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Instrument Development: Youth Anger, Youth Forgiveness, and Youth Emotional Support

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INSTRUMENT DEVELOPMENT: YOUTH FORGIVENESS, YOUTH ANGER, AND YOUTH EMOTIONAL SUPPORT

by

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ABSTRACT
INSTRUMENT DEVELOPMENT: YOUTH FORGIVENESS, YOUTH ANGER, AND YOUTH EMOTIONAL SUPPORT

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The role of forgiveness, anger, and emotional support, among the adolescent population, continues to receive significant interest among the research community. To date, there are no measures of forgiveness, anger, and emotional support that have exclusively examined these constructs among the African-American, adolescent population within a short-term, specified amount of time. The purpose of this study was to develop and validate a measure of perceived level of anger, support, and forgiveness among African-American adolescents. In addition, these measures were specifically created to be utilized in future research to capture the relational dimension between level of perceived anger, forgiveness, and support within the African-American, adolescent population. In order to examine the psychometric properties of each measure, the study was divided into 2 independent studies. Study #1 involved preliminary item analyses for each measure; participants included 90 African-American high school students who completed measures of forgiveness, anger, and support. Study #2 involved tests of reliability and validity; participants included 220 African-American high school students who completed measures of forgiveness, anger, support, and depression symptomology. The results imply that with some initial adjustment each measure produced overall strong reliability. Overall, validity was indicated by significant correlations with corresponding constructs.

The results of this investigation indicate a relational dimension between anger, forgiveness, and support. This study provides significant implications for the field of psychology and future research.

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Chapter I

Introduction

Forgiveness is an individual process. It involves developing positive feelings, thoughts, and behaviors towards the offender, not harboring resentment and anger. It also means letting go of negative thoughts, feelings, and behaviors towards the offender. According to Joanna North (1987), a modern philosopher, forgiveness requires giving up anger and resentment and offering the offender a gift in the form of "compassion, benevolence, and love". Forgiveness does not mean one has to completely cease anger, condone the wrongdoing, forget, justify, or only partially forgive. It does not mean that one needs to reconcile or mend fences with the person. However, one cannot reconcile if one does not forgive. At the individual level, forgiveness is an important component of well-being indicating that *forgiveness* has been linked to decreases in negative affect like anger, depression, and anxiety (Fitzgibbons 1986; Freedman & Enright, 1996; Reed & Enright, 2006; Seybold, Hill, Neumann, & Chi, 2001) as well as to increases in physical health (Seybold et al., 2001;Wilson, Milosevic, Carroll, Hart, & Hibbard, 2008). The purpose of this study is to develop a measure of forgiveness and other related constructs.

According to the Enright's process model of forgiveness (2001), there are four phases in the process of forgiveness that include: uncovering one's anger, deciding to forgive, working on forgiveness and discovery and release from an emotional prison. Each phase is predicated upon the success of the other and explores aspects of anger and the anger experience. For example, during the first phase the individual becomes aware of the emotional pain that has resulted from a deep, unjust injury. Characteristic feelings of anger or even hatred may be present. As these negative emotions are confronted and

the injury is honestly understood, individuals may experience considerable emotional distress. Deciding on the appropriate amount of energy to process this pain and still function effectively is an important consideration during this phase. However, as the anger and other negative emotions are brought out into the open, healing can begin to occur. Additionally, this phase provides eight guidepost/questions, like a checklist, in which those forgiving need to ask themselves: Have you avoided dealing with your anger? Have you faced your anger? Has anger affected your health?

The topic of forgiveness with the adolescent population is an appropriate and applicable topic to explore because the constructs of forgiveness found in adults are already in place among adolescents which include propensity to lasting resentment, sensitivity to circumstances, willingness to forgive, and willingness to avenge (Chiaramello, Mesnil, Sastre, & Mullet, 2008). Furthermore, during adolescence a sense of forgiveness begins to develop that goes beyond "childhood conceptions" and their reasoning about forgiveness are distinct from children and adults populations (Enright, Santos, & Al-Mabuk, 1989, p. 108). Several research articles indicate that forgiveness can contribute to positive development outcomes during adolescence such as movement from negative to more positive thoughts, behaviors and emotions (Klatt & Enright, 2009).

A considerable amount of research has found a relationship between forgiveness and the emotion of anger (Hansen, Enright, Baskin, & Klatt, 2009; Seybold et al., 2001). Anger is one of the most frequently experienced emotions and its source and expression has been examined from multiple theorists and perspectives (Averill, 1983; Kemp & Strongman, 1995). According to Nelson, Finch, and Ghee (2012) anger is defined as an "internal experience of a private, subjective event (i.e., emotion) that has cognitive (e.g.,

thoughts, self-statements, private speech, images, attributions), and physiological components" (p. 97). In addition, anger has been described as a “complex psychophysical phenomenon with wide-ranging implications for physical, mental, and social wellbeing” (Gaylin, 1994, p. 50) and should be viewed from a social, cultural context (Tavris, 1989).

