express grievances and establish justice; and to assert or defend social identities (Tedeschi & Felson, 1994). They go further in stating that anger and aggression are choices based on the angry individual’s perceptions of the value of outcomes, probability of success, and negative costs.



### Consequences of Anger

In Victorian times, anger was seen as destructive, damaging, and something to be controlled (Kemp & Strongman, 1995). A woman's display of anger was seen as unfeminine. In contrast anger was considered necessary in men so that they might have an edge in business and politics (Kemp & Strongman, 1995). Rather than extinguish anger, it was seen as sometimes useful if used appropriately.

For the last twenty years, however, Western culture has sought to have people "manage" their anger (Kemp & Strongman, 1995). This has been especially true for men, who have been seen as prone to breaking out in uncontrolled angry displays. It has been seen as less of a problem for women, who supposedly have learned to control (suppress) their anger (Kemp & Strongman, 1995). The physiological consequences of anger have been empirically researched. For instance, suppressed anger was found to be an important factor in increased risk for hypertension (Abernethy, 1995). Anger has been related to other kinds of poor physical health such as headaches, GI disturbances, and heart attacks (Davis, 1998).

Psychologically, anger has been related to some kinds of emotional disorders (Davis, 1998). Rage is one of the hallmark symptoms of Borderline Personality Disorder (DSM IV, 1994). Neighbors (1990) notes that one six-month report shows the prevalence rates for all phobias and lifetime rates for agoraphobia as significantly higher for blacks than whites. The relationship between anger and other emotions - anxiety, guilt, depression, dependency, and sex are complex. Hostility and abuse can cause painful guilt (Davis, 1998). Anger turned inward on

the self is often used to explain depression. Relationships between sexual feelings and aggression, such as bondage, sadism, rape, masochism are not yet well understood (Davis, 1998).

Violence, crime, spouse and child abuse, divorce, stormy relationships, and poor working conditions have also been identified as negative social consequences of anger. While great atrocities have been inflicted by crazed men such as Hitler, Stalin, or other terrorists, studies suggest that ordinary people can rather easily become evil enough to discriminate against, hurt, and brutalize others (Davis, 1998). Statistics in the United States show that 1 in 5 women has been raped and our murder rate is several times higher than most other countries (Bureau of Justice Statistics, 1999). Within families there is also much violence. Davis (1998) estimated that between 1/4 and 1/2 of all wives have been physically battered. Most disturbing are the statistics show that children ages 3 to 17 are the most violent: 20% per year abuse their parents, 93-95% hit or kick their parents intentionally (Bureau of Justice Statistics, 1999). In addition 10% of children were dangerously and severely aggressive with siblings during 1997 (Davis, 1998). About 25% of all murders are committed by teenagers (Bureau of Justice Statistics, 1999).

For adolescents, anger management is especially a problem. 40% of youths have been in a fight in the last year (Davis, 1998). 25% of adolescent males have carried a weapon at least one day in the last month - of that 25%, 60% carried a knife and 25% a gun (Bureau of Justice Statistics, 1999).

Many scholars see adverse social conditions - racism, oppression, discrimination, and poor economic conditions - as the primary cause of

psychological problems among African Americans (Neighbors, 1990). Lack of power, low self worth and personal competence have been seen as important correlates of oppressive social conditions and mental health status. According to Neighbors (1990), giving emphasis to social, political and economic change is the most effective means of primary prevention in low-income African American communities. Neighbors (1990) states that “numerous activities (e.g. education about violence, formation of support groups for violence victims, vocational programs, offering alternatives to gang activity) have been described in literature as means for raising consciousness about the serious problems caused by black-on-black anger” (p. 169).

The consequences of anger are profound and many times severe for African American people. African Americans may come to therapy with anger as a presenting complaint. The anger may be related to racism, discrimination, or socioeconomic status (Abernethy, 1995). Compounding the problem, a White therapist may evoke anger because he or she is viewed as part of “the system” rather than someone who could help. Ignoring these reasons for anger in the African American client may result in unsuccessful therapy where the client leaves with his or her perception of Whites reinforced and the therapist discouraged because traditional anger management therapy just didn’t work the way it was supposed to. In the next section of this paper, anger management therapy, its usefulness for African American clients, and ways to adapt traditional anger management models for use with African American adolescents will be discussed.

