THE RELATIONSHIP BETWEEN STATE-TRAIT ANGER EXPRESSION AND ATTRITION RATES OF AFRICAN AMERICANS IN COURT ORDERED ANGER MANAGEMENT TREATMENT

by

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I am grateful to my heavenly father for his grace, mercy, and patience with me. I have struggled emotionally through this process in ways I could not have imagined. I was blessed with a foundation that never wavered in my parents Wanda Reed and Jesse Childers. I never would have made it this far without their prayers. I love them more than words can say and appreciate their patience with me. The sacrifices they have made so that I could be the person I am today are immeasurable and do not go unnoticed.

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Kimberly M. Childers

ABSTRACT

THE RELATIONSHIP BETWEEN STATE-TRAIT ANGER EXPRESSION AND ATTRITION RATES OF AFRICAN AMERICANS IN COURT ORDERED ANGER MANAGEMENT TREATMENT

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Adviser: Michael Chaney, Ph.D.

This research examined the relationship between state-trait anger and attrition rates of African Americans in court ordered anger management (COAM). In this study, archival data was collected from African Americans clients sentenced to COAM from 2011-2018 at a university counseling clinic. The results indicated that no relationship exists between state-trait anger and attrition from COAM. Men were found to have higher scores on state anger physical and trait anger reaction. Results also indicated that younger participants were more likely to have higher state anger verbal and state anger physical scores than older participants.

These results yielded shed light on the need for appropriate pre-screening, cultural sensitivity, and recognition of possible bias in the referral process from judicial systems for African Americans. The sociopolitical implications of African Americans receiving harsher criminal sanction and possibly inappropriate clinical treatment as part of those sanctions is an area for future research. While the clinical implications for counselor educators and clinicians suggest that additional training is needed to increase advocacy for African American clients in COAM.

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LIST OF ABBREVIATIONS

COAM	Court Ordered Anger Management
STAXI-2	State Trait Anger Expression Inventory 2
AM	Anger Management
UCC	University Counseling Clinic
CRT	Critical Race Theory
EST	Ecological Systems Theory
ESBC	Emotional Skill Building Curriculum
APA	American Psychological Association
CBT	Cognitive Behavior Therapy
COMPAS	Correctional Offender Management Profiling Sanctions
CES	Counselor Education and Supervision
ACA	American Counseling Association
MSJCC	Multicultural and Social Justice Counseling Competencies

CHAPTER ONE

INTRODUCTION

This study specifically seeks to explore archival data collected from African American clients who sought court mandated anger management (AM) counseling in a university counseling clinic (UCC). All participants were involved in criminal cases that resulted in a probation requirement of AM treatment. These services fulfill a court mandate in lieu of incarceration or other criminal penalties for the participants. As part of the treatment program, all participants were given the State-Trait Anger Expression Inventory-2 (STAXI-2) (Spielberger, 1999) to measure anger prior to participation in an AM treatment group.

Research Problem Statement

For many years AM treatment has been used to address anger, aggression, and violent behavior (DiGiuseppe & Tarfate, 2003). Although the stated goal is to address anger as a source of a crime, it is commonly used as a punitive tool by court systems (O'Hare, 1996; Vairo, 2010). Research asserts that AM treatment will reduce aggression and violent behavior (Lee & DiGiuseppe, 2018). The support for such research is immense (Beck & Fernandez, 1998; Bundy et al., 2011; Taylor et al., 2016). In a study of 32 adult males, a reduction in anger was reported after completion of a 12-week AM program (Naeem et al., 2009). Another study of participants with a substance use disorder found they were responsive to AM treatment and reduced their level of anger and were able to maintain these gains for 90 days post treatment (Reilly & Shopshire, 2000). Although anger and AM have been studied for years, researchers assert that there is still

much to be learned (DiGiuseppe & Tafrate 2007; Henwood et al., 2015). Scholars have examined AM in relation to various groups based on gender, race, and age (Bailey, 2020; Neel, 2012; Thomas & Gonzalez-Prendes, 2009), while also considering specific subpopulations of violent offenders, such as substance abusers, persons with intellectual disabilities, and adolescents (Bailey et al., 2019; Browne & Smith, 2018; Lawson & Brossart, 2009; Sanderfer & Johnson, 2015; Schamborg et al, 2016). The aforementioned have been studied individually and in various groupings.

Although anger and AM have been studied for years, there is still much to be learned (DiGiuseppe & Tafrate 2007; Henwood et al., 2015), particularly as it relates to race. There is a dearth of research that specifically addresses African Americans who participate in court mandated psychoeducational group AM treatment. For example, in a meta-analysis of 13 studies that assessed post AM recidivism rates, there was no mention of participant racial demographics (Henwood et al., 2015). Trimble et al., (2015) studied 105 males offenders' responsiveness to cognitive behavioral therapy in anger management treatment and found improvement in state and trait anger, although the researchers did not indicate the ethnic demographics of the population. While another study with a sample of over 2000 participants also did not identify the ethnic demographics of the sample (Lievaart et al., 2016). In another study Neel et al., (2012) uses perception of facial expressions to assess emotion. This study included a sample of 129 students who were asked to look at four photos of posers, two White men and two White women and identify their perception of the person's facial expression. A limitation of the study was the lack of diversity in the sample and the poser photographs. The previous study expanded on previous research by Becker et al., (2010) which found that

black faces were not identified as angry more than white faces. While these results do appear positive the researchers did not indicate the ethnic demographics of the sample population. Studies also fall short in having ample sample sizes to make their results generalizable to African American populations (DiGiuseppe & Tarfate, 2003). When McDermott et al., (2012) conducted a study of college students, the results indicated that men who reported ambivalence about their own gender roles were at increased risk to use coping strategies that escalated anger and blaming others. The results of this study were difficult to generalize to African Americans with any significance as they only represented 14.6% of the study population. Henning and Freuh (1996) conducted a study of incarcerated adults, they found that those who did not participate in treatment were more likely to reoffend. Although these results seem promising in support of treatment outcomes, 95% of the participants were White, which leaves concerns as to whether the results can be generalizable to African Americans. As can be seen, African Americans are routinely missing from the data or included in small numbers that implore the need for more meaningful research to address the cultural and sociopolitical nuances that African Americans experience as it relates to anger, AM and court mandated treatment.

While the AM research is incomplete, existing research does show that African Americans experience high levels of anger as a result of stressors, such as racial discrimination (Dorr et al., 2007), poverty (Daniel, 2000), and social inequities (Stein, 2016). Historically African Americans have experienced powerlessness that is rooted in conditions of discrimination and disempowerment (Gibbons et al., 2012; Gonzalez-Prendes & Thomas, 2009; Park et al., 2018). Unfortunately, systemic racism continues to sustain the racial discrimination of African-Americans (Forsyth & Carter, 2014).

Responses to such injustices include depression (Hunter et al., 2017), anxiety (Lee et al., 2015), and anger (Thomas, Gonzalez-Prendes, 2009). African Americans' responses to anger many times are pathologized and met with punitive responses (Forsyth & Carter, 2014; Gonzalez-Prendes & Thomas, 2009). While their White counterparts are described as being assertive, African Americans outward expressions of anger are described as aggressive (Forsyth & Carter, 2014; Gonzalez-Prendes & Thomas, 2009). The connotations that surround the terms assertive and aggressive are inherently different. The literature defines assertive as standing up for one's self and personal rights, which evokes a sense of empowerment. Aggression, on the other hand, is defined as noncompliance, argumentative, and hostile; aggressive actions are characterized with an intention to inflict harm and as evoking a sense of fear (Buss & Perry, 1992; Cox et al., 2004; Matlasz et al., 2020). The use of terminology and stereotypes of "angry Black men and women" contribute to issues related to implicit bias and documented disparities in prison sentencing in judicial decision making (Bailey et al., 2020).

Extensive research supports the notion that African Americans receive disparate sentences when compared to their White counterparts (Freiburger & Hilinski, 2010; Leiber et al., 2018). Studies show that African American men are more likely to be sentenced to prison instead of probation and when sentenced to probation have a higher probability of having their probation revoked in comparison to White men (Freiburger & Hilinski, 2010). While research on probation sentencing is limited due to the various types of possible outcomes (e.g. community service, counseling, restitution, etc…), new research on probation sentencing as a whole is growing (Kimchi, 2019; Steinmetz & Henderson, 2016).

Based on the aforementioned research, additional scholarship is needed focused on the African American population who is court mandated into anger management treatment. Although anger has been extensively studied, the representation of African Americans is lacking. With limited research it is difficult to generalize results and effectiveness of treatment techniques to African American populations. This is of special concern due to the unique exposure of African Americans to racism, discrimination, and social inequality all of which contribute to anger. Because African Americans are disproportionately incarcerated, receive harsher criminal penalties, all while being part of a racially oppressed group it warrants additional study to understand the reasons that may impact their attrition rates from court mandated treatment. Thus, the following research questions were developed.

Research Questions

This study explores the archival data records of African Americans who were court mandated to participate in group AM treatment that took place in a university counseling clinic located at a small Catholic University located in a large urban metropolitan city in the Midwest. Respondents participated in court mandated anger management treatment between 2011-2018. Because this population has been understudied, the following questions will be evaluated:

1. What is the relationship between the attrition rates of African Americans in anger management and their state-trait anger?

2. Will the state-trait anger of African Americans differ based on demographic variables such as age and gender?

The following hypotheses are expected:

1. There will be a correlation between state-trait anger and the attrition rate of African Americans in AM treatment. Specifically, higher scores on the STAXI-2 will be associated with higher rates of attrition.

2. Men will have higher overall STAXI-2 anger-out scores than women.

3. Age will be inversely related to participants' STAXI-2 scores. Specifically, as age increases STAXI-2 scores will fall within normal ranges.

Theoretical Framework

This dissertation uses Critical Race Theory (CRT) (Bell, 1973; Crenshaw, 1995) and Ecological Systems Theory (EST) (Bronfenbrenner, 1986) to gain a deeper understanding of African Americans in relationship to anger, anger management, and attrition from court-mandated AM programs. CRT was developed as a response to the deceleration of the Civil Rights Movement and the impact it was having on race, racism, and American law (Delgado et al., 2017). CRT is the study of how race, racism, and power structures support the ongoing marginalization of people based on race, ethnicity, and gender (Bernal, 2002); it addresses the ongoing need for methodological attention to race in research and practice (Ford & Airhihenbuwa, 2010). CRT therefore, will be used, to examine how institutional legal structures maintain systems that perpetuate the marginalization of minority groups. In other words, by using a CRT framework, this study will guide the underpinnings of race and legal systems that disenfranchise minorities as they are mandated to and experience AM treatment.

Another theoretical framework undergirding this study is Bronfenbrenner's (1976) Ecological Systems Theory (EST). This theory was originally developed to explain the effect of and exchange of social contexts on the development of children (Bronfenbrenner, 1986). Although Bronfenbrenner's theory focused on children, it can be used to understand the persistent influence of social contexts and the environment on African Americans and their response to anger and anger management treatment. EST is a hierarchical theory of five nested ecosystems and the influence they have upon each other (Bronfenbrenner, 1976; Kilanowski, 2017). The microsystem comprises people and places that garner the most influence on an individual, such as family, peers, home, school, and work (Bronfenbrenner, 1986). Next, the mesosystem, is the relationship between microsystems. For example, if African Americans live in an unsafe neighborhood (microsystem), that lack of safety impacts their home life (microsystem), such as decisions on when to come home for fear of violence or rules given to their children. Next, the exosystem describes the relationship between ecosystems, one in which the individual has an immediate role (e.g. home) and one in which their role is peripheral or indirect (e.g. legal systems, social services, health systems). Although as a group African Americans may not have direct contact with legal entities, the laws impact the charges and sentences they may receive if arrested and convicted of a crime. The macrosystem comprises the values, attitudes, and ideologies that influence the culture or group, such as the biased belief that African Americans are more violent or dangerous than other groups. The final ecosystem is the chronosystem, which is the role of time; it concerns when an event occurs in a person’s life and the larger historical context of an event (Bronfenbrenner, 1986). Utilizing EST in this study may inform not only the

correlations between African Americans and their immediate environment but also the global systems that have indirect influence on their experience of anger. As highlighted in Chapter Two, African Americans are disproportionately living in poverty, incarcerated, given heftier sentences than other groups, and suffer from stereotypes that attempt to dictate how their anger should be expressed. As this population enters court mandated anger management treatment, the aforementioned factors are at work in their lives. Exposure to violence and chaos in a microsystem (i.e. home, school, parents) places the individual at risk to behave more aggressively (Boxer et al., 2013, Evans & Kim, 2013). Applied together in this study, CRT and EST provide a theoretical scaffolding for understanding the race-specific experiences of African Americans who are court mandated to AM treatment.