A focus on anger during adolescence is important to explore because identity, independence, and integration are primary features within this developmental period (Freeberg, 1982). Adolescence is seen as a time frame devoted to “feeling secure as a separate individual with self-worth and self-esteem”, requiring that the individual “recognize and accept times of dependency as well as the responsibility inherent in independence” (Freeberg, 1982, p. 29). Also, during adolescence the individual strives for “self-integration within the framework of the family and community, but first requires individuation, which is often seen as anger” (Freeberg, 1982, p. 29). In addition, adolescents are faced with increasing cognitive and socioemotional challenges at school and changes in the emotional, social, and psychological relationships with their parents and peers (Steinberg & Morris, 2001). Although most adolescents cope well with these challenges, for some adolescence it can be a time of increased negative emotions (Steinberg & Morris, 2001).

More specifically, the topic of anger within the African American adolescent population is important due to this population’s disproportionate exposure to violence, poverty, and racism (Williams, Neighbors, & Jackson, 2003). Crouch, Hanson, Saunders, Kilpatrick, and Resnick (2000) summarized the results related to SES and race from the National Survey of Adolescents (NSA) and found that African American youth across all income levels report witnessing family violence and being physically and sexually

assaulted at higher rates than European American youth. Overall, over half (57%) of the African American participants in the NSA reported witnessing violence, 24% reported being physically assaulted, and 13% reported being sexually assaulted as compared to 34 % of European American participants reporting witnessing violence, 15% being physically assaulted and 6% being sexually assaulted. The negative effects of this population's disproportionate exposure to violence has been associated with difficulties in emotional, behavioral, and adaptive functioning including depression, anxiety, posttraumatic stress disorder, increases in fighting behavior, and unhealthy sexual behaviors, beliefs, and norms (Cooley- Quille, Boyd, Frantz, & Walsh, 2001; DuRant, Pendergrast, & Cadenhead, 1994; Paxton, Robinson, Shah, & Schoeny, 2004; Wingood, DiClemente, McCree, Harrington, & Davies, 2001).

According to the U.S. Census (2010), African Americans have the highest percentage of children, under the age of 18, living in poverty, over 35% of African American children compared to approximately 17% for European American children. A review of the literature by Bradley and Corwyn (2002) identified negative effects of poverty (low SES) which include health outcomes, cognitive and academic attainment, and socioemotional development. Additionally, the researchers highlight that the literature consistently argues that stress accounts for much of the difference in outcomes between low-SES and high-SES children (Shonkoff & Phillips , 2000). Specifically, adolescents from lower socioeconomic groups, regardless of race, experience higher levels of negative life changes such as changing schools, increased number of arguments between parents, and death of a family member, which reflect their level of life stress. However, when positive life changes were not considered, African Americans reported

significantly more negative life changes. In addition, such negative life changes are related to perceived health status and adjustment such as reported visit to a counselor, current physical and personal problems, and diagnosed illness as well as reported drug use (Gad & Johnson, 1980).

Furthermore, research has shown that African Americans report higher levels of racial discrimination compared to European Americans at every level of age, gender, education and income (Forman, Williams, & Jackson, 1997). Racism is an "added burden for nondominant populations" with negative psychological and physiological effects (Williams, 1999, p.173). Personal experiences with racism have been associated with higher levels of hopelessness and a poorer self-concept, which were fully mediated by trait anger, which suggests that when "examining the relationship between racism and psychological symptoms, the role of trait anger is central" (Nyborg & Curry, 2003, p.265). One possible explanation for these findings, suggested by the authors, is that those who have experienced more racism in their lives are more likely to develop trait anger because of these encounters (Nyborg & Curry, 2003).

Research has examined the relationship between emotions and the effects of social support resources (e.g., emotional and informational support). Emotional support is characterized as expressions of values for another's own worth and experiences and acceptance despite any difficulties or personal faults, and informational support is defined as helping an individual define, understand, and cope with problematic events (Cohen & Wills, 1985). Cohen and Wills (1985) suggest that emotional and informational support may be functional components most universally needed in response to a variety of stressful events. Emotional and informational support is thought to affect mental and

physical health through its influence on emotions, cognitions, and behaviors (Cohen, 1988). In the case of mental health, social support is thought to maintain regulation of these response systems (e.g., emotions) and prevent extreme responses associated with dysfunction (Cohen, 1988).

Relationships between forgiveness, anger, and the outcomes effects of emotional support (e.g., emotion regulation) continue to be examined (Worthington and Scherer, 2004). Emotional regulation is defined as "extrinsic and intrinsic processes responsible for monitoring, evaluating, and modifying emotional reactions …to accomplish one's goal" (Thompson, 1994, p.26- 27). Emotion regulation has also been defined as "the processes by which individuals influence which emotions they have, when they have them, and how they experience and express these emotions" (Gross, 1998, p.275). Emotion regulation also involves "changes in how response components are interrelated as the emotion unfolds, such as when large increases in physiological responding occur in the absence of overt behavior" (Gross, 1998, p.275).