## Anger Management Therapy

### Cognitive Behavioral Models of Anger Management Therapy

Empirical research has shown that cognitive behavioral anger management therapy, and specifically cognitive restructuring, learning relaxation, coping skills, and social skills training, is an effective means to increasing emotional control and lowering inappropriate anger expression (Deffenbacher, Thwaites, Wallace & Oetting, 1994; Hudley & Graham, 1993; Kellner & Tutin, 1995; Lockman, Coie, Underwood & Terry, 1993).

Many adolescents do not have the adequate anger management skills needed to express anger in healthy ways. A plethora of skills training manuals and programs are available to assist the therapist and client in gaining those necessary skills. Although empirical research has shown anger management therapy to be an effective means of reducing inappropriate anger expression, little research has been done to provide information about how to best help adolescents whose anger is the result of racial discrimination.

The final section of this paper discusses three anger management programs currently available and the short-comings of using these models when counseling African American adolescents who are angry because of racial discrimination. The section also focuses on adapting these models for use with racially oppressed African American adolescents.

Three cognitive behavioral therapy (CBT) programs were selected to serve as representatives for anger management therapy treatment plans. Each of the programs selected have a slightly different focus. The first program, titled "The Anger Guide: A Blueprint for 12 Time-Limited Sessions" (Black, 1996), was

developed for counseling dual diagnosed clients and combined anger management skills training with substance abuse treatment. The second program titled “The Anger Workbook” (Carter & Minirth, 1993), was developed by two Christian doctors and used at the Minirth & Meir Christian-based clinics located in Texas, Virginia, California, and Illinois. The clinics offer outpatient treatment, day treatment programs, hospital programs, and ministry. The third program titled “When Anger Hurts: Quieting the Storm Within” (McKay, Rogers, & McKay, 1989), is a self-help anger management book and is available at most national bookstores.

Cognitive behavioral anger management therapy commonly has several defined goals. The first goal, to help the client gain knowledge about the kinds of anger and the ways anger is commonly expressed, are taught to the client and form the foundation for anger management therapy. McKay, Rogers, & McKay (1989) discuss myths about anger to help the reader understand the causes of anger and provide short self-tests to aid the reader discover how they express their anger. Carter & Minirth (1993) describe the “many faces of anger” (p. 3) followed by an anger inventory for each workbook reader to complete. Dispersed throughout this chapter are quotations from the Bible (New King James Version) that are used to illustrate each concept. Black’s (1996) anger treatment plan was developed as a guide for professionals working with groups or individuals dealing with anger. Worksheets and videos help the presenter identify and discuss common anger stances.

Once the client has gained a basic understanding of anger, the second goal is to help the client gain insight into the role anger plays in the client’s life and the

costs of his or her anger. McKay, Rogers & McKay (1989) accomplish this by stating that the “sole function of anger is to stop stress” (p. 46) and then to discuss how anger stops four types of stressful arousal: painful affect, painful sensations, frustrated drive, and threat. In separate chapters, the physiological and interpersonal costs of anger are described and the reader is asked to complete an “anger impact inventory” (p. 39). Carter & Minirth (1993) define anger as an intent to preserve personal worth, essential needs, and basic convictions. Questions for the reader to answer are scattered throughout the text focusing on the reader’s anger and spiritual well-being. Black (1996) offers a succinct description of the role of anger in worksheet form and then asks the client to develop an “anger line” (p. 46) to list situations and events that angered him or her. While Black does not specifically address anger from racial oppression, she does include a worksheet titled “recipient of unjust anger line” (p. 47) so that clients can list times when they were the recipient of other people’s hurtful anger. Black (1996) includes worksheets to assess whether substances frequently associated with anger and aggression are used by the client, what happens to the client’s anger when they use substances, and whether the client uses substances in an attempt to control his or her anger. Similar to 12-step AA programs, she asks the client to take a “personal inventory of how anger has affected his or her life” (p. 16), use the list to admit how one has been hurtful, make another list of those the client has harmed and make direct amends to those people whenever possible (p. 17).