Purpose of the Study

As previously demonstrated, there is a clear lack of research on African Americans who participate in and discontinue court mandated AM treatment. Researchers have provided innumerable studies on AM with various populations, focusing specifically on adults, adolescents, intellectually disabled, men, women, etc. However, the extant literature demonstrates a lack of research on African American populations in any meaningful numbers. Results therefore cannot be generalized to African Americans in most instances because there either were no African American participants, or the number of African American participants was too small for comparison. By assessing STAXI-2 scores at the onset of treatment, the needs of individual clients can be addressed in a timely manner to possibly prevent early termination. This study will provide information that can be utilized by professional

counselors and counselors-in-training as they work with African Americans who enter court mandated AM. Gaining a better understanding of African American clients and how they experience and express anger may lead to improved suggestions for program improvement and knowledge of offenders as well as decrease attrition (Silver & Teasdale, 2005).

Definition of Terms

This section will delineate terms used in this study. The labels African American and Black are used interchangeably to define anyone who self-identifies as a person with African ethnic origins (Richardson et al., 2010). Court mandated treatment is defined as psychological treatment in which a forced choice is imposed on a person in order to avoid harsher negative consequences, such as incarceration or other legal means of restitution (Honea-Bolles & Griffin, 2001; Rosen, 2017). Court mandated, court ordered, and coerced treatment are used interchangeably throughout this study. State-Trait anger expression according to research (Vagg & Spielberger, 1999) encompasses two categories that impact anger expression. First state anger is defined in the literature as the intensity by which anger is felt currently or some other time specified by the test administrator, such a specified time in the past or if placed in a certain situation (Vagg & Spielberger, 1999; Speilberger & Reheiser, 2010). Secondly trait anger is a person's overall disposition in becoming angered (Vagg & Speilberger, 1999), it is indicative of temperament in various situations. Anger management has been defined in the literature as reducing anger and the intensity in which it is experienced through therapeutic intervention (Potter-Efron, 2005; Trimble et al., 2015). Also, most importantly when working with people of color it should include legitimating the real experiences of

injustice (Novaco, 1985). Finally, attrition, also referred to as early termination, is defined as a client's decision to cease psychotherapy treatment after attending at least one session, without completion of a predetermined number of sessions or without the agreement of the treatment provider (Olver et al., 2011).

Procedures/Methodology

This quantitative study utilizes archival data collected from a university counseling clinic's anger management treatment program between 2011-2018. Program participants were adults who had been court mandated to participate in anger management treatment. Descriptive statistics will be generated for the factors that may impact scores on the STAXI-2 assessment. Frequencies and percentages will be calculated for nominal and ordinal data, such as age, attrition, and gender, because the use of predictive analysis has been used numerous times to assess risk factors and trends for attrition (Carney et al., 2006; Tollefson et al., 2008).

Significance of the Study

African Americans are more likely to be sentenced to AM, while also being more likely to terminate from treatment before completion, than their White counterparts. Although it is possible that some portion of African Americans are referred to AM inappropriately, an obvious risk factor for drop out, it is unlikely that this factor explains all premature dropout. Therefore, gaining more understanding of the factors that may contribute to African Americans attrition from AM can prove valuable in reducing recidivism, improving client/counselor relations, and early barrier identification. This knowledge may contribute to the general body of research that addresses AM, attrition, and African Americans. Identifying potential risk factors may advance research through

implications for future research. In addition, these findings may inform counselors and counselors in training when working with this population. By having a better understanding of African Americans in court mandated anger management treatment, practitioners can improve service delivery and cultural competence.

Limitations of the Study

Some of the potential limitations of this study include the small sample size and the limited data available. Recidivism rates were not addressed which could have proven to be valuable information in relation to attrition rates for this population. Although completion and non-completion is assessed it does not necessarily measure change and the reduction or increase in behavior that can be labeled as angry, hostile, or aggressive. Another potential limitation is the limited descriptive data that was collected. Additional data on education, socioeconomic status and criminal conviction could have provided enriched details on risk factors related to attrition.

In addition, the use of archival data has potential limitations in this study. The dataset is from the past, which means consideration should be taken as to the time in which the data was collected. Social, environmental, and political factors can all influence the time frame in which the data were collected (Heng et al., 2018) Another limitation is that the dataset is rigid and based on a previous researcher's goals (Turiano, 2014) and additional factors that a new research may want to consider are not available for analysis.

Personal bias is also a factor as this writer identifies as an African American woman. This writer will assess the data objectively and discuss the findings based on the results.

Organization of the Study

In the next chapter, anger is defined and explored. As the key component of this study it is important to delve into a discussion of how anger is defined in the professional literature. Next, anger in reference to various theoretical orientations offers a foundation from which anger can be assessed when working with clients. Finally, chapter three provides an overview of the methods used in this study.

CHAPTER TWO

LITERATURE REVIEW

This literature review provides an examination of the relationship between anger, anger directed behaviors, and anger expression in African Americans who have been court ordered to participate in treatment. In order to understand the relationship between African Americans and anger, a review of attachment development provides a foundation regarding emotional development. Scholars indicate a relationship between anger control and deficiencies in the developmental areas of emotional regulation and attachment (Lawson & Brossart, 2009; Novaco, 2011). Attachment styles provide an infrastructure for adult emotional development and emotional regulation (Brodie et al., 2019). The early experiences children have with caregivers provide an imprint on future emotional development and emotional regulation strategies (Bowlby, 1969; Ford & Gross, 2018). Persons who have not developed healthy attachment styles are more likely to exhibit dysfunctional interpersonal interactions (Gross & Jazaieri, 2014). These dysfunctional interpersonal interactions may result in unhealthy anger expression in adulthood (Boudreaux et al., 2014). As anger becomes more pervasive in a person, unhealthy anger interactions may lead to prolonged negative consequences, such as relationship problems, poor social functioning, and problems with the criminal justice system (Messina et al, 2016; Mikulincer & Shaver 2005). Consequently, African Americans who are mandated into anger management (AM) treatment must contend with treatment or more punitive consequences if they do not comply. In addition, they are also faced with higher attrition rates from counseling than other populations (Bailey et al., 2020). To better understand

the dynamics of anger management in relation to African Americans and their probability of completing such treatment, it is important first to examine how anger is defined within the professional literature.

Research Scope and Search Criteria

This literature review includes articles and research from the following online databases: PsychInfo, PsychARTICLES, PsycEXTRA, PsychBOOKS, Psychology: A SAGE Full-Text Collection, Mental Measurements Yearbook, and Criminal Justice Periodicals. The search was subject and keyword driven, individually and in strings, and included the following terms: anger, aggression, anger management, violence, hostility, African Americans, court mandated treatment, attrition early termination, court-ordered treatment, and the State-Trait Anger Expression Inventory (STAXI-2) (Spielberger, 1999). While these searches yielded many studies on AM and attrition from court-mandated AM, few studies on court-mandated AM and subsequent attrition were found to examine African Americans in any meaningful way. In the sections that follow, I first define anger and the broad scope from which it is viewed. From there an exploration of relevant theories of anger will be discussed. This will lead to an examination of the STAXI-2 assessment to better learn how this tool assesses anger and its use with African Americans. Next, emotional regulation and attachment theory will provide a foundation for how anger coping strategies are learned and acted out. An examination of existing studies of court-mandated AM in relationship to anger, anger management and African Americans. Finally, an outline reason for attrition from treatment will be examined especially in relation to African Americans.

Defining Anger

The American Psychological Association defines anger as "antagonism toward someone or something that you feel has deliberately done you wrong" (American Psychological Association, n.d., para. 1). While this definition of anger provides a cursory meaning it does not take into account the varying facets that encompass this emotion. Anger is broadly defined as a maladaptive emotion as a response to stress provoking stimuli such as social conditions that involve a threat or frustration (Cox et al.,1999; Maxwell et al., 2005; Novaco, 1976). Scholars indicate that the negative emotional response to anger results in conflict and personal discomfort and is potentially problematic in relation to the intensity, frequency and manner of expression (Maxwell et al., 2005; Novaco, 2011). Scholars define anger as a multidimensional construct with distinct characteristics in affective, behavioral, and cognitive dimensions (Novaco, 2011; Scheff, 2015). The affective dimension of anger is defined as a negative emotional state or experience (Cox & Harrison, 2008; Maxwell et al., 2005). While, the behavioral dimension of anger consists of emotions and cognitions, also viewed as aggression or the action that occurs as a result of anger (Cox & Harrison, 2008; Besharat & Shahidi, 2010). The cognitive dimension of anger is described as the ideas and perceptions that one has related to a stimulus or environment (Cox & Harrison, 2008).

Research also has documented anger as an adaptive method of resolving perceived threats (Lench, 2004). Ellis and Grieger (1986) purported that a successful outcome serves the basic needs of the person, and their anger would be considered healthy, while behavior that does not serve their basic needs would be considered unhealthy (Ellis & Grieger, 1986; Scheff, 2015). This perception of healthy anger and

unhealthy anger is differentiated in terms of outcome. Anger can give one a way to express negative feelings or motivate one to find solutions to problems (Kazdin, 2000).

As previously mentioned, the definition of anger is difficult to hone down to one widely acceptable definition. Anger encompasses both cognitive and physical aspects which in and of themselves have a multitude of layers. However, taking a closer look at how anger is conceptualized based on theory offers a template in which to understand anger in varying contexts.

Theories of Anger

Because the above definitions are broad, examining anger through various theoretical frameworks provides a holistic view of the emotion. Cognitive theory examines anger in relation to appraisal and the perception and meaning ascribed to it (Cox & Harrison, 2008). Based on a person's emotional state and personality traits, their response to an eliciting event will determine the emotional and behavioral response (Deffenbacher, 1994). Social constructionists describe anger as a social construct not necessarily intraphysic or solely biological in nature (Averill, 1983). In other words, a person's reaction to a stimulus is a construction of the environment and the meaning one attaches to the context of a given anger-provoking situation (Berkowitz & Turner, 2017). Similarly, developmental theorists suggest that anger is a social construct, but also claim emotions are learned through modeling of others behavior or vicarious stories (Averill 1983; Hay, 2019). Biological theory asserts that anger and aggression are caused by neurological changes in the brain (Schore, 2001). Neurological research indicates that four areas of the brain are responsible for anger: the amygdala, ventral striatum, ventromedial prefrontal cortex, and the insula (Ochsner et al., 2012). The amygdala, the

area most commonly discussed in the literature, is linked to the perception of emotion (Ochsner et al., 2012). Chronic stress during childhood increases activity in the amygdala during emotion regulation, which may be a contributing factor to physiological and psychological stress regulation difficulties (Kim et al, 2013).

Emotions, including anger, are a combination of physiological and expressive states, cognitive evaluation, instrumental acts, and subjective experiences (Averill, 1983). Anger is complex and no one response is sufficient for the whole person. As such, a physical response may not be sufficient to address the cognitive evaluation of anger. For example, punching a wall doesn't necessarily appease the thoughts and appraisal of the anger experienced.

State-Trait Anger and Anger Expression

Spielberger (1999) identified anger as a two-component construct that incorporates state anger and trait anger. State anger is an emotional-physiological subjective disposition. Feelings may be experienced along a continuum from mild emotion (e.g., irritation, annoyance) to intense emotion (e.g., rage, fury) (Deffenbacher et al., 1996; Spielberger & Reheiser, 2010), while physiological changes may present on a continuum from moderate changes, such as tensing of facial and skeletal muscles, to the activation of the autonomic nervous system (flight or fight responses) and the release of adrenal hormones (Foley et al., 2002). Thus, state anger is the emotional and physical response to anger-provoking stimuli in which the intensity undulates over an abbreviated period of time (Spielberger et al., 1999).