Interventions with others provide the individual with an environment in which observational learning and conversation surrounding emotions and emotion regulation can occur, which aid in the development of acceptable emotional regulation strategies (Thompson, 1994). As developing individuals become more skilled at regulating arousal, emotion and its expression it can become "better integrated into the child's growing repertoire of strategic behavior" (Thompson, 1994, p. 26). Emotion regulation occurs by enhancing one's access to coping resources. In this sense "what is regulated is the availability of external support for managing emotional arousal" (Thompson, 1994, p. 36). Access to coping resources, as an aspect of emotional regulation, is enhanced by

seeking familiar and trusted social partners (Thompson, 1994). These interpersonal relationships are important not just because they have "mutual, long-term effects on the arousal and management of emotions" but also because of the "emotional dimensions of the relationship themselves", the "social expectations that they engender" and they influence the "interpretation of emotionally arousing situations and the coping resources that are available" (Thompson, 1994, p.42).

A focus on social support during adolescence is vital because it is a period marked by multiple developmental transitions which may contribute to difficulties with emotion regulation (Dahl, 2004). The ability to manage one's emotions through emotional regulation strategies is "central to the socialization process and its outcomes" (Thompson, 1994, p. 26). The lack of emotional regulation strategies have been linked to increased risk for non-suicidal self-injury and related to disordered eating (Adrian, Zeman, Erdley, Lisa & Sim, 2011; Sim & Zeman, 2006). Specifically, research by Hessler and Katz (2010) examined associations between emotional competence (i.e., awareness, regulation, and comfort with expression) and adolescent risky behavior. Children from a longitudinal study participated at age nine and again at age 16. Results suggested that children with poor emotional regulation had a higher likelihood of using hard drugs. In addition, difficulty regulating emotions was associated with having more sexual partners and greater behavioral adjustment problems.

A focus on forgiveness, anger, and emotional support within the African American, adolescent population is vital to explore due this population's disproportionate exposure to negative life events (Gassin, Enright, & Knutson, 2005) and the profound changes in every dimension of the adolescent individual including sexual maturity,

abstract thinking, and social relationships (Rew, 2007) which may increase the likelihood of having difficulty in regulation negative emotions, such as anger (Nyborg & Curry, 2003). In addition, this population's disproportionate exposure to negative life events and resulting anger is associated with many negative psychological and physiological health outcomes (Cooley-Quille et al., 2001; Gad & Johnson, 1980). According to Worthington and Scherer (2004) not only is forgiveness related to positive health outcomes, it mediates physiological processes in such a way as to support the conceptualization that forgiveness is an emotion-focused coping strategy.

Specifically, research by Jones, Peacock, and Christopher (1992) found that although African American adolescents may lack some of the skill needed for coping and expressing anger, they often report knowledge of acceptable expressions of anger such as "talking to someone, physical activity, and talking to the person who made them angry" (Jones et al., 1992, p. 463). Research by Gross and John (2003) found that individuals who utilize suppression, as an emotion regulation strategy, experience and express lesser positive emotion and experience greater negative emotion, and is associated with worse interpersonal functioning and related negatively to well-being. Specifically, research has shown that African American adolescents suppress the expression of angry feelings more often than European adolescents thus creating unhealthy psychological and physiological effects, which include psychological distress, low self-esteem, significantly elevated blood pressure, symptoms of distress (cardiovascular arousal, sleep disturbances), and increased weight (Johnson, 1989; Johnson & Greene, 1991). Although African American adolescents suppress the expression of angry feelings more than European American, they report the ability to recognize when they are angry and recognition is an early step in

the process of understanding and management but awareness and sharing of feelings may assist in the mastering control of this powerful emotion (Jones et al., 1992).

According to the National Adolescent Health Information Center (2003), the adolescent population is growing and is expected to keep increasing through 2050 and is more racially/ethnically diverse than the general population, which warrants a continual focus on this developmental period with an emphasis on the exploration of culture and contextual factors. More specifically, anger, emotion regulation strategies, and forgiveness are central topics to explore within the African American, adolescent population due to their potential physiological and psychological effects. An examination of each concept from a social, cultural perspective is vital in understanding the etiology, expression, and/or management in an attempt to create interventions that will equip this population with the awareness, knowledge, and skills that will provide opportunities for physiological and psychological health and general well-being. The purpose of this study is to evaluate the initial development and psychometric properties of three instruments, Level of Anger, Anger and Support, and Tendency to Forgive, with the African American, adolescent population. The Level of Anger Scale (LAS) was created to measure one's perceived level of anger (Appendix B). The Anger and Support Scale (AAS) was created to measure one's perceived level of support surrounding the emotion, anger (Appendix D). The Tendency to Forgive Scale (TTFS) was created to measure one's perceived general level of forgiveness (Appendix F).