The third goal in anger management therapy is helping the client learn that anger and anger expression are choices under the client’s control and that the

client is responsible and held accountable for how he or she expresses anger. McKay, Rogers & McKay (1989), use a two-step model of anger to teach their principles of choice and responsibility. They describe anger as a two-step process that starts with stress, and the experience of arousal, and the resulting coping mechanisms used to control the uncomfortable thoughts and feelings (p. 53). Journaling, by keeping track of occasions when one feels angry and answering four questions about stressors and trigger-thoughts, is encouraged to better understand the role anger plays in one's life. Case studies and short exercises are given to guide the reader in taking responsibility for his or her anger expression. Carter & Minirth's (1993) second chapter provides an explanation of why they believe anger is a choice. Later, in chapter 6, they focus on self-inflicted anger, and point to pride, fear, loneliness, and inferiority as ways that one's beliefs act to influence one's anger. Carter & Minirth (1993) call pride "a spiritual disease" (p. 119). Fear is the result of "forgetting God is in charge of one's life" (p. 149). Loneliness occurs because "sin causes us to be estranged from God and thus inhibited from fully knowing and experiencing contentment" (p. 158). Inferiority, according to Carter & Minirth (1993) occurs in all Christians because "we become aware that we do not measure up to God's perfect standards" (p. 171). One may only assume that Black (1996) believes that anger is a choice, and that the client is responsible for how he or she expresses anger, because the subject is not addressed in her program.

The fourth goal of these three anger management programs is perhaps the clearest connection to CBT. Clients are taught that thoughts effect feelings and behaviors where thoughts are labeled "triggers," and behaviors are identified as

anger expression (McKay, Rogers & McKay, 1989). While all three anger management programs are based on CBT, only McKay, Rogers & McKay (1989) and Black (1996) teach the client about distorted or irrational beliefs and how they affect feelings and behavior. McKay, Rogers & McKay (1989) state that thoughts that trigger anger “fall into two categories: shoulds and blamers” (p. 82). They use examples to show how distorted beliefs incite anger. Black (1996) uses worksheets to assist the client in understanding how the cognitive behavioral connection works. Handouts 8, 9, 9A, 11 and 13, “beliefs that fuel anger,” “thoughts, emotions, behavior,” “thoughts, emotions, behavior logs,” “distorted thinking styles and “defenses” are the worksheets in her program that cover this material.

A large portion of each of the three programs is used to cover the final goal: teaching, and have the client practice, a variety of anger management techniques such as thought stopping, replacing irrational thoughts with rational beliefs in the form of healthy self-talk, using relaxation activities to cope with stress, time outs to gain control over unwanted anger expression, using program solving to work through conflict, and response choice rehearsal to keep focus on the problem or stop anger escalation. Because they are similar in content, the programs will not be discussed individually.

#### Cautions and Adaptations When Using Anger Management Programs

As stated previously, childhood aggression has become a serious contemporary problem. Racial oppression and discrimination of African American people by those of the majority culture continues practiced in the United States. One of the direct responses to the frustration felt by African American adolescents,



as a result of oppression, has been an increase in aggression (Houston, 1990). When anger management therapy fails to address anger due to oppression it can not help but be less than effective. The final section of this paper explores how traditional anger management therapy can be adapted to more effectively work with this population.

The anger management programs reviewed in this paper were rooted in CBT. Cognitive behavioral theory grew out of learning theory (Corey, 1991). These theories include Rational Emotive Therapy, Cognitive Therapy, and Cognitive Behavioral Modification (Corey, 1991). Considered to be traditional models of psychology and therapy, they were based on White, middle class and primarily male standards (Sue & Sue, 1990). According to Kincade & Evans (1996), "there are problem areas when counselors only view their clients through a Cognitive Behavioral framework" (p. 96). This suggests that adapting anger management programs for use within the multicultural context will be beneficial when counseling African American adolescents who are angry because of oppression. Before attempting to adapt one's theory to the multicultural perspective, Ivey, Ivey & Simek-Morgan (1993) think it is important to be aware of specific multicultural issues that apply to clients and their level of awareness of these issues.