Trait anger, on the other hand, refers to individual personality traits that impact how one responds to anger-provoking stimuli in varying situations (Birkley & Eckhardt,

2019; Spielberger, 1999). Personality traits are considered stable characteristics that map patterns of thoughts, feelings, and behaviors (Matthews et al., 2009). Individual trait differences may account for the frequency, intensity, and duration of state anger (Novaco, 2011). According to Spielberger and Reheiser (2010) the dispositional differences in personality traits and character influence one's perception of situations as frustrating and/or annoying. Accordingly, individuals who score as high in trait anger find a wide selection of situations as anger provoking and likely experience high state anger once provoked (Spielberger & Reheiser, 2010). Additional research supports Spielberger's theories on trait anger, according to Birkley and Eckhardt (2019) in a study (N=180) of college students those who scored high in trait anger were more likely to support and engage in acts of aggression toward intimate partners. A key limitation in regard to this study is the relatively homogenous sample which included 83% Caucasian and 62% female. Consideration should be given in generalizing this data to other populations such as African American males. The aforementioned research is supported by additional data that indicates those with high trait anger have a higher probability of engaging in coping strategies that involve physical and verbal aggression (Deffenbacher, 1994; Spielberger & Reheiser, 2010). Thus, the response to perceived injustices and frustrations is mitigated by individual differences in personality traits (Makinstosh et al., 2014). Consequently, individual differences based on culture, environment, and upbringing impact personality trait development (Akee et al., 2018). How anger is perceived also impacts how one responds to anger. Aggression can be a common outward expression of anger due to frustration; according to Besharat and Shahidi (2010), anger manifests from social conditions that are perceived as threatening or frustrating, possibly resulting in aggressive

behavior that can lead to violence against self or others. (Beshart & Shahidi, 2010; Bushman, 2002; Novaco, 2013).

When taken in context, anger is assessed as anger in the moment (state anger) and the propensity towards angry reactions (trait anger). Finally, anger is assessed via how is expressed and whether it is expressed outwardly towards others or inwardly towards self. Of these, one of the many ways in which anger may be expressed is through aggression. Aggression in early research was identified as the behavioral partner of anger, defined as a reaction to pain avoidance or an interference with pleasure seeking (Freud, 1936). This idea seems to be supported in contemporary research, which describes the instrumental aggression used to avoid or remove an obstacle (Atherton et al., 2016; Kassinove & Sukhodolsky, 1995).

While the expression of anger can be harmful to all, it is more detrimental to those who are experiencing toxic life conditions, such as lower socio-political status (Park et al., 2018). The social conditions to which many African Americans are exposed magnify the disparity between their reality and desired expectations. Approximately 23.8 % of African Americans live at or below the poverty line, which is more than twice the overall poverty rate of 10.5% (Creamer, 2020). African American men are incarcerated at a rate six times greater than White males (Bureau of Justice Statistics, 2017). It is plausible that these disparities are anger provoking. Additionally, being reared in sustained poverty and chaotic environments over time has a significant impact on a person's cognitive ability to process and regulate emotions (Evans & Kim, 2013). The ability to regulate one's emotions can reduce acts of aggression, which are precipitated by anger (Kang & Chasteen, 2009). Without proper emotional regulation skills, this population is

susceptible to an array of negative consequences, so it is important to understand how emotional regulation is represented in the extant literature.

Emotional Regulation and Attachment Theory

Emotional regulation has been defined as the capacity to track, recognize, and comprehend feelings when activated mentally and to proceed with goal-driven behavior (Ford & Gross, 2018; Goodall et al., 2012). Bowlby (1969) provided the seminal research on attachment theory, which will be covered, and how emotional bonds are created. Bowlby (1969) noted that infants are born with a collection of behaviors, known as attachment behaviors, focused on maintaining proximity to supportive others, known as attachment figures. These attachment figures are the central focus for meeting infants' physiological and psychological needs (Bowlby, 1969).

Infants are faced with intense emotions such as anger as part of the developmental process; as the central nervous system develops in infants, they attempt to compensate for their discomfort by seeking out attachment figures (Bowlby, 1982/1969, 1973). Proximity seeking is a primal and innate emotional regulation device that is intended to elicit protection and to alleviate distress (Bowlby, 1982/1969, 1973; Mikulincer et al., 2003). The development of the infant/attachment figure relationship is the foundation on which emotional development is based (Hay, 2019; Mikulincer et al., 2003) and a basis from which the expression of anger can be understood.

As the infant/attachment figure dyad evolves, proximity seeking becomes either successful or unsuccessful. A child's attempts to seek assistance and comfort are either met or unmet by attachment figures. As children develop, they begin to exhibit either secure or insecure attachments (Bowlby, 1980). When attachment figures show

themselves as trustworthy and consistent, attachment security develops (Mikulincer et al., 2003). Children develop a sense that they can trust the attachment figure to come to their aid when in distress. If attachment figures are inconsistent and unresponsive (Hay, 2019), however, attachment insecurity develops. Children who are securely attached are generally playful, social, and uninhibited in exploring their environment when responsive attachment figures are near (Bowlby, 1980; Mikulincer et al., 2003), whereas children who have insecure attachments may become angry during separation and fearful of exploring their environment, even in the presence of attachment figures (Hay, 2019). These children learn that they cannot rely on attachment figures for comfort or protection. As adults, insecure attachment may lead to distrust of others and a negative self-concept, while also influencing anger related behavior (Mikulincer et al., 2003; Niesenbaum & Lopez, 2015).

A disruption in the infant/attachment figure dyad can negatively impact the child's ability to relate to others. According to Evans and Kim (2013), one type of disruption is poverty and the chronic stress that accompanies it. Poverty and chronic stress damage both the child's biological and psychological regulatory systems (Evans & Kim, 2013). Researchers indicate that children in impoverished environments have restricted language environments, are subject to harsher disciplinary techniques, have less responsive parents, and are exposed to more conflict and stress (Conger & Donnellan, 2007; Hoff et al., 2002), all conditions that disrupt their coping skills and can lead to unmitigated expressions of anger (Hay, 2019). Because 23.8% of African Americans live at or below the poverty line, more than double the national average of 10.5% (Creamer,

2020), poverty and its disruptive relationship to attachment may disproportionately impact African Americans.

Children often learn to regulate their emotions based on modeling from their parents (Eisenberg et al., 1998). African American mothers have been found to up-regulate their child's positive emotions by providing positive reinforcement of such emotions more so than European American mothers (McKee et al., 2015). By engaging in this activity or expressing the mother's own positive affect, this modeling provides an imprint for the child of what is expected and the positive outcome from this behavior (McKee et al., 2015). Although they, particularly mothers, tend to emphasize positive emotions and outcomes of positive emotions, African American parents are more likely than White mothers to be dismissive of their children's negative emotions, particularly expressions of anger (Nelson et al., 2012; Parker et al., 2012). It is possible that African American parents are dismissive of or downplay negative emotions as a means to shield children from behaving in ways that society may deem threatening or inappropriate, for example being stereotyped as an aggressive Black man or an angry Black woman (Nelson et al., 2012). Unfortunately, the effect can be to suppress emotions, sending signals that a child's emotions are not important, valid, or warrant expression (McKee, 2015). As African American children transition from adolescence to adulthood, their methods of relating to others emotionally can result in negative peer relationships and poor social interactions (Sullivan et al., 2010). Not only might they see their emotions as insignificant but also, they may see others' emotions as unwarranted. Furthermore, because all of their negative emotions have been denied, they have few models for how to express anger and disappointment appropriately.

The previous literature demonstrates that the ability to regulate emotions is significantly impacted by the relationships developed with early caregivers. A deeper look at attachment styles and anger provide a description of how these two constructs interact with one another.

Attachment Style

Attachment figures provide care that is foundational to the development of self-esteem and interpersonal interaction patterns in children (Gross & Jazaieri, 2014) that may affect their experience with emotional regulation and the expression of anger (Nisenbaum & Lopez, 2015). Because children learn the script that is developed between themselves and the attachment figure over time, a presumption ensues about what behavior they can expect from other caregivers. As children develop, they take these beliefs into adolescence and adulthood; these beliefs then become assumptions about how others will engage with them (Hay, 2019). When assessing attachment, both attachment anxiety and attachment avoidance provide a framework from which to view anger (Nisenbaum & Lopez, 2015). These two styles, attachment avoidant and attachment anxiety, are rooted in insecurity and are usually indicators of difficulty with emotional regulation and interpersonal relationships (Nisenbaum & Lopez, 2015). Researchers have indicated that attachment anxiety is the fear of abandonment and rejection and the degree with which it is experienced (Brennan et al., 1998; Sandberg et al., 2019). The all-consuming fear of rejection and abandonment colors the lens from which behavior is perceived. The attachment anxious person tends to seek out more social connectedness to reduce the anxiety produced by fear of rejection (Zimmer-Gemback et al., 2017) and is more likely to lash out in anger when the expected rejection occurs (Hay, 2019).

However, in seeking out support, it is important to determine if this is a means to problem solve or to perpetuate ongoing conflict. In a study of 97 couples, researchers found that the help seeking behaviors of men with anxious attachment styles led to further conflict (Nisenbaum & Lopez, 2015). This should be of special interest to counselors working on anger issues with men.

Attachment avoidance, however, is defined as a difficulty in building social and emotional bonds with others and discomfort with interdependence. Attachment avoidant persons utilize less social support and express a limited range of reactions in response to anger (Nisenbaum & Lopez, 2015; Zimmer-Gemback et al., 2017). Research indicates that African Americans have higher rates of avoidant attachment in comparison to Caucasians (Montague et al., 2003; Wei et al., 2004). As indicated in the previous section, scholars posit that differences in emotional socialization and environmental factors, such as lower SES, may contribute to this variance (Agishtein & Brumbaugh, 2013). For example, African American children are reared with more punitive responses to a child's emotions, which seems to confirm previous statements regarding African American mothers' tendency toward dismissive/avoidant styles in response to their child's negative emotions (McKee, 2015). This behavior may be considered a protective factor, albeit teaches children their negative emotions should be avoided or have little bearing on others, this behavior also prepares African American children for the bias and oppression they may face and the blatant disregard towards their emotions.

Attachment style influences the interpretation of others' behavior, the meaning attached to that behavior, and the help seeking strategies and coping skills utilized (Ford & Gross, 2018) as well as the anger that is expressed when these skills are inadequate.

Attachment security develops when affect regulation strategies are successful and the child's needs are met both physically and emotionally (Bowlby, 1980; Vrticka, 2012). Security-based strategies help to dissipate distress while building personal resources. Researchers assert that securely attached individuals display pro-social behaviors that are indicative of emotional wellbeing, assert positive concepts about self and others, possess optimistic ideas on their ability to manage stress, and exhibit efficacious stress management (Allen et al., 2005; Diamond et al., 2012; Mikulincer & Florian, 1998). In contrast, attachment insecurity is associated with suppression of unwanted feelings, low levels of intimacy, projecting negative self-images onto others, and the repression of negative memories, all behaviors that may lead to the inappropriate expression of anger (Lafontaine & Lussier, 2005; Mikulincer et al., 2003). Consequently, when proximity seeking is unsuccessful and attachment insecurity develops, individuals still seek a means to cope with distress by way of secondary attachment strategies that may include continuing to seek others for support, turning inward to develop self-soothing coping mechanisms (Johnson, 2019), or using anger as a coping mechanism (Miers et al.,2007; Pittman, 2011). Maladaptive coping strategies, such as the display of intense or misdirected anger in those who have insecure attachment styles, lead others to distance themselves from the behavior and the person acting out the behavior (Nisenbaum & Lopez, 2015) instead of strengthening the relationship, which would be the desired outcome. These secondary attachment strategies are implemented to address a specific regulatory goal. To navigate relationships and interactions, most adults learn to regulate their emotions and apply these skills within their relational interactions (Denham et al.,

2003), but as this dissertation research suggests, when attachment strategies are unsuccessful, anger and aggression can result.

As previously stated, the relationship between early caregiver relationships and how it impacts emotional regulation offers an explanation for how one might respond to anger provoking stimuli. While this explanation may be relevant and accurate it only serves as a subjective excuse for behavior. The outward expression of anger is what is viewed by others with little to no knowledge as to the origins of the behavior or any understanding as to what primal needs the behavior is trying to satisfy. When this outward expression of anger breaks the rules of society and leads to legal intervention it can lead to criminal charges and an impetus by the court system to correct the offender's behavior through anger management treatment.