Chapter II

Literature Review

Forgiveness

Forgiveness has been defined as overcoming negative thoughts, feelings, and behaviors directed at an offender and replacing them with positive thoughts and feelings (Enright & the Human Development Study Group, 1991) and the psychological and physiological benefits of the implementation of forgiveness has been displayed in different contexts and with various populations, confirming the generalizability of forgiveness interventions (Gassin et al., 2005; Waltman et al., 2009) A study by Worthington et al. (2010) performed a rigorous test for adaptation of the forgiveness psychoeducational intervention. For example, five pre-test/post-test interventions were conducted in the Philippines adapting a forgiveness model for both religion and culture. The researchers concluded that adaptation to both the culture and religious terminology was generally effective, suggesting robust application in practice with different contexts and populations. According to Gassin et al. (2005) forgiveness interventions have been implemented with such groups as survivors of sexual abuse (Freedman & Enright, 1996), college students in conflict with parents (Al-Mabuk, Enright, & Cardis, 1995), substance abusers (Lin, Mack, Enright, Krahn, & Baskin, 2004), mentally ill criminals (Chapman et al., 2001), terminal cancer patients (Hansen et al., 2009), and older adults (Ingersoll-Dayton, Campbell & Ha, 2009) and has demonstrated a decrease in negative psychological experiences and increase in positive psychological characteristics.

Research has found that forgiveness has an impact on psychological as well as physiological processes (Wilson et al., 2008). Research by Waltman et al. (2009)

assessed the effects of *forgiveness* therapy on *cardiac functioning*, *forgiveness* and related variables. Patients assigned to the *forgiveness* group showed significantly fewer mental stress-induced reduction in myocardial blood flow, from pre-test to the 10-week follow-up as well as significantly greater gains in *forgiveness* from pre-test to post-test and from pre-test to follow-up compared to the control group. Additionally, research by Seybold et al. (2001) examined correlated forgiveness scale scores with a variety of psychophysiological and other physiological factors. Results indicated that higher levels of forgiveness correlated with better health habits, lower hematocrit levels (indication of lower risk of most acute generalized infections and some local infections) and lower white blood cells counts. The authors concluded that the results supported the hypothesis that forgiveness is positively associated with indices of good health. Research by Carson et al. (2005) examined the relationship of forgiveness to pain, anger, and psychological distress. Results indicated that a relationship exist in patients with chronic low back pain. Furthermore, results suggest that patients who report an inability to forgive others might be experiencing higher pain and psychological distress that are mediated by relatively higher levels of state anger.

Also, forgiveness therapy has also been administered in conjunction with other approaches to therapy to evaluate its effectiveness on forgiveness and related psychosocial factors. Research by Luskin, Ginzburg, and Thoresen (2005) evaluated the efficacy of a combination of rational-emotive group therapy with emotional refocusing techniques in promoting forgiveness and related psychosocial factors. Participants in the intervention group showed significant improvement in their tendency to forgive, willingness to forgive, level of hurt, anger, perceived self-efficacy, hope, and spiritual

growth. The tendency to forgive, perceived self-efficacy, willingness to forgive and anger remained significant at follow-up. In addition, research by Gordon, Baucom, and Snyder (2004) examined the efficacy of an integrative treatment design to help couples recover from an extramarital affair and found that the majority of the couples were less emotionally and martially distressed and the injured partners reported greater forgiveness regarding the affair at the end of treatment. The integrative treatment intervention included strategies from forgiveness, cognitive-behavioral, and insight-orientated therapies.

Forgiveness and Anger

Research has found the effectiveness of forgiveness therapy in the reduction of anger. Enright and Fitzgibbons (2000) concluded that anger reduction was the key component of the beneficial impact of forgiveness on mental health. Furthermore, numerous research articles conclude that forgiveness therapy has been effective in the reduction of different aspects of anger (Hansen et al., 2009; Konstam, Chernoff, & Deveney, 2001). For example, Harris et al. (2006) evaluated the effects of a 6-week forgiveness intervention on health-related psychosocial variables, such as perceived stress and trait-anger. The researchers found a significant decrease in trait anger compared to the control group at post-test and follow-up. In addition, research by Barber, Maltby, and Macaskill (2005) found that forgiveness of others is negatively correlated with the angry after thoughts, which involve the person maintaining thoughts about and possibly re-enacting the angry episode in their mind, and angry memories, which involve the individual constantly dwelling on the injustices that they have experienced.

In addition to the reduction of aspects of anger, utilization of forgiveness interventions have simultaneously shown significant improvements in other psychological constructs, such as depression, total and trait anxiety, self-esteem, and *forgiveness. Research by Al-Mabuk and Downs (1996) presented a modified version of the forgiveness intervention to be utilized with parent survivors of adolescent suicide. Results indicated psychological gains including lower anger, anxiety, and guilt and increased self-esteem compared with control participants. In addition, research by* Lin and colleagues (2004) examined the outcome of forgiveness therapy among patients with substance dependence from a local residential treatment facility and found that participants who completed forgiveness therapy had significantly more improvement in total and trait anger, depression, total and trait anxiety, self-esteem, forgiveness, and vulnerability to drug use than did the alternative treatment group. Most benefits of forgiveness therapy, such as forgiveness, anxiety (and trait anxiety), depression, self-esteem, and vulnerability to drug, remained significant at 4-month follow-up. *Furthermore, numerous research articles highlight that most of the benefits of forgiveness therapy remain significant at follow-up* (Coyle & Enright, 1997; Reed & Enright, 2006).