### Cultural Issues

Ivey, Ivey & Simek-Morgan (1993) believe counselors need to be aware that for African American clients, "oppression will likely play a role in whatever problem they present"(p. 105). The authors present a model illustrating various types of cultural issues that will affect counseling with the client. Although CBT

traditionally tends to locate the concern in the individual (Corsini & Wedding, 1995; Corey, 1996), an individual issue may actually stem from the family, community, state, or even country. Ivey, Ivey & Simek-Morgan (1993) list the following multicultural issues in their model: language differences and the fact that some African American clients will be bidialectic; gender; religious beliefs and practices; affectional orientation; age; physical issues; history of trauma; amount of education; socioeconomic situations, including healthcare, finances, employment, housing, transportation, food, clothing, safety, and relaxation opportunities (p. 106). Ivey, Ivey, & Simek-Morgan (1993) remind counselors that “all clients are combinations of many multicultural issues, and that differing ones may be proponent at different times” (p. 105).

### African American Identity Development

Just as clients bring differing combinations of cultural issues to counseling, so do they have differing degrees of cultural identity development. Jackson (as cited in Ivey, Ivey & Simek-Morgan, 1993), proposed a five-stage developmental theory that described how cultural consciousness grows and changes for African Americans. He suggests that counselors diagnose the consciousness level of their clients in order to work more effectively with the client. The five stages of Black identity development are presented as a “movement of consciousness” (Ivey, Ivey, & Simek-Morgan, 1993, p. 100) from naive lack of awareness to action and awareness of self and one’s place in society. Jackson’s five levels of identity development are: (1) naiveté: the individual has no awareness of self as African American; most commonly individuals in this level are children; (2) acceptance: the

individual thinks of self as “non-White” and “White” may be seen as the correct way of being. Individuals at this level are often subservient and highly cooperative; (3) resistant and naming: the individual identifies as African American and may immerse him or herself in the culture. The individual knows the meaning of Black and racism; (4) redefinition and reflection: the awareness of being an African American continues and the person still identifies as against Whiteness rather than pro-African American; (5) multiperspective internalization: the individual sees him or herself as an African American with pride in self and an awareness of others. The individual recognizes and accepts the worthwhile dimensions of all cultures and fights those aspects that represent racism and oppression.

#### Adapting CBT to a Multicultural Context

With an understanding the client’s multicultural issues and level of identity development one may turn toward adapting CBT to a multicultural context, focusing on African American clients. Although generalized for this paper, one must be cognizant of the fact that each client is unique and the use of stereotypes should be avoided by the counselor. CBT, regardless of the specific course of counseling, holds premises that apply across the span of all cognitive behavioral therapies.

There are several principles of CBT that lend themselves well to working with African American clients. First, CBT tends to be structured and the purpose of therapy is behavioral and cognitive change (Corey, 1996). According to Ridley (1995) and others (Houston, 1990; Locke, 1992; Sue & Sue, 1990), African Americans in general tend to appreciate counseling that is structured and a counselor who is able to clarify the purpose of counseling in a way that is

acceptable to the client. Second, the CBT worldview has been described by Ivey, Ivey & Simek-Morgan (1993) as “an attempt to integrate the three major philosophic traditions of idealism, realism, and existentialism” (p. 253). Rather than emphasize one worldview as “right,” cognitive behavioral theorists see changing how one thinks about the world as more important than actual events as they occur (Corey, 1996). This point is of particular importance and allows CBT to empower the multicultural client. Keeping this point in mind will help the counselor avoid seeking to change the client’s values except when they are self-defeating and overly rigid. Third, because how one thinks about the problem is important to CBT (Corey, 1996), one’s internal coping mechanisms are the focus of therapy. How African American’s cope with frustration due to oppression is often maladaptive and changing how one thinks about the oppression is often enough to empower the client to develop healthy and direct responses to the frustration (Houston, 1990).