Court Ordered Anger Management Treatment

Treating Anger

The most common method to treat anger is cognitive behavior therapy (CBT) (Saini, 2009). Cognitive behavior therapy, if not used alone, is a component of various other treatment methods, such as psychoeducation and skills focused treatment (Saini, 2009). CBT has shown significant improvement in AM skills across the three anger regulation skill domains: arousal calming, cognitive coping, and behavioral control (Mackintosh et al., 2014). Cognitive treatment approaches include changing cognitions and ideas about anger and anger provoking stimuli and environments (Carney & Buttell, 2005). In general, cognitive therapies may involve methods of relaxation, reframing of events, coping skills (i.e., imagery and distraction), and interpersonal or social skills training (Beck & Fernandez, 1998). These techniques are practiced for use later when

confronted with an anger-provoking stimulus; successful execution usually is followed by contingent reinforcement (Beck & Fernandez, 1998).

Skills based training teaches participants how to handle anger in a proactive manner (Glancy & Saini, 2005). Sessions focus on communication, listening skills, constructive and negative feedback, clarification of options in difficult situations, and assertiveness in initiating reasonable requests and declining unreasonable requests (Glancy & Saini, 2005). Students who completed a social skill focused AM intervention have reported reductions in trait anger, general anger, and anger expression (Deffenbacher et al., 1996).

However, traditional CBT programs have not always been successful in decreasing actual physical aggression (Howells et al., 2005; Lindsay et al., 2004) and CBT treatment by itself is less effective than increased mental health support (Mackintosh et al., 2014). In fact, the most successful interventions focus on multiple treatment modalities (Messina et al., 2016; Zigler et al., 1992).

Court Mandated Treatment

According to O'Hare (1996), court mandated clients may not characterize themselves as having psychological distress upon initial contact. Several reasons may account for this. They may not have perceived the reasons for referral as distressful. They also may be preoccupied with the coercive methods that brought them to treatment. For example, clients mandated to chemical dependency treatment often do not have an opportunity to reach a "rock bottom" in which they realize their chemical dependency is problematic so they will willingly seek treatment (Vairo, 2010). In other cases, clients may have been inappropriately referred to AM.

Legal entities, not the client, determine that the situation or circumstances warrant the individual to enter AM treatment. Little if any consideration is given to the circumstances that brought them to the court's attention. Individuals are not allowed to make an autonomous determination as to whether there is a problem that requires treatment. In a study of 26 violent offenders in Harlem ranging in age from 18-69, most did not characterize themselves as violent or as having problems with anger (Feldman, 2016). For example, one respondent indicated that he was with a person who shot someone and was subsequently charged, although he personally had not perpetrated any violence (Feldman, 2016). Such an example poses a potential problem with the validity of the referral process for AM treatment. Some participants acknowledged that they may have been better served by receiving treatment to address trauma. Many clients feel their anger and actions are justified based on the circumstances. Participants candidly discussed the need to use violence or aggression as a means to navigate illegal economies and as a self-defense. As these individuals enter treatment, they begin encumbered by pressure from the legal system. The premise of informed consent is problematic when clients reject the problem definition and comply based on coercive measures and punishment (Croxton, 1988). This is of special concern because many mandated clients are from oppressed racial minority populations (O'Hare, 1996). In fact, some critics implicate practitioners as working in collusion with a system that sustains oppressive social structures (O'Hare, 1996).

Practitioners are taught to build trusting relationships with clients, so they can engage in assessment and problem interventions (De Jong and Berg, 2001). This model of counseling is built upon the assumption that clients are present in the counseling session

voluntarily. Mandated clients often see practitioners as intrusive extensions of the mandating body (i.e. the court system) rather than as allies. Research has demonstrated that mandated clients may be less responsive to counselors' efforts to empathize and to build rapport (Honea-Boles & Griffin, 2001; Sotero et al., 2016). Moreover, research on African Americans and their experience with involuntary counseling is absent from the literature.

As a result, mandated treatment can provide innocuous results that may lead to harm rather than healing (Feder and Dugan, 2002). The appearance that treatment is providing a fix can be harmful to the client and others. Some previous research on the efficacy of court mandated male batterer programs, although not undisputed (Feder & Dugan, 2002), has indicated that an instrumental factor in women returning to the batterer was his participation in treatment (Gondolf, 1987; Hamberger & Hastings, 1993). Although the results of therapy were inconclusive, women were placed at risk because they returned home with a false hope of improvement (Hamberger & Hastings, 1993; Morrison et al., 2018). More research needs to be done on the efficacy of involuntary treatment because of the potential for poor results.

Due to the high stakes for court mandated clients, it is important to understand the reasons why they may decide to terminate treatment early in light of the ramifications. Attrition factors are especially concerning for African American clients in AM as they receive harsher sentences in comparison to other racial groups. Gaining more knowledge in this area may help to reduce attrition rates by identifying factors that may lead to early termination.

Attrition Factors

When clients cease treatment before a mutually agreed upon end, it is difficult to determine if treatment was successful or if a program was effective. Gaining a better understanding of treatment attrition can improve client and counselor relationships and improve program effectiveness and efficacy.

As articulated in the last section, the coercive nature of being mandated to AM can contribute to attrition. The counselor's approach and even basic counseling assumptions also can contribute to attrition. For example, Rogerian counseling methods can be counterproductive when working with court mandated clients (De Jong &Berg, 2001) because attempts to build rapport through active listening and empathy may not be well received by court mandated clients. Participants in COAM find these methods to be superficial and are on guard at the outset of counseling due to the forced nature. Mandated clients find counselors as invasive into their lives and their recommendations as unrealistic and potentially harmful (Snyder & Anderson, 2009; De Jong & Berg, 2001). When paired with specific race and cultural factors, problems with counseling assumptions leave African American clients with additional risk factors for attrition. African Americans have a higher probability of terminating psychotherapy services than Whites (Lester et al., 2010; Sue et al., 1991; Ward & Brown, 2015), Hispanics, and Asians (Sue et al., 1991). Researchers have indicated that 47% of participants in a mixed sample terminated therapy early in a meta-analysis of 125 psychotherapy studies (Wierzbicki & Pekarik, 1993). Another study indicated that 73% of African American participants were likely to terminate treatment early in comparison to 45% of White participants even when they controlled for education and income levels (Lester et al.,

2010). Scholars have offered some of the following reasons to explain this attrition: mistrust of health providers (Boyd-Franklin, 2003), limited resources (Daniel, 2000), treatment stigma (Boudreaux et al., 2014; Snowden, 2001), ethnic/racial matching of the counselor and the client (Alegria et al., 2008), and historical unethical mistreatment in health systems (Beasley, 2013; Suite et al., 2007). This unethical mistreatment may also be due to implicit bias of clinicians who believe African Americans may not be compliant (Awidi & Hadidi, 2021). The socialization and lived experiences of African Americans are diametrically different from those of Whites (Ford & Helms, 2012). In a study of 8,762 people of whom 2,890 were African American, researchers found that inadequate treatment for depression was found across populations (Alegria et al., 2008). However, African Americans were more likely to receive inadequate treatment for several reasons. Researchers identified poor communication between ethnic/racially mismatched clients and treatment providers as one reason for inadequate treatment. Qualitative interviews of Black participants in the study also indicated that past mistreatment by treatment providers strongly influenced their decision to seek treatment. In essence, how they had been treated in the past was very much a part of their current awareness when seeking treatment, and it impacted their relationship with providers. All of these factors become problematic because they may lead clients to leave treatment before they have been able to benefit from it. Past mistreatment by providers reverberates with African Americans when seeking treatment in the future, and poor communication with providers only serves to widen this gap in treatment services.

When the social environment of the African American is unfolded, there is a long history of this group being misled and subjected to treatment with little to no consent. For

example, African American males were unwittingly used as research subjects who had lifesaving medical treatment withheld from them for over 40 years during the infamous Tuskegee Experiment (Scharff et al., 2010; Suite et al., 2007). The fallout of this unethical research project led to widespread changes in research standards to assure safe and ethical standards were adhered to with human subjects. However, this change did not assure that African Americans were always protected from unethical research practices. As recently as the 1990's, African American adolescent boys were part of a research study through a major university that included withdrawal from prescribed medication and the administration of drugs that were linked to increased aggressive behavior (Scharff et al., 2010). Participants were misled and induced to participate with monetary compensation, just as they were with the Tuskegee experiment. Such egregious historical examples explain African Americans' mistrust of healthcare providers and influence how this population responds to court mandated treatment.

Conclusions

Research indicates that dysfunctional expressions of anger can have detrimental consequences that lead to criminal penalties. Although courts may provide anger management treatment in lieu of incarceration or other criminal penalties, the efficacy of such mandated programs have not been adequately evaluated, especially for African Americans who are disproportionately incarcerated and receive harsher penalties compared to Caucasians. Unfortunately, research demonstrates that African Americans are at greater risk of attrition from Anger Management treatment. With such high stakes, it is imperative to learn as much as possible about why some clients do not complete treatment. Numerous complex factors at both the societal and individual level may

impact attrition. Cultural factors such as racism, discrimination contribute to social inequality and poverty, which, taken as a totality, likely leads to anger as well as creates conditions for having difficulties managing anger. Individual factors such as attachment security, emotional regulation, severity of anger, gender, and age may also impact anger management. This dissertation study will examine factors at the individual level with the goal of identifying especially vulnerable clients to dropping out of treatment prematurely. The hope is that this research will provide insight into treatment planning and treatment retention, thereby reducing premature dropout. With this knowledge the following research questions were developed:

1. What is the relationship between the attrition rates of African Americans in anger management and their STAXI-2 scores?
2. Will STAXI-2 scores of African American differ based on demographic variables such as age and gender?

CHAPTER THREE

METHODOLOGY

This chapter discusses the methodology and design utilized in exploring the relationship between client outcomes and client characteristics. A detailed description of the research design, participants, procedures, and instruments are also provided. This chapter concludes with data analysis and validity and reliability considerations. The current study utilized quantitative methods consisting of logistic regression. This research design is most appropriate when analyzing the impact of dichotomous variables on an outcome (Creswell, 2012). Basic statistical analyses were conducted on the demographics and State-Trait Anger Expression Inventory 2 (STAXI-2) (Spielberger, 1999) using correlations and t-tests to determine if any of the characteristics or inventory responses are correlated. In addition, other analysis includes t-tests to examine differences between groups, such as men and women.

Study Population and Size

Participants

Information and data about the participants in this study were accessed through original archival data from a university counseling clinic (UCC) located in a large, midwestern urban city of the United States. The data collected in this study were obtained from the participants in the process of their enrollment in anger management treatment. Participants were referred by the court system. De-identified data was used, and participant names and case numbers were not used. The archival data were already stored and identified by the program.

The participants were part of a group or individual anger management treatment program that utilized the emotional skill building curriculum (ESBC), a cognitive behavioral treatment program which also incorporates developmental components (Pickover, 2010). The ESBC is a 13-session program that builds on empathy development and understanding the perspective of others (Pickover, 2010). The program's curriculum is built on the assertion that individuals referred for anger management have insecure attachment styles. The deficits that may result from an insecure attachment style may impair perspective taking and empathy development (Pickover, 2010). The ESBC program has been developed for use with adults and adolescents.

Original archival data was collected from 94 individuals who were under legal jurisdiction (e.g. parole, probations etc.) and required to attend anger management (AM) treatment. Each participant self-identified as an African American woman or man. Participant ages ranged from 20 to 67 years with a mean age of 34.63 years. Of the 94 participants 64.9% (*N=61*) were women and 35.1% (*N=33*) were men. Institutional Review Board (IRB) approval was obtained to assure all participants and their records were treated ethically based American Counseling Association (ACA) ethical codes (2014).

The population was based on a convenience sample of individuals who participated in AM treatment from 2011-2018 at a university counseling clinic (UCC) in a large, midwestern city of the United States. The UCC utilized is on the campus of a small private Catholic university in an urban setting. The UCC provides individual and group counseling to the surrounding community and university students at no cost.

Services in the UCC are provided by practicum counselors while under the supervision of a licensed professional counselor.

Process for Obtaining Data Files

Original archival data files were available to the principal researcher through the clinical software database Therascribe and as hardcopy case files. Any files that did not have complete demographic information were not be included in the analysis. Access to the case files was granted to the principal investigator while she was employed by the UCC. Upon resignation of employment, a data sharing agreement was obtained from the UCC for the purposes of data analysis.

Instruments

Two instruments were used by the UCC to evaluate client characteristics and outcomes: a demographic questionnaire and the STAXI-2 (Spielberger 1999). Raw data from each were made available to the researcher. As part of the AM treatment all participants completed the STAXI-2 prior to the onset of treatment.