Forgiveness and African Americans

Researchers have suggested that interventions to promote forgiveness should, when possible, be tailored to members of a particular group (Worthington, Sandage, & Berry, 2000). Research on the adaptability of forgiveness interventions suggests forgiveness interventions can be effective even with substantial cultural and religious adjustment (Worthington et al., 2010) and has shown to be effective with a variety of

clients (Gassin et al., 2005). Furthermore, culture and race appear to be important factors in forgiveness and culturally loaded issues, such as racial discrimination, must be addressed (Worthington et al., 2000).

One aspects of the African American experience that has been examined in literature includes historical racial and personal offenses and forgiveness. Ergüner-Tekinalp (2009) state that in a racially divided society, such as United States, the concepts of reconciliation and the offering and acceptance of forgiveness should be considered for overcoming the harmful effects of prolonged racial discrimination and offenses and may serve as a "balm for healing the wounds of both the oppressed and the oppressor" (p.2). Furthermore, research by Ergüner-Tekinalp (2009) found that individuals' own forgiveness of historical racial offenses was significantly positively correlated with perception of group forgiveness and use of religion. Because in the African American community, physical ailments, such as hypertension and heart disease, and psychological ailments, such as depression, have been attributed to anger due to chronic racism and discrimination (LaMar, 2010; Steffen, McNeily, Anderson, & Sherwood, 2003; Peters, 2006), any intervention that serves to reduce these emotions could impact favorably on the individual's psychological and physical well-being. Encouraging forgiveness, therefore, may be one way to improve the physical and psychological well-being of African Americans (LaMar, 2010).

Research has found that culturally competent care for African Americans requires sensitivity to spirituality as a component of the cultural context (Newlin, Knafl, Melkus, & D'Eramo, 2002). Spiritually is defined as an "acknowledgement of a non-material force that permeates all affairs, human and non-human" (Mattis & Jagers, 2001, p.522).

Spirituality has been shown to influence African American's understandings of forgiveness, justice, the meaning and purpose of life, and their responses to oppression (Mattis & Jagers, 2001). Furthermore, African Americans use spirituality as a coping resource when faced with health challenges and it has a significant positive impact on their health (Ferraro & Koch, 1994) and psychological outcomes (Allen & Marshall, 2010). Specifically, research by Watlington and Murphy (2006) examined spirituality as a correlate of posttraumatic stress symptoms and depression symptoms in African American survivors of domestic violence and found that higher levels of spirituality were associated with fewer depression symptoms and utilization of higher levels of religious coping strategies.

More specifically, there are several elements of the forgiveness process that are compatible to unique aspects of African American experience. Attributive dimension of African American spirituality include personal growth, liberation, hope and interpretation of experience (Newlin et al., 2002) which are integral aspects of the forgiveness process (Enright, 2001). The forgiveness process' focus on internal as well as external expressions of anger is important to highlight with this population. Research has found that many African Americans suppress their angry thoughts and feelings due to feeling powerless and the fear of potential loss of life sustaining opportunities (Willis, 1995) which is rooted in historical and contemporary discrimination and oppressive realities (Simons et al., 2006; Stevenson, 1997). The forgiveness process is designed to help one cope with anger that has some of these characteristics: anger that is caused by a real injustice, anger that causes one to engage in self-destructive behaviors, and anger that affects one's health and well-being (Enright, 2001). The first characteristic, anger is

caused by a real injustice, is critical to a culturally sensitivity response to the African American experience. Allowing an individual to express that a real injustice has occurred can be powerful and freeing to an individual. Oftentimes, the daily stressors and injustices experienced by African Americans have not been acknowledged by mainstream society (Dijk, 1992).

The next characteristic, anger that causes one to engage in self-destructive behavior, is also a critical component to the African American anger experience. Research has found that factors that contribute to the experience of anger among African Americans have led to self-destructive behaviors (Gibbs, 1998; Terrell, Miller, Foster, & Watkins, 2006). Anger that affects one's health and well-being is the final characteristics of the forgiveness process that is applicable to the African American anger experience. A considerable amount of research has confirmed the relationship between anger and health and overall well-being within the African American population (Alkhadher, 2004; Begley, 2006).

Forgiveness and adolescents

As children progress into early adolescence, they become capable of reasoning that considers social disapproval and approval for their responses to transgressions (Worthington, Jennings, & DiBlasio, 2010). Furthermore, during adolescence, children are thought to be capable of reasoning abstractly about forgiveness (Worthington et al., 2010). A study by Chiaramello et al. (2008) examined whether the constructs of forgivingness found in adults were already in place among adolescents. Results indicated that the same factor structure found among adults was also found among adolescents; indicating a presence of the construct of forgiveness among adolescents. Several research

studies have implemented the forgiveness intervention with this population, including participants that are racially, culturally, and religiously diverse.