Although CBT can generally be effective in working with African American clients, there are some limitations to the theory. First, any counselor using this theory must avoid what Ivey, Ivey & Simek-Morgan (1993) term “manipulative behavioral counseling” (p. 248). Manipulation occurs when the counselor makes a decision for the client without the client’s awareness or when the client feels forced to go along with the counselors choice whether or not he or she agrees. Some African Americans were taught to be passive, dependent, and unassertive for survival reasons (Houston, 1990). Rather than control the client, Ivey, Ivey & Simek-Morgan (1993) believe it is more useful for the client to be empowered by the counselor. One means of doing this is by urging clients to

“make decisions based on personal preference rather than absolute musts and learn to live with their decisions comfortably” (Ivey, Ivey & Simek-Morgan, 1993, p. 256). Second, CBT counselors use techniques to assist clients to restructure irrational thoughts, distorted assumptions, and change behaviors (Corey, 1996). Challenging beliefs may not fit well with African American socialization patterns and fails to consider the multicultural and environmental issues (Ivey, Ivey & Simek-Morgan, 1993). For an oppressed individual, “focusing solely on the individual will be seen as blaming the victim” (Ivey, Ivey & Simek-Morgan, 1993, p. 245). According to Ivey, Ivey & Simek-Morgan (1993), “multicultural dimensions can be added to the automatic thoughts chart by adding a column focusing on the context” (p. 272). Third, the CBT counselor should be aware of African American values and adapt commonly used CBT techniques as needed. For instance, Houston (1990) talks about “Africanisms” or elements of African culture that have survived (p. 17). One of the most enduring Africanisms is the practice of the oral transfer of information rather than relying on written word. Other Africanisms relate to the concept of time, religious practices and beliefs, honoring the family and group over the individual - having a collective destiny, emphasizing cooperation, valuing emotionality, and being highly respectful of the role of the elderly (Houston, 1990).

“CBT techniques are often readily accepted by minority clients due to their clarity and effectiveness” (Ivey, Ivey, & Simek-Morgan, 1993, P. 248). However, effectiveness does not equate with cultural appropriateness and suggests CBT, and specifically anger management therapy, will be more helpful to African American clients when the culture of the client is kept in mind. In the next section, the anger

management therapies mentioned earlier in the paper will be once again addressed and ideas for adapting them for use with African American clients will be reviewed.

### Adapting Anger Management Therapy to a Multicultural Context

Many of the techniques used in these anger management therapies work well with African American clients. Stress reduction training, teaching relaxation techniques, role playing, modeling, goal setting, and problem solving are interventions which have been suggested as effective with African American clients (DeLucia-Waack, 1996; Ivey, Ivey & Simek-Morgan, 1993; Locke, 1992; Ridley, 1995; Sue & Sue, 1990). These interventions are observable and engage the client. Whether or not the results are immediate, they instill clients with a sense of self-efficacy and a sense that change is possible (Kincade & Evans, 1996). Furthermore, role playing and modeling allow clients to practice new behaviors in a safe environment (Houston, 1990).

Houston (1990) discusses the degree of frustration African Americans feel as a result of chronic oppression and identifies aggression as a direct response to strong and long endured frustration. He goes on to state that African American adolescents cope with frustration in two ways. One of the direct responses to frustration is aggression. Commonly the aggression is justified by displacing the responses originally aroused by the oppressor and "symbols" - a White owned grocery store is robbed, a White woman is raped, a White person is accused of being intentionally racist - are used as a way to avoid having to deal with the "real enemy" of oppression (Houston, 1990). As often, however, African Americans cope with frustration by repressing their anger, becoming depressed and self-hating

or attempt to overidentify with White culture, denying their own African American heritage (Houston, 1990). Black's (1996) use of an "anger line" and an "recipient of unjust anger line" may be a useful means of helping the client understand the social condition in which he or she lives, thus avoiding repression and displaced aggression. To assist the client in identifying the role(s) anger has served in his or her life, Black (1996) asks the client to complete two exercises. The "anger line" (Black, 1996) is a graph that shows situations or events that angered the client. A horizontal line is drawn. Above the line, the client notes situations or events that angered him or her and what the client did with the anger. Below the line, the client notes events or situations in which he or she had cause for anger but for whatever reason he or she discounted, minimized, or denied his or her anger. Also noted in the section below the line are notes of what the client did or told himself or herself to mask the feeling of anger. The second exercise, called the "recipient of unjust anger" (Black, 1996), is a graph noting times when the client was the recipient of other people's hurtful anger. This time the client draws a vertical line and marks the top "birth" and the bottom "today." The client then lists his or her age and the corresponding anger, such as silent punishment, name-calling, verbal put-downs, rage attacks, physical abuse, and who dispensed it. According to Black (1996), clients have a tendency to forget or not admit how their anger has been hurtful to others and themselves. She states that making a list shows the client's willingness to work through anger. Talking about his or her anger allows the client to move out of denial.