Demographic Questionnaire

A 10-question demographic questionnaire created by the university was used to gather participant characteristics. The data collected included: age, race, gender, insurance status, reason for referral, past counseling services, referral source, and whether the client was court mandated to participate in treatment. This questionnaire was completed by the practicum counselor during the intake appointment with the client.

State-Trait Anger Expression Inventory - 2 (STAXI-2)

At the onset of treatment each participant included in the data set also completed the STAXI-2. The original STAXI (Spielberger, 1988) was expanded to measure aspects

of personality and how various components of anger impact the development of medical conditions (Spielberger, 1999). A unique component of the STAXI-2 is that it is constructed to assess the intensity of anger experienced and individual personality traits that impact proneness towards anger (Spielberger, 1999).

The STAXI-2 (Spielberger, 1999) is a 57-item self-report assessment designed to reflect different dimensions of the experience and expression of anger. The items are rated on a 4-point Likert scale and usually take approximately 15 minutes to complete (Spielberger, 1999). Respondents rate the frequency of anger expressed toward other persons or the environment, suppressed anger, and how often they attempt to control angry feelings. The STAXI-2 consists of six scales: State Anger (S-Ang), Trait Anger (T-Ang), Anger Control-Out (AC-O), Anger Control-In (AC-I), Anger Expression-In (AX-I), and Anger Expression-Out (AX-O). It also has five subscales, which include: State Anger/Verbally (S-Ang/V), State Anger/Feeling (S-Ang/F), State Anger/Physically (S-Ang/P), Trait Anger/Temperament (T-Ang/T), and Trait Anger/Reaction (T-Ang/R). An Anger Expression Index (AX Index) also is included, which is a composite score of the anger control and anger expression scales (AX-O, AX-I, AC-O & AC-I) (Spielberger, 1999). Table 1 provides a brief description of each scale and subscale.

Studies indicate that the STAXI-2 is an effective assessment for planning treatment and evaluating the effectiveness of therapeutic interventions (Lievaart, Franken, Hovens, 2016; Deffenbacher et al., 1996). The STAXI-2 has demonstrated strong face validity (Foley et al., 2002; McEwan et al., 2009). As a psychometric tool, respondents can easily ascertain that the STAXI-2 is focused on measuring anger

Table 1 STAXI-2 Overview of Scales and Subscales*

STAXI-2 Scale/Subscale	Description of scale/subscale
State Anger (S-Ang)	Measures intensity of angry feelings and desire to express anger at a particular time
Feeling Angry (S-Ang/F)	Measures intensity of current angry feelings
Feel like expressing anger verbally (S-Ang/V)	Measures intensity of current feelings in relation to the verbal expression of anger
Feel like expressing angry physically (S-Ang/P)	Measures intensity of current feelings in relation to the physical expression of anger
Trait Anger (T-Ang)	Measures how often angry feelings are experienced over time
Angry temperament (T-Ang/T)	Measures the disposition of experience of anger without specific provocation
Angry reaction (T-Ang/R)	Measures the frequency that angry feelings are experienced in situations that involve frustration and/or negative evaluations
Anger Expression-Out (AX-O)	Measures how often angry feelings are expressed in verbally or physically aggressive behavior
Anger Expression-In (AX-I)	Measures how often angry feelings are experienced but not expressed (suppressed)
Anger Control-Out (AC-O)	Measures how often a person controls the outward expression of angry feelings
Anger Control-In (AC-I)	Measures how often a person attempts to control angry feelings by calming down
Anger Expression Index (AX Index)	Provides a general index of anger expression based on responses to AX-O, AX-I, AC-O, and AC-I items

*Adapted from Spielberger, 1999. The original table includes the number of items for each scale and score range.

Administration of the STAXI-2 should be conducted by someone who has completed a four-year degree in counseling or a closely related field in addition to psychometric training (Par Inc Manual). Although the assessment is written at a sixth-grade reading level, it can be read to an examinee if necessary (Schamborg, Tulley & Brown, 2016). The STAXI-2 manual **(**Spielberger, 1999) indicated normative data was collected from an American sample of 1,644 (977 women and 667 men) and a hospitalized psychiatric sample of 276 (105 women, 171 men). The groups were further segregated into three age groups 16-19 years, 20-29 years, and 30 years and older (age range 16-63 with a *M* age of 27). The STAXI-2 has been represented as an appropriate measure with various populations: domestic violence (Foley et al., 2002), developmentally delayed (Novaco, 2004), and forensic populations (Schamborg et al., 2016). STAXI-2 internal consistency reliabilities, as measured by alpha coefficients, range between r = .73 and r = .95 for the primary scales and r =.73 to r =.93 for the subscales, with a median r = .88 (Freeman & Klecker, 2003). Internal consistency was assessed with the current sample and a Cronbach's alpha coefficient was measured at r=.73.

Research Questions

1. What is the relationship between the attrition rates of African Americans in anger management and their STAXI-2 scores?
2. Will STAXI-2 scores differ based on demographic variables such as age and gender?

Hypotheses

1. There will be a correlation between STAXI-2 scores and the attrition rate of African Americans in AM treatment. Specifically, higher scores on the STAXI-2 will be associated with higher rates of attrition.
2. Men will have higher overall STAXI-2 anger-out scores than women.
3. Age will be inversely related to participants' STAXI-2 scores. Specifically, as age increases STAXI-2 scores will fall within normal ranges.

Data Analysis

All data was loaded into SPSS (Version 22) [Computer Software]. Data was screened for missing data and these cases were not used. Descriptive statistics were analyzed to look at participant characteristics such as age and gender providing an overview of the data. This included frequencies, percentages, means, and standard deviations. Frequencies and percentages were analyzed and included for both nominal and categorical data. This data includes age, attrition, and gender.

In order to answer the first research question, scores from the STAXI-2 were used to predict whether participants would successfully complete the anger management treatment. Completion was determined based on case notes indicating participants had completed the required number of sessions. A specific number of sessions could not be utilized as various referring bodies requested different numbers of sessions be completed in order to consider the participants' completion successful. Failure was defined as participants who did not complete the required number of sessions based on case notes that indicated the participants did not complete the required number of sessions. To

measure this relationship, the study utilized logistic regression. This research design is most appropriate when analyzing the impact of multiple variables including one dichotomous variable on an outcome (Creswell, 2012). This predictive analysis, if significant, will show that higher STAXI-2 scores are indicative of difficulty managing anger, which will predict high rates of attrition from AM treatment. This study hypothesis is that the higher the anger score, the more likely they are to drop out of treatment. If this logistic regression is significant on individual scores, another regression analysis will be run to determine whether what range of scores indicates anger issues. Per the STAXI-2 manual (Spielberger, 1999) scores within the 25th-75th percentile are considered within normal ranges and scores above the 75th percentile is indicative of a problem managing anger.

CHAPTER FOUR

RESULTS

Introduction

The purpose of this quantitative study was to explore the relationship between state-trait anger in African Americans and attrition from court mandated anger management treatment. This study answered the following research questions: What is the relationship between the attrition rates of African Americans in anger management and their STAXI-2 scores? Secondly, will STAXI-2 scores differ based on demographic variables such as age and gender of participants? This chapter contains the results of the study and the summary of findings.

Interpretation of Findings

As previously stated, the number of sessions was not used as an indication of treatment completion. However, the data indicated the more sessions attended, the higher the likelihood of completion (see Figure 1). Because participants were referred from various legal entities, the number of sessions that each person needed in order to be considered completed varied. For example, some participants were required to complete one session while another participant may have been required to complete 10 sessions. The majority of the participants 57.3% attended 1-3 sessions. The likelihood of completing treatment increased with the number of sessions between 1-3 (see figure 1).

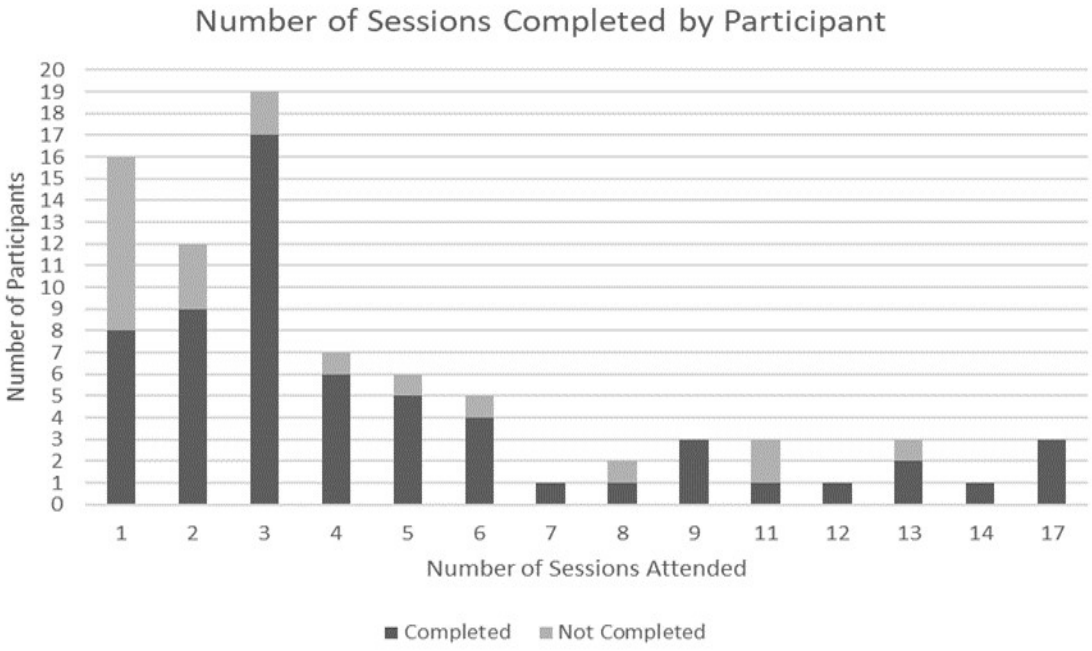

Figure 1 Completion Rates. The number of sessions attended by participants. The dark grey bars represent completed participants, while the light grey bars represent participants that attended, but did not complete sessions.

To test the hypothesis that higher state anger scores on the STAXI-2 would be associated with higher rates of attrition, a logistic binomial regression was performed. The participants who dropped out had a mean state anger score of 47 .00 (n = 20, SD =6.070) and the participants who completed treatment had a mean state anger score of 47.61(n = 62, SD =7.723). The results showed that state-trait anger scores did not significantly predict the likelihood of dropping out of anger management counseling ($\chi^2(1) = .112$, Wald = 0.11, $p = .74$). Thus, the data did not support the research hypothesis as demonstrated by the binomial logistics regression model, ($\chi^2(1) = .112$, $p = .738$).

Age

The third research hypothesis stated that age would be inversely related to participants' STAXI-2 scores. The age of the participants in this study ranged from 20-67 years, with a mean *(M)* of 34.82 and a standard deviation (*SD*) of 12.49. A logistic regression was performed to better understand the effect of age on completion rates. Results showed that age was not a significant predictor of completion rate (p= .062).

Pearson correlation analyses were conducted to investigate the relationship between age and each anger scale. As shown in Table 2, the overall pattern of correlations between age and anger scales were not statistically significant. However, two anger scales were significantly correlated with age in the hypothesized direction. Specifically, age was negatively correlated with the state anger verbal scale (r=-.226, p<.05, see Table 2), meaning that older individuals had lower state anger verbal scores. Age was negatively correlated with the state anger physical scale (r=-.222, p<.05, see Table 2), meaning that older individuals had lower state anger physical scores. A simple linear regression was conducted to test the effect of age on the composite Anger Expression Index score. Data analysis showed that age was not a significant predictor of the composite Anger Expression Index score, (β = .045, $t(80)$ = .439, p = .662).

Gender

The second research hypothesis stated that men would have higher overall STAXI-2 anger-out scores than women. The current sample consisted of 54 women (65.9%) and 28 men (34.1%). Correlations were used to investigate the hypothesis that STAXI-2 scores would be positively correlated with gender.