For example, research by Park (2003) implemented a forgiveness curriculum in Korea with female adolescents who were victims of peer abuse and found that the intervention participants demonstrated less anger, delinquency, aggression, and hostile attributions than participants in two control groups. Furthermore, gains were maintained at a 6-week follow-up. Gambaro, Enright, Baskin, and Klatt (2008) conducted a study of forgiveness counseling with adolescents showing high trait anger. Results indicated that forgiveness counseling was more effective than the alternative treatment in reducing school conduct problems by promoting forgiveness, self-reliance, academic achievement, and positive attitudes toward teachers and parents; results held at 4-month follow-up.

Additionally, forgiveness research with adolescents has focused on the reduction of various other negative emotions, such as depression, aggression, revenge, and anxiety (Freedman & Knupp, 2003) and its utilization as a coping strategy (Flanagan, Vanden Hook, Ranter, & Reich, 2012). Research by Shechtman, Wade, and Khoury (2009) evaluated the effect of a *forgiveness* counseling *intervention* with Arab adolescents in an intergroup conflict in Israel. Results indicated that students in the *forgiveness intervention* condition reported more increased empathy and greater reductions in endorsement of aggression, revenge, avoidance, and hostility than students in the control condition; these trends continued after treatment was terminated. In Hong Kong, forgiveness has been introduced as a developmental guidance curriculum for adolescents (Hui & Ho, 2004). The results indicated that those who received the forgiveness programs showed a better

understanding of forgiveness, had a more positive attitude towards their offenders, and were more willing to apply forgiveness as a strategy in dealing with future offenses.

Forgiveness, African Americans, adolescents

Although the forgiveness process acknowledges the unique perspectives of the adolescent population (Enright, 2001) currently, there is limited research examining the relationship between forgiveness and anger with the African American, adolescent population. A deeper understanding of the relationship between forgiveness and anger is warranted due to this population's disproportionate exposure to violence, racism and poverty and its overall effect on their psychological and physiological well-being (Brown et al., 2000; Klonoff et al., 1999). Additionally, research surrounding forgiveness with African American adolescents' population is essential due to the potential lack of coping skills (Johnson, 1989) and tendency to suppress the expression of angry feelings, thus creating unhealthy psychological and physiological effects (Johnson & Greene, 1991).

Although limited research exists with this population, some strides are being made in the research community. A manual-based forgiveness intervention program by Gassin et al. (2005) was designed to help children in a central-city environment. This program is being implemented in the inner city of Milwaukee, one of the top 10 segregated cities in the United States (Population Studies Center, 2011) where "Black households have been confined to geographically isolated inner-city neighborhoods" and "relatively poor employment outcomes, among other factors" are prominent characteristics (Stoll, 2005, p. 1). This manual-based forgiveness intervention serves as "remediation for children already suffering from excessive anger and its consequences and as prevention for all children against the development of further psychological and

relational problems related to toxic levels of this emotion" (Gassin et al., 2005, p. 325). The goal is to have increasingly more complex ideas about forgiveness introduced over the years so that, at the end of high school, the students will have an opportunity to deeply understand the concept of forgiveness and to make informed choices about its relevance within their own lives.

Existing Forgiveness Measures

The Forgiving Personality Scale (FP) is a 33-item, self-report scale that assesses a respondent's general tendency to grant forgiveness across a variety of instances and relationships (Kamat, Jones, & Row, 2006). Higher scores on the FP indicate a higher tendency to forgive. The scale produced a reliability coefficient alpha of 0.93 and adequate validity with a majority Caucasian, college-aged population (Kamat et al., 2006).

Forgiveness Questionnaire (Mullet, Barros, Loredana Frongia, Neto, & Shafighi, 2003) is an 18-item, self-report questionnaire that assesses the respondents' willingness to forgive under various circumstances. A 17-point scale is provided for each item; the two extremes of the scale are labeled completely disagree to completely agree. Each participant's rating is converted to a numerical value expressing the distance (number of points, from 1 to 17) between the chosen point on the response scale and the left anchor, which served as the reference. The questionnaire has produced alpha coefficients for three subscales (enduring resentment, sensitivity to circumstances, and overall propensity to forgive) ranging from .75 to .82 with an adult population living in Italy and France (Mullet et al., 2003).

The Forgiveness of Others Scale (FOOS) is a 15-item, self-report trait scale that measures forgiveness of others as part of an inventory to sample personality disordered behaviors (Mauger et al., 1992). The items refer to taking revenge, justifying retaliation, holding grudges, and seeing others as the cause of one's hurt. The FOOS measures "deficits in forgiveness behavior" by having respondents give a True or False response to statements about their forgiveness behavior (p. 171). The scale has produced a reliability coefficient of .79 and has demonstrated adequate validity with outpatient counseling clients from Christian counseling centers (Mauger et al., 1992).