Given the variety of religions practiced by African Americans, and the importance of religious beliefs to the African American community (Houston,

1990; Sue & Sue, 1990), using Carter & Minirth's Christian based anger management self-help workbook would be obviously disrespecting the client who was not Christian. Further, given what we know about oppression and racism, some clients would be offended by Carter & Minirth's conception of the causes and solutions for anger. For instance, Carter & Minirth suggest that one should "live in humility rather than self-preoccupied pride" (p. 115) discounts that gaining pride, especially Black pride, is a valuable part of Black identity development. Suggesting that one who is fearful is "very unassertive and cowardly" (p. 147) or that fear is "due to inner insecurity that inhibits us from living in healthy ways we know we should" (p. 136) denies the very real fear African Americans feel because of racism, discrimination, and oppression. Carter & Minirth suggest that one is "lonely because one fails to connect to people - like store clerks" (p. 155) because "one believes others don't understand him or her" (p. 156), which also discounts the African American experience. The above examples suffice to illustrate the lack of consideration the authors gave the multicultural context when writing the text.

All three anger management programs could benefit from understanding how African American's cope with anger and stress. Historically, African American cultural preferences on dealing with stress have been passive (Houston, 1990). Ivey, Ivey & Simek-Morgan (1993) suggest that rather than being assertive (as defined by CBT), some African American adolescent males overcompensate with "bustling bravado and nearly suicidal fearlessness in an exaggerated attempt to demonstrate masculinity" (p. 113). Other African Americans use "tales of accomplishment by means of shrewdness, craftiness, guile, and trickery to cope" (Ivey, Ivey, & Simek-Morgan, 1993, p. 115) with the anger they feel due to



oppression. Using music as a means of expressing oneself is another way African Americans commonly cope with oppression (Ivey, Ivey & Simek-Morgan, 1993). This suggests that understanding the differing ways African American's cope with stress would assist counselors to offer interventions that match cultural preferences.

Finally, although CBT and anger management therapy talk about empowering the client, the programs reviewed for this paper did not include specific suggestions for accomplishing that goal. Glover (1999), suggests that fostering resilience through teaching social competence, critical thinking, autonomy, and urging African Americans to become involved in local government decision making are effective means of empowering clients. For example, to increase social competence in the client, Glover (1999) suggests helping the client gain empathy toward people of the dominant culture; exploring with the client about the values of the dominant culture and how they differ from the client's values; and increasing communication skills. These ideas could easily be added to any anger management program used to counsel African American clients.

### Conclusion

Increased knowledge of multicultural issues contributes to better relationships between counselors and clients. The differences that exist between members of the dominant culture and member of African American culture help form each culture's worldview. If counselors are to work effectively with issues such as anger due to racism and oppression, they must be aware of these differences and how they change the interactions between counselor and client. It is hoped that the ideas discussed here will be used to gain a better understanding of

how to adapt cognitive behavioral anger management therapy when counseling the African American client. This conclusion provides a summary of themes and issues that emerged from the review of literature on racism, anger, and anger management therapy and their adaptation for use in the multicultural context of counseling African Americans.

In the first section, racism was defined and its features reviewed. The effects of racism and oppression were found to be far reaching. The second section focused on anger, its causes and consequences. The negative consequences of anger and aggression for African American adolescents were identified. The third section covered cognitive behavioral theory and anger management therapy and how each could be adapted for use in a multicultural context.

Although current research and literature are not yet able to identify an effective model to deal with this problem and this population, in general cognitive behavioral and anger management therapy works well with multicultural clients, including African Americans. Until such a model exists, the counselor should gain knowledge about the client's cultural perspective before beginning therapy. Understanding how racism and oppression negatively color the African American life experience is vital. Tailoring the anger management program to fit the specific needs and life experiences of the African American client offer the best hope of successful therapy.

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