Table 2 Correlation Matrix for All Scales for Age

Scale	Pearson Correlation (*r*)	Significance (*p* value)
State Anger	-.119	.287
State Anger/Feeling	-.136	.222
State Anger/Verbal	-.226*	.041
State Anger/Physical	-.222*	.045
Trait Anger	-.118	.292
Trait Anger/Temperament	.019	.867
Trait Anger/Reaction	-.003	.975
Anger Expression Out	.042	.710
Anger Expression In	-.010	.927
Anger Control In	.021	.854
Anger Control Out	.182	.101
Anger Expression Index	.049	.662

*Levels of Significance * p<.05, ** p<.01*

As shown in Table 3, gender was significantly correlated with two of the 12 anger scales. Specifically, gender was negatively correlated to the state anger physical scale (r = -.27, p <. 05, see Table 3), meaning men were more likely to score higher on the state anger physical scale than women. Gender was negatively correlated with the trait anger reaction scale (r=-.287, p<.05, see Table 3), meaning men were more likely to score higher on trait anger reaction than women. Therefore, this hypothesis was fully/partially supported? As an additional exploratory test, a simple linear regression was performed to explore whether there was an overall effect of gender on the composite Anger Expression Index score. The regression analysis revealed that gender was not a significant predictor, (F(1,80)= .193, p=.662).

Independent samples t tests were used to examine whether or not women and men differed on their STAXI subscale scores and specifically, whether men would have higher overall STAXI-2 anger-out scores than women. Results showed that men and women differed significantly on two of the 12 anger scales. Specifically, on the state anger physical scale, men had significantly higher scores (M=43.64, SD=9.51) than did women (M=39.39 SD=5.80; t(80)= 2.168, p < 0.05, d=0.54). For the Trait Anger Reaction scale men scored significantly higher (M=46.64, SD=9.41) than women (M=42.85, SD=8.82; t(80)= 2.537, p<0.01, d=0.61). The hypothesis that men would have higher overall STAXI-2 anger-out scores than women was not supported, anger expression out scale (p =.541).

Table 3 Correlation Matrix for All Scales for Gender

Scale	Pearson Correlation (*r*)	Significance (*p* value)
Completion	-.070	.531
State Anger	.003	.975
State Anger/Feeling	.049	.661
State Anger/Verbal	-.066	.558
State Anger/Physical	-.271*	.014
Trait Anger	-.198	.075
Trait Anger/Temperament	-.111	.323
Trait Anger/Reaction	-.287**	.009
Anger Expression Out	-.069	.541
Anger Expression In	.027	.810
Anger Control In	-.015	.896
Anger Control Out	.139	.213
Anger Expression Index	-.012	.912

*Levels of significance * p<.05, ** p<.01*

Medium effect sizes were demonstrated related to gender on State Anger Physical (d=0.54) and Trait Anger Reaction (d=0.61). There was no significant difference between men and women on the other subscales: State Anger (p=.975), State Anger Feeling (p=.661), State Anger Verbal (p=.558), State Anger Physical (p=.014), Trait Anger (p=.075), Trait Anger/Temperament (p=.323), Trait Anger/Reaction (p= .009), Anger Expression Out (p=.541), Anger Expression In (p=.810), Anger Control In (p=.896), Anger Control Out (p=.213), and Anger Expression Index (p=.912). A second simple linear regression was performed to understand the effect of gender on the composite Anger Expression Index score. Results indicated that gender was not a significant predictor of Anger Expression Index scores, (β= -.302, t(80) = -.111, p=.912).

Completion

A post hoc analysis also sought to see if those who completed the program had lower scores on any of the STAXI-2 subscales. An independent samples t-test revealed no significant differences on scale scores for those who completed the program and those who did not. Specifically, there were no significant differences in state anger (p=.747), State Anger Feeling (p=.402), State Anger Verbal (p=.911), State Anger Physical (p=.288), Trait Anger (p=.386), Trait Anger/Temperament (p=.986), Trait Anger/Reaction (p=.879), Anger Expression Out (p=.899), Anger Expression In (p=.567), Anger Control In (p=.694), Anger Control Out (p=.633), and Anger Expression Index (p=.840). These results are consistent with a logistic regression analysis that had indicated that completion was not a significant predictor of anger expression index explaining only .001% of the variance, (χ2(1)= .042, p= .837).

CHAPTER FIVE
DISCUSSION

This research study expands the literature by exploring factors that are associated with attrition rates of African Americans in court mandated anger management treatment and assesses if state-trait anger was a predictive factor. Although this study failed to show evidence that attrition rates could be predicted based on state-trait anger scores or that gender and age were related to program attrition rates, this study revealed that age and gender were significantly correlated with specific subscales of the STAXI-2. There were significant correlations between age and state anger verbal and state anger physical scores. Also, gender was significantly correlated to state anger-physical and trait anger reaction scores. In the chapter that follows, I examine the implications of these findings for clinical practice and social change. Further, limitations of the study are examined. I close with suggestions for future research.

Importance of the Study

The focus of this study was on predictors of attrition rates of African Americans. Before discussing the results, it is important to provide background about the larger historical and societal context of the United States. African Americans are vulnerable to implicit bias based on racial stereotyping (Han et al., 2020; Kochel et al., 2011). Historically, the legal institutions charged with maintaining law and order have shown negative bias when sentencing African Americans (Bailey et al., 2020; Freiburger & Hilinski, 2010). Overall, African Americans receive harsher criminal sanctions than their White counterparts and other groups (Bailey et al., 2020; Freiburger & Hilinski, 2010).

These inequitable penalties cause substantial hardship on African Americans who have or are suspected to have violated the law (Han et al., 2020). This has engendered the mistrust African Americans have in judicial and mental health systems (Scharff et al., 2010; Suite et al., 2007). Because African Americans are penalized with harsher sentences and/or the potential for referral to inappropriate treatment, these feelings of mistrust continually are fed in their communities (Bailey, et al., 2020; Bell et al., 2015).

When considering the current media attention that African Americans receive in the United States due to police brutality, it is important to understand the impact of the intersectionality between race and legal sanctions. With African Americans receiving harsher criminal sanctions than other groups (Bailey et al., 2020), understanding their attrition rates from mandated treatment provides an opportunity to increase their persistence in therapy. The criminal justice system in the United States has a documented history of bias against African Americans (Bailey et al., 2020). African Americans are viewed as more threatening and aggressive than others (Sturmey, 2017). With this bias, we see African Americans disproportionately referred to anger management by legal systems. Legal institutions, who are charged with maintaining law and order, show negative bias when sentencing African Americans (Bailey et al., 2020; Freiburger & Hilinski, 2010). Individuals in positions of judicial power may impose inequitable penalties on African Americans, thereby causing substantial hardship on those who have or are suspected to have violated the law (Han et al., 2020).

Once referred, some African Americans leave treatment before completing all court mandated requirements. This attrition comes with additional consequences that may include incarceration, further restrictions, and financial restitution, all of which pose

significant barriers to work/life balance and engagement in opportunities for vocational advancement (Bailey, et al., 2020). Unfortunately, a public database does not exist to indicate which individuals complete anger management treatment after referral (Feldman, 2016), so researchers must seek other ways to determine why people leave and who is most at risk for leaving treatment prematurely. Therefore, this study sought to determine if an instrument like the STAXI-2 might play a role in predicting the attrition of a specific population from court mandated treatment.

Attrition Results

The first hypothesis suggested that higher scores on the STAXI-2 would be associated with higher rates of attrition. However, this study found no significant differences in the scores of those who completed and those who did not complete treatment, meaning the STAXI-2 scores were not a predictor of whether or not clients would complete treatment. Based on this information, clinicians may not be able to use the STAXI-2 to ascertain which clients may have a higher risk of attrition. Other factors must be considered to determine clients' risk of attrition which are discussed below.

As indicated in Chapter Four, 64 (75.6%) participants successfully completed the anger management treatment program and 20 (24.4%) did not. This finding is in line with a previous meta-analysis of clients in psychotherapy, showing that approximately 20% of clients drop out of treatment early (Swift & Greenberg, 2012). While this data is consistent with the extant literature, the questions of why people fail to complete treatment and how to predict and prevent that attrition remain. Prior studies have cited the following variables as possible reasons for attrition: race (Lester et al., 2010; Sue et al., 1991; Ward & Brown, 2015), mistrust (Boyd-Franklin, 2003; Scharff et al., 2010),

sociocultural/socioeconomic factors (Santiago et al., 2013; Snowden & Thomas, 2000), stigma (Bourdeaux et al., 2014; Davis, 2008; Thomas, 2002), age (Thomas, 2002) and clinician skill level (Swift & Greenberg, 2012). The results of this study posit an additional factor for exploration: inappropriate referral based upon cultural bias.

When considering African American attrition rates from anger management programs, special attention should be given to treatment design barriers that impact participation. These barriers include sociocultural barriers that incorporate personal values and beliefs about mental health treatment (Scharf et al., 2010). These sociocultural barriers (e.g. race, cultural taboo, social stigma), unwittingly discourage the participation of African Americans in treatment. For example, participants may not see the value or benefit of treatment. Treatment stigma is another barrier. African Americans may not be responsive to terms like mental health treatment or mental illness (Boudreaux et al., 2014). Due to the historical maltreatment of African Americans in relation to mental health treatment. For a period of time census reports were falsified to show the further north African Americans lived the higher the incidence of mental illness. This was used as a scare tactic to deter African Americans from leaving the oppressive south. The remnants of this treatment over a century ago still remains with many African Americans as intergenerational trauma (Kawaii-Bogue et al., 2017). This well-known history of inhumane and substandard care of African Americans by mental health professionals could be a deterrent to help seeking and treatment completion even when a problem exists. In a study of over 400 people found that participants with anger problems were reluctant to seek help (Boudreaux et al., 2014). Reduced help seeking behaviors may translate into early termination for those who are mandated into anger management

treatment. Accepting treatment is seen as an admission of a problem they may not be willing to face. The client-counselor relationship is yet another factor (Kivlighan et al., 2019; Beasley, 2013; Scharff et al., 2010). Some studies indicate that African Americans prefer African American counselors (Cabral & Smith, 2011). Ethnic matching has been used to explain an increase in utilization of services and improved clinical outcomes (Cabral & Smith, 2011; Beasley, 2013). Finally views on treatment also may be influenced by the participants' age. Younger clients may not take treatment seriously or may not fully understand the ramifications of early termination (Thomas, 2002).

Previous research also has discussed the mistrust African Americans have in judicial and mental health systems (Scharff et al., 2010; Suite et al., 2007). This mistrust may continually be fed by inappropriate treatment, including referrals. Because African Americans are penalized with harsher sentences and/or the potential for referral to inappropriate treatment, these feelings of mistrust continually are fed in their communities (Bailey, et al., 2019; Bell et al., 2015). In this study, a large number of participants who were referred for treatment scored significantly below the threshold of 65 for referral or additional treatment. The mean scores for participants in this study ranged from 38.41 to 51.02.

When viewing the results of the current study, it is alarming that such a significant number of participants did not meet the treatment criteria for referral to anger management. Therefore, counselors must ask how improper treatment referrals impact attrition rates for mandated clients. While attrition and recidivism are not the same, it is important to consider that attrition has been linked to recidivism (Lockwood & Harris, 2013). Additional research by Bonta and Andrews (2016) has indicated that providing

treatment to low-risk offenders can increase, rather than decrease, recidivism rates, furthering the concern for clients in this study with low STAXI-2 scores. In either case, individuals may not see their behavior as problematic and may even see their anger as a significant part of their identity or as consistent with their role in their families or communities. Attempts to change this part of their identity may be rejected, leading them to terminate from treatment early.

Although judiciaries may use pre-sentencing tools, such as the Correctional Offender Management Profiling for Alternative Sanctions (COMPAS) questionnaire, there are conflicting data on the effectiveness of this tool at predicting recidivism (Dressel & Farid, 2018). Other research suggests that the COMPAS is no more accurate than human prediction (Dressel & Farid, 2018). This limitation in possible tool efficacy is concerning when we such tools may be used to identify appropriate criminal sanctions that include mental health treatment. The faulty recommendations that may occur as a result of tools like the COMPAS may be harmful to African American clients. Since African American clients may receive harsher criminal penalties due to implicit bias and racism it is even more alarming when tools are also utilized that are not efficacious in treatment recommendations. Although the participants in this study were not diagnosed by treating professionals prior to treatment implementation, the spirit of misdiagnosis comes to mind as do the clinical implications that plague the misdiagnosis of African American clients in relation to mental health. Clinicians have found that misdiagnosis of African Americans influences treatment planning and service delivery (Bell et al., 2015). One study of African American psychiatric patients indicated that two-thirds of the study population had a diagnosis that did not take into consideration other variables, such as

intellectual disability, substance abuse, or childhood trauma (Bell et al., 2015), all of which could have influenced and changed their diagnosis and treatment delivery. This same study, for example, indicated a small percentage of participants had been diagnosed with schizophrenia. As studies like this demonstrate, misdiagnosis is an ongoing problem in the clinical treatment of African Americans.