The Forgiveness Likelihood Scale is a 10–item, self-report scale designed to measure tendency to forgive across situations; the scale was developed as part of an earlier study involving college women who had been wronged in a romantic relationship (Rye, 1998). The scale asks respondents how likely they are to forgive in 15 scenarios described in one or two sentences (e.g., family member humiliates the respondent, a stranger breaks in and steals money, and a significant other betrays the respondent). Higher scores indicate a greater tendency to forgive. The scale has produced a reliability coefficient of .85 and demonstrated adequate validity with university students enrolled in an introductory psychology course; the majority of the participants were female and Caucasian (Rye et al., 2001).

The Heartland Forgiveness Scale (HFS) is an 18-item, self-report scale that measures a person's general tendency to be forgive (Thompson et al., 2005). The HFS consists of three, six-item subscales that measure forgiveness of self, forgiveness of others, and forgiveness of situations with higher scores indicating higher levels of forgiveness. The forgiveness subscale has produced coefficient alphas ranging from .72

to .75, the forgiveness of others subscale has produced coefficient alphas ranging from .78 to .81, and the forgiveness of situations subscale has produced coefficient alphas ranging from .77 to .82, and demonstrated adequate validity with university students at a large, public, Midwestern university (Thompson et al., 2005).

The Forgiveness Non-Retaliation Scale (FNR) is an 8-item, self-report scale that intends to measure traits thought to underline kin and reciprocal altruism, forgiveness/non-retaliation (Ashton, Paunonen, Helmes & Jackson, 1998). Higher scores on the FNR indicate a greater tendency to forgive and not seek retaliation. The FNR has produced a coefficient alpha coefficient of .75 and demonstrated adequate validity with undergraduate students in an introductory psychology course (Ashton et al., 1998).

The Disposition to Forgive Scale is a 10-item, self-report scale that measures one's disposition to forgive (McCullough, Emmons, & Tsang, 2002). Respondents indicate the extent to which they engage in 10 different responses when people anger of hurt them (e.g., I don't hold it against him/her for long or I will find a way to even the score). Higher scores indicate greater tendency to forgive. The scale has produced an alpha coefficient of .81 with a predominately Caucasian, female, adult population.

The Transgression Narrative Test of Forgivingness (TNTF) is a 5-item, self-report, scenario-based measure intended to assess the disposition to forgive transgressions across situations and over time (Berry, Worthington, Parrott, O'Connor, & Wade, 2001). Two items reflect intentional transgressions by acquaintances, two reflect negligent transgressions by friends, and one reflects an intentional transgression by a relative followed by an apology. Higher scores indicate a higher tendency to forgive. The TNTF has produced coefficient alphas ranging from .78 to .83 with a racially diverse

undergraduate student population at an urban, mid-Atlantic state university (Berry et al., 2001).

Several limitations with the utilization of existing forgiveness measures include: length, scenario-based, and lack minority and/or adolescent representation in sample populations. My Tendency to Forgive Scale (TTFS) is a measure that assesses one's perceived level of forgiveness, is self-explanatory, easy to use, time-conserving, and normed with an adolescent, minority population. In addition, the measure will be readily available at no cost as a means of providing a service for researchers and providers.

In summary, there has been a lot of recent research surrounding forgiveness and its promising physiological and psychological effects within various contexts, exhibiting its adaptability. Furthermore, it has been presented as one potentially compatible area to explore in an effort to improve the physical and psychological well-being of the African American community. In addition, many of these promising physiological and psychological effects have been found with various racially, culturally, and religiously diverse adolescent groups. However, there is still a need for additional research that directly focuses on forgiveness within the African American, adolescent population.

Anger

Anger is one of the most frequently experienced negative emotions (Averill, 1983). Anger has recently been defined as a syndrome of relatively specific feelings, cognitions, and physiological reactions that are linked with an urge to injure some target. According to these theorists, anger tends to be aroused when an individual is prevented from attaining an important goal or interfered with in the fulfillment of a need by an external agent's improper action (Berkowitz & Harmon-Jones, 2004). Furthermore, a

considerable amount of research has highlighted the relationship between anger and multiple health outcomes, such as behavior disorders, trait anxiety, cardiovascular disorders, and general health (Alkhadher, 2004; Begley, 2006; Chesney & Rosenman, 1985; Quartana & Burns, 2007).

Anger and Ethnicity

Research by Finney, Stoney, and Engebretson (2002) emphasized the importance of examining ethnicity in relation to anger, in an attempt to uncover vulnerable individuals. Research have shown that there are many factors that contribute to the experience of anger among African Americans; powerlessness, denied opportunities, and perceived racism, rooted in historical and contemporary discrimination and oppressive realities (Simons et al., 2006; Stevenson, 1997). Powerlessness has been defined as the inability to access valued resources, such as income, education, and employment status. Furthermore, the feeling of powerlessness creates barriers that limit, or even deny, the individual's capacity to implement solutions to problems, while simultaneously increasing an internal sense of helplessness, low self-efficacy, and physical and emotional distress. This suggests that powerlessness encompasses an external reality and an internal subjective experience (Thomas & Gonzalez-Prendes, 2009).