Clinicians who are not trained to identify barriers to treatment may unwittingly miss the signs that lead to attrition. Several studies have indicated that clients are at an increased risk when being treated by trainee clinicians (those working towards a degree) (Aubuchon-Endsley & Callahan, 2009; Spruill et al., 2004; Swift & Greenberg, 2012). This is of significant concern with the current study because all clinicians were trainees in a university-based clinic. The clinicians' limited experience may have impacted their ability to build relationships with clients and to implement appropriate interventions (Aubuchon-Endsley & Callahan, 2009; Spruill et al., 2004). Moreover, counselors in training are more likely to work with younger clients who are at higher risk for attrition based on age (Thomas, 2002).

Research is not clear as to the reasons why individuals leave anger management treatment before completion. However, we can glean from research that various social and environmental factors can contribute to attrition. It is imperative that individuals mandated to anger management be screened appropriately for treatment and that consideration be given to the unique circumstances of why they were mandated into treatment.

Gender Results

The second research hypothesis, which also was denied, asserted that men would have higher anger expression out scores on the STAXI-2 than women. This null finding could be accounted for by what Butler (1990) has labeled gender performance or the tendency for some women to "move like boys" (Bernard & Carlile, 2020), behaving in ways that are stereotypical of men, due to stressful stimuli (Wesemann et al., 2021). Women are historically socialized not to express anger and studies have indicated that women show higher rates of anger suppression than men (Wesemann et al., 2021), but living in stressful, chaotic circumstances (e.g. impoverished & violent neighborhoods) and fearing for their safety may make some women feel compelled to behave in ways that they attribute to men, such as monitoring their surroundings and taking risk assessments of their social environments (Bernard & Carlile, 2020). African American women in particular have been stereotyped when expressing anger. Too often they are perceived as "angry black women" with the connotation of being hard to get along with, unreasonable, and physically aggressive (Evans-Winters & Esposito, 2010), while White women who display similar behaviors are not viewed with the same stigma (Salerno & Peter-Hagen, 2015). Although it is unknown if the women involved in this study were more comfortable in expressing anger, further study of gender performance could shed light on the equity of anger and its expression between genders.

Although the data analysis revealed that men and women did not have significant differences in most of the STAXI-2 scores, it was found that men had significantly higher scores on the state anger-physical scale. Men were more likely to express anger in ways that used physical behavior, such as throwing punches and hitting things, perhaps because

it is normalized masculine behavior (Sloan, 2012). Women are less likely to express anger with outward acts of aggression. Prior research has indicated that women are more likely to internalize their anger with self-harm, such as self-mutilation, suicidal gestures, and substance abuse (Eamon et al., 2001). With that said, researchers should revisit speculation about gender performance to investigate why it is not as likely to extend to physical expression in women.

Age Results

The third research hypothesis asserted that age would be inversely related to participants' STAXI-2 scores. Specifically, it stated that as age increased, STAXI-2 scores would decrease. Previous studies have indicated that anger declines with age (English & Carstensen, 2014). Age was negatively correlated with the state anger verbal scale ($r=-.226$, $p<.5$, see Table 3). This finding supports previous research (Phillips et al., 2005) that indicated older adults were less likely to express anger verbally. There could be several reasons for this finding. The state anger verbal scale measures the intensity of current feelings in relation to verbal expression (Speilberger, 1999). As a person ages, their verbal expression of anger may lessen based on maturity and increased reasoning skills (Thomas, 2002), whereas younger people have limited emotional resources and less practice controlling their verbal expressions of anger (Thomas, 2002). Older adults are skilled at reducing their exposure to stressors that are anger provoking (Stawski, 2008). Their perception of situations may also be different (Cox & Harrison, 2008; Spielberger & Reheiser, 2010). While each of the participants was involved in an incident that led to criminal charges, older adult participants may not have viewed the circumstances with as much concern or stress as younger participants.

Age is a common factor considered when researching attrition (Roseborough et al., 2016). However, research provides inconclusive results in relation to age. Although older studies (Reiss & Brown, 1999) indicated that age was not a significant factor in early treatment termination, more recent studies indicate that younger clients are more likely to terminate treatment before completion (de Haan et al., 2015; Roseborough et al., 2016). Findings from the current study support the latter, suggesting that age may be a factor related to attrition rates.

Young adults may not fully understand the consequences of terminating treatment early (Thomas, 2002). As previously mentioned, when considering attachment and emotional regulation, African American mothers were observed to down-play negative emotions, which may in turn have led to children not having proper guidance in how to handle anger (McKee et al., 2015). This lack of guidance may have been the case for the young adults who left treatment early. Limited experience with the expression and validation of anger may have led to cognitive dissonance, in participants presented with information that was inconsistent with their values and beliefs. Participants in this study would have been discussing anger, the antecedents to anger, and the consequences in a group setting. Cognitive dissonance may have caused participants to withdraw from treatment. The treatment curriculum for participants in this study consisted of activities that incorporated role plays and discussions that may have caused participants to feel ill equipped to participate due to limited knowledge and skill development. Such concerns offer one possible explanation for why younger participants showed an increased rate of early termination. In other words, they may have felt uncomfortable talking about feelings they never learned to properly express. Counselors working with younger clients

may want to put clients at ease in the initial session by reflecting upon their uncertainty and possible limited skills. Normalizing any apprehension may serve as a protective factor to reduce attrition.

Implications

This study fills a gap in the literature because it documents anger management scores in an African American population, a population whose experience with anger management has not been previously documented. Although there is a lack of research on court mandated anger management (Lee & DiGiuseppe, 2018) in general, there is even less literature on African Americans in court mandated anger management. This study also brings to question whether participants were properly referred for the correct treatment protocol. In addition to the aforementioned considerations, the role of implicit bias and racism are factors that may impact the initial sentencing of African Americans into anger management. The implications of serving African Americans who are sentenced to anger management treatment are explored in the sections that follow.

Sociopolitical

Consideration should be given to the sociopolitical implications of mandating African Americans into anger management. As demonstrated by the extant literature, African Americans are vulnerable to implicit bias based on racial stereotyping (Bailey et al., 2020; Han et al., 2020; Kochel et al., 2011). Unfortunately, judicial systems have been notorious for doling out punishments to African Americans who differ from those given to their White counterparts (Bailey et al., 2020; Freiburger & Hilinski, 2010). Counselors have an ethical obligation to advocate on behalf of their clients not other entities (ACA, 2014, Section A.7.1). For example, counselors should advocate with legal

entities to treat the underlying issues and address the presenting problem without being boxed into providing a specific treatment that may not meet the clients' needs. Research indicates that men and minorities suffer harsher criminal penalties and are viewed as more dangerous and aggressive (Ulmer et al., 2016; Brewer & Heitzeg, 2008). These biased views are dangerous to African Americans involved in the legal system. The broad discretion of judiciaries has unfair consequences for African Americans (Bailey et al., 2020). Biased assumptions about people or groups can lead to inappropriate decision making (Snowden, 2003). When assessing bias, race and cultural factors should be considered as mitigating factors in sentencing guidelines. Considering bias means that racial factors are used as a means to understand differences rather than to reify them. African Americans experience of anger may be race based as a result of discrimination (Isom Scott & Seal, 2019) like institutional racism (Miller & Vittrup, 2020) and/or socioeconomic factors (Zilioli et al., 2017). Appreciation for these factors can be used to create culturally sensitive treatment options (Snowden, 2003).

Counselor Education and Supervision (CES)

The information gathered in this research provides data that counselor educators and supervisors (CES) can use to inform their pedagogy. This research provides the field of CES with knowledge that African Americans mandated to anger management treatment may not meet the criteria as having a problem with anger. Therefore, counselors in training should not begin treatment with preconceived notions about participants' need for treatment. CES professionals should encourage trainees to provide pre-screening assessments to determine the appropriateness of treatment. Specific assessments, such as the Brief Trauma Questionnaire (Schnurr et al., 1999), Life Stressor

Checklist (Wolfe et al., 1997), and the Beck Depression Inventory (Beck et al., 1996), could be used during an initial intake to assess for issues other than anger that may be of concern. Counselors in training and CES professionals should be prepared to advocate on their clients' behalf when it is determined that anger management is not the most appropriate treatment. Referring agents should be educated on the need for accurate assessment and the harm that can be done to individuals who are mandated to an inappropriate treatment. When clients are provided appropriate treatment, recidivism rates may be decreased (Henwood et al., 2015). Attrition rates also impact the skill development of counselors in training. When clients leave treatment early, trainees are unable to acquire skills associated with middle to late-stage treatment (Spruill et al., 2004). Improvements in client retention will help trainees build skills and subsequently impact retention rates as well (Aubuchon-Endsley & Callahan, 2009).

In addition, counselor educators should prepare counselors in training during skills courses to model advocacy with judicial systems and address race, bias, and power differentials with clients. New counselors in training may be intimidated by judicial personnel and find it easier to "go along" with the referral source recommendations. It is important the CES challenge counselors in training on their own bias and personal values that may impact their ability to advocate. For example, women may find it difficult to challenge male figures based on personal experiences and values. Younger counselors in training may also find it difficult to challenge court personnel who are seen as authority figures. Counselor in training may receive resistance from judicial entities when advocating for treatment contrary to a court order. CES and should have counselors in training practice during skills training what these conversations will entail and how to

advocate with data and research to support their clinical decisions. Finally, CES also can advance the counseling profession by modeling how to discuss power differentials between clinicians and clients. New counselors in training may have difficulty relating to clients especially those who are older and from different race and ethnic groups. However, studies indicate using the clients' language (De Jong & Berg, 2001; Sotero et al., 2016) and validating their feelings (Novaco, 2011) of injustice can enhance rapport building and assist clinicians in building a trusting relationship.

Clinical

Clinicians working directly with clients who have been referred to anger management treatment have a responsibility to advocate for their clients, not legal entities. (ACA, 2014, Section A.7.a). The client, although court mandated, is still the primary focus and concern of the clinician. As such, the clinician has an obligation to discuss appropriate treatment with the client and the referring agents. At times, the referring agent and the client's needs may be in direct opposition. In these instances, the clinician should be required to educate legal entities on the harm that can come from forced treatment, incorrect treatment, and the impact on recidivism (ACA, 2014, Section A.4.a). Counseling ethics advise counselors when faced with an ethical dilemma that conflicts with legal regulations to work to resolve the issue in the best interest of the client, while still adhering to legal standards (ACA, 2014, Section I.1.c.). Clinicians should be careful to understand legal mandates but work to find a balance that will not harm the client while also ensuring they meet legal requirements. The justice system's ability to conduct screenings before it mandates people to anger management is questionable, which creates a problem for clinicians providing treatment and having to

divide their allegiance between courts and their client. The possible incongruence between the courts' goals and the clients' goals places the clinician in the middle, trying to satisfy both. The ability for counselors to advocate, assess bias, and build rapport with African Americans takes skill, knowledge, and the ability to look at clients' circumstances holistically, while considering the current situation as well as environmental, social, and historical factors that may contribute to the presenting issue.

Counselor competency also plays an integral role in reducing attrition. The Multicultural and Social Justice Counseling Competencies (MSJCC) (Ratts et al., 2016) specifically address the imbalance that may exist between client and counselor due to social and cultural differences and thus offers suggestions on creating an equitable relationship. The MSJCC identifies quadrants where clients' and counselors' identities intersect based on social schemas of privilege and power that influence the counseling relationship (Ratts et al., 2016). To develop competency, counselors need to be self-aware. Counselors must understand their own identity and any privilege or marginalization that comes with their identity. While being in tune with themselves, they also must understand their clients' worldviews or make an effort to understand their worldview and how their multiple identities intersect. Self-aware counselors use their knowledge to advocate for their clients. This advocacy can take on many dimensions in relation to African American clients who are mandated into anger management treatment, such as assessing how historical factors like racism and bias contribute to the client's current problem (Ratts et al., 2016). Advocacy also may include addressing norms and values that perpetuate injustice in the community (Ratts et al., 2016). Conducting

empirical research that focuses on the injustice in counseling literature is a form of advocacy as well (Ratts et al., 2016).

Research indicates that African Americans benefit from psychoeducation interventions that focus on the disempowerment they may experience (Alvidrez et al., 2005). These methods can help to validate their feelings and explain some of the behavior and emotions they may be experiencing. Psychoeducation interventions may include asking clients to journal about their feelings and experiences with anger. Once clients can identify anger provoking stimuli and the physical and emotional indicators this is step towards understanding and regulating emotions. This also provides an opportunity for clients to validate the feelings for African Americans who experience discrimination and the relationship that has to anger. These methods may be helpful to African Americans in court mandated treatment in which they do not necessarily agree with the need for treatment. Clinicians may ask clients to read books that increase awareness and empower clients such as the 48 Laws of Black Empowerment which provides synopsis of actions for personal growth and development that will impact the clients community as well. When the practices are incorporated older African Americans have been found to remain in treatment longer than those who do not receive psychoeducational interventions (Alvidrez et al., 2005). Also, incorporating strengths-based approaches that address the perceived power differential in treatment has also proven to be effective in engaging African Americans and forging a collaborative relationship (Kawaii-Bogue et al., 2017). Specifically showing the client their strengths by treating them as the expert this builds rapport and recognizes their knowledge and wisdom. Clinicians can reframe information clients have shared to show the client new perspectives the build on positive attributes. In

addition, culturally responsive elements may increase participation and retention. For example, incorporating family members into treatment. Research indicates that African Americans are more responsive to the considerations of their family and by providing families with psychoeducational information this may also increase treatment adherence (Kawaii-Bogue et al., 2017).

Limitations

This study acknowledges several limitations that may have impacted the research. It utilized archival data from 2018 for African Americans court mandated into treatment in a metropolitan area. The data do not include any information on the reason participants did not complete treatment. Having more specific information regarding the reasons for attrition would be helpful in tracking participants, evaluating program efficacy, and assessing recidivism.

Another limitation with the data collected is that the STAXI-2 was only administered pre-treatment. There are no post-treatment results with which to compare. This lack of comparison does not offer any insight into the benefits of treatment. Another notable concern with this population is the problem of response bias; the clients may have answered the questions in a way that they believed would be socially desirable. When looking at the data closely, it is apparent that nearly all *t* scores for all participants fell well below the 65 needed to indicate problems with anger. It begs the question if clients were answering honestly or not. Another question with regard to response bias is the impact of the counselor-client relationship. As stated earlier, many clients may view treatment providers as extensions of the court, which impacts rapport building in the beginning. It is possible that post-treatment assessment may have yielded significantly

different scores, such as an increase in *t* scores, because clients felt comfortable being honest as a trusting client-counselor relationship developed.

Both internal and external validity issues are probable in this research design. According to Creswell (2012), single subject design does not use a control group, which may pose a threat to internal validity because there is no opportunity to compare groups. Participants may develop or change during the time they are being assessed; this maturation may impact their overall outcomes (Creswell, 2012). The post-treatment maturation of clients may impact recidivism. Also, the expectations of participants may impact their scores on the assessment.

Finally, during the assessments, clients may be in the room with a practicum counselor and/or other participants. The Hawthorne effect of clients performing better when being observed is therefore a potential issue. Moreover, the self-report nature of the STAXI-2 lends itself to participants under- or over-reporting symptoms (Groth-Marnat, 2009). Due to a historical mistrust of mental health institutions, African American clients may under report symptoms (Snowden, 2001).

Recommendation for Future Research

Since no statistical relevance was found, further study on attrition is recommended. A larger sample size may have been helpful to increase generalizability of attrition rates. Some areas of this research were approaching significance and may have indicated different results with a larger sample. In addition, several data points were not available, such as the reason for mandated treatment from the referral source or the participant. Having this information would provide a more accurate view of participants that the clinician could have used to accurately assess and provide treatment.

Ideally a future research design would gather more demographic details from clients, such as marital status, educational background, and reason for referral, all of which have been noted to impact attrition from treatment (Harris et al., 2020). When conducting future research at the onset of treatment, participants should be given the STAXI-2. If they do not meet the criteria for anger, additional assessments should be given, such as the Beck Depression Inventory (Beck et al., 1996) or the Post Traumatic Stress Diagnostic Scale (Foa, 1996). These scales can identify issues outside of anger that may influence the behavior that led to court mandated treatment. When designing future treatments, it may be beneficial to inquire about environmental factors that may lead to attrition, such as employment, transportation, and family obligations.

The results of this study did foster the development of new questions that future researchers may want to consider. For instance, is there a difference in the rate at which African Americans and whites are mandated into anger management treatment? In the future researchers may want to get documentation directly from court systems regarding the methods they utilize to determine if a person is mandated into anger management and assessing the validity and efficacy of any tools used in the pre-sentencing process. In addition, another question could be posed such as what is the incidence of multiple disorders in African Americans mandated into anger management? This question would allow researcher to not only assess for anger but also depression, anxiety, and other disorders that could have overlapping symptoms similar to anger. Qualitative questions could also be researched to better understand African Americans experience with mandated anger management. Specifically, how do African Americans interpret their need for anger management and how does treatment impact self-concept?

Furthermore, it would be helpful if future research utilized the STAXI-2 as a pre-screening tool to determine if clients are in need of anger management treatment before referring them for services. Pre-sentencing tools would ensure that participants are referred for meaningful services that address their issues instead of individuals being referred for treatment based on subjective components like criminal charges or implicit racial bias. Those who are found to need treatment also should be provided post-assessments to determine the effectiveness of that treatment.

Although the program from which the data was collected was free, there was a financial cost if participants had to take unpaid time from work to participate. As such, future research should consider how time requirements could contribute to early termination because participants may prioritize employment requirements over treatment requirements (Bailey et al., 2020). When faced with financial hardships, individuals are placed in situations in which either decision--to attend or to work-- can have dire consequences. This is a factor that counselors and judiciaries must take into account. To support participants in their treatment programs, a more holistic view of their circumstances should be considered.

In addition, conducting studies into clients' prior trauma may be useful when working with African Americans mandated into anger management. Research indicates that African Americans' exposure to trauma impacts their expression of anger (Forsyth & Carter, 2014). Immediate and delayed symptoms of trauma include anger, irritability, hyperarousal, and difficulty with self-regulation (Center for Substance Abuse Treatment, 2014), all hallmarks of problems with managing anger. It is not uncommon for symptoms to be miscategorized. This is especially problematic when bias leads decision makers to

see African Americans' possible symptoms of trauma as explicit anger without considering individual circumstances and/or cultural factors, all of which could be assessed pre-sentencing to lead to appropriate treatment outcomes.

Additionally, qualitative research methods would shed light on how the clients perceive COAM treatment. Such research may include photovoice methods (Wang & Burris, 1997) which would allow clients to capture images that help them express emotion. By utilizing the SHOWED method (Wang & Burris, 1997) with photovoice participants are able to discuss the photos from an individual interpretation to a more global expansion of the clients environment. This type of methodology also provides the client with some ownership and value as they choose the photos, thereby reinforcing strength-based practices.

Conclusion

This study found that the STAXI-2 is not sufficient to predict attrition rates from court mandated anger management for African Americans. Although the results are not generalizable, they do provide some insight into the concerns that African Americans and clinicians must consider in court mandated treatment. African Americans are vulnerable in that their attrition from treatment is increased due to racism, historical mistreatment by professionals, legal disparity, and personal values that do not align with help seeking. This study indicated that participants did not meet the STAXI-2 threshold for having a problem with anger management, begging the question whether referrals from legal entities were appropriate or fraught with bias, which is consistent with prior research that demonstrates African Americans are subject to sentencing disparity, leaving them with longer and harsher penalties (Bailey, 2020). This study also brings to light the limited

research on African Americans in court mandated treatment, especially for anger management. With such little research on this topic, it was difficult to compare and contrast this research with other findings.

Counselors charged to work with African Americans who are court mandated to treatment should advocate for pre-sentencing assessments when possible, to ensure that an appropriate treatment course is pursued. Assessments should consider the possibility that depression, trauma, or some other emotional health issue may be the instigating problem. Specifically, within the African American population, assessments should also consider sociopolitical and cultural implications of diagnoses and treatment. African Americans present more distrust of counselors within treatment than other groups. It would behoove counselors to understand that they can build a trusting relationship with this vulnerable population via their advocacy and appreciation for the cultural factors that influence their perceptions and decision-making skills, all which influence the expression of anger.

APPENDIX A

IRB LETTER

OAKLAND UNIVERSITY

Institutional Review Board

December 15, 2020

Protocol #: IRB-FY2021-107

Research Team:
Kimberly Childers
Michael Chaney

The following study, "The Relationship Between State-Trait Anger Expression and Attrition Rates of African Americans in Court Mandated Anger Management Treatment", has been has been determined to be No Human Subjects Research according to federal regulations.

The IRB decision is based on the following:

Research with De-identified Private Information. The project is limited to the use of existing de-identified private information that meets all of the following criteria:

1. The private information was not collected specifically for the currently proposed research through an intervention or interaction with living individuals; and
2. The use of private information in this project is not in violation of the terms under which the private information was originally collected; and
3. The research team will only receive information that is fully de-identified. "De-identified" means that: (i) The identity of the individual cannot be readily ascertained from the information available to the research team; or (ii) The information available to the research team does not include any of the 18 identifiers defined in the HIPAA Privacy Rule; and (iii) De-identified data cannot be linked back to individuals directly or through coding systems; and
4. The project is not under FDA regulations.

A data sharing letter from the data owner Dr. Sheri Pickover, PhD, LPC, Associate Professor & Program Director, Department of Counseling & Special Education, Central Michigan University, has been provided in this submission. The letter provides information that support all of the aforementioned required criteria to consider this research with existing de-identified private information as not human subject research.

Please retain a copy of this correspondence for your records.

If you have any questions, please contact the IRB staff.

Thank you.

APPENDIX B

DATA SHARING AGREEMENT

CMU
CENTRAL MICHIGAN UNIVERSITY
College of
Education &
Human Services

(989) 774-3709
(989) 774-xxxx

ehs.cmich.edu
picko1s@cmich.edu

Central Michigan University,
Mt. Pleasant, MI 48859

Sheri Pickover, PhD, LPC
Associate Professor
EHS 354

Dear Ms. Childers,

I am writing in response to your request to using existing data from the University of Detroit Mercy Counseling Clinic for your dissertation study. The requested data was collected as part of a grant funded program evaluation of an anger management treatment protocol provided at no cost to individuals referred to the Counseling Clinic for court mandated counseling. The collected data was approved by the University of Detroit Mercy Institutional Review Board (approval number 1516-41) and all participants in the study reviewed and signed an informed consent that clearly outlines their rights, the benefits and risks of participation and provided verification that all data would be stored and report in an anonymous and de-identified manner. Please accept this letter as my approval for you to use this de-identified data. Specifically, you are approved to receive and analyze the following clinical records:

1. Counseling Clinic files from January 1, 2011 through August 15, 2018
2. Data from STAXI-2 assessments
3. Data from post-treatment surveys
4. Data from referral source surveys
5. Data from client clinical files

Per your request, I will ensure the following safeguards are met:

1. Only de-identified data will be shared that cannot be linked back the client will be shared with you. The sharing of such data does not violate the client's original consent to participate to have their records used for research purposes.
2. The process for removing the identifiable information will be done in a manner that reduces any risk of possible disclosure.

Sincerely,

Sheri Pickover

Sheri Pickover, PhD, LPC
Associate Professor & Program Director
Department of Counseling & Special Education

APPENDIX C

COPYRIGHT APPROVAL

Creating Connections, Changing Lives. PAR

Sent Via Email: kmchilders@oakland.edu

October 7, 2021

Kimberly Childers
Oakland University
318 Meadow Brook Rd.
Rochester, MI 48309

Dear Kimberly Childers:

In response to your recent request, permission is hereby granted to you to include Table 1: *Brief Overview of the STAXI-2 Scales and Subscales* from the State-Trait Anger Expression Inventory-2 (STAXI-2) Professional Manual in your dissertation entitled, *The Relationship Between State-Trait Anger Expression and Attrition Rates Of African Americans In Court Ordered Anger Management Treatment*. If additional material is needed or further publication of your dissertation in a Journal (or otherwise), it will be necessary to write to PAR for further permission.

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