Research indicates that anger is the most frequently reported emotional reaction to experiences with everyday racism and discrimination (Swim, Hyers, Cohen, Fitzgerald, & Bylsma, 2003). There is some evidence that for African Americans anger is fueled on a daily basis and that African Americans are in a perpetual state of rage that is a manifestation of denied educational and employment opportunities, racism, and desperation of the African American life. The rage is customarily suppressed to prevent

loss of control and loss of career advancement (Willis, 1995). Research by Brondolo and colleagues (2005) highlight the connection between experiences of discrimination and anger. They found that discriminatory interactions increase the likelihood that individuals will use reactive or immediate anger management styles. However, workplace discrimination was found to increase the likelihood of using an anger-suppression style, a style that has been associated with experiencing and expressing less positive emotion, experiencing greater negative emotion, worse interpersonal functioning and well-being (Gross & John, 2003). For example, research by Magai, Kerns, Gillespie and Huang (2003) examined ethnic differences in the link between anger experience and anger inhibition and that of circulatory disease (CD). Experienced anger and anger inhibition were significant predictors of CD only for the African American group and the relation between experienced anger and CD was mediated by anger inhibition. The authors concluded that cultural factors play a role in the development of an anger-inhibitory style and that this trait may pose a serious risk factor for circulatory disease.

Effects of contributing factors

A considerable amount of research has investigated the various negative effects of racism, discrimination, and overall stressors of life, which contribute to the experience of anger among African Americans (Brown et al., 2000; Thomas & Gonzalez-Prendes, 2009). Research by Landrine and Klonoff (1996) found that *racial discrimination is rampant in the lives of African Americans and is strongly related to negative physical and psychological consequences*. Perceived racial or ethnic discrimination is one aspect of racism and a class of stressors that could have consequences for health and for understanding disparities in health (Mays, Cochran, & Barnes, 2007; Williams &

Mohammed, 2009). In addition, Williams (1999) argues that exposure to racism and discrimination directly adversely affect health in multiple ways, such as residence in poor neighborhoods, racial bias in medical care, the stress of experiences of discrimination and the acceptance of the societal stigma of inferiority, which can have deleterious consequences for health.

An examination of the psychological outcomes of racial discrimination is vital because mental health is a component of overall health and addressing health issues requires a critical examination of factors that influence mental health (Watkins, Green, Rivers, & Rowell, 2006). Research by Schulz and colleagues (2006) conducted a longitudinal study that examined the relationship between everyday discrimination, depressive symptoms and self-rated general health among African American women. They found that a change over time in discrimination was significantly associated with a change over time in depressive symptoms (positive) and self-rated general health (negative) independent of age, education, or income. The researchers conclude that everyday encounters with discrimination are causally associated with poor mental and physical health outcomes; this association holds above and beyond the effects of income and education. A review of the literature by Watkins et al. (2006) state that literature suggests that racism/discrimination is a major factor that contributes to depression and depressive symptoms in African American men. Furthermore, data from the Summary Health Statistics for U.S. Adults, revealed that African Americans reported higher frequency of experiencing sadness, restlessness, and the notion that "everything is an effort," when compared with other racial counterparts (Pleis & Lethbridge-Cejku, 2007).

Furthermore, physiological responses to perceptions of racism may, over time, may be related to numerous health outcomes. Intergroup racism may play a role in the high rates of morbidity and mortality in this population (Clark, Anderson, Clark, & Williams, 1999; Giscombe´ & Lobel, 2005). Physiological responses following exposure to psychologically stressful stimuli most notably involve immune, neuroendocrine, and cardiovascular functioning (Cacioppo, 1994; Cohen & Herbert, 1996; Herd, 1991, as cited in Clark et al., 1999). Additionally, research by Williams, Yu, Jackson, and Anderson (1997) found that racial or ethnic discrimination over the lifetime predicted well-being, number of bed days, and chronic conditions for African Americans. Research by Steffen and colleagues (2003) examined whether perceived racism was associated with higher ambulatory blood pressure measured during daily life. Results indicate that perceived racism is related to higher ambulatory blood pressure, which may contribute to the incidence of hypertension and hypertensive-related diseases observed in African Americans.

In relation to health disparities, for most of the 15 leading causes of death including heart disease, cancer, stroke, diabetes, kidney disease, hypertension, liver cirrhosis and homicide, African Americans have higher death rates than European Americans (Kung, Hoyert, Xu, & Murphy, 2008). Poverty alone cannot fully explain these differences; even when socioeconomic status (SES) is controlled for, there is still an excess of 38,000 deaths per year or 1.1 million years of life lost among African Americans in the United States (Franks, Muennig, Lubetkin, Jia, 2006). In addition, there are residual racial differences in health at every level of SES for multiple indicators of health status, including self-rated health, heart disease mortality, hypertension and

obesity (Pamuk et al. 1998, as cited in Williams & Mohammed, 2009). Research by Vines et al., (2007) highlight that an excess in abdominal fat, that may predispose African American women to chronic health conditions such as diabetes and cardiovascular disease, is associated with daily stress. A study by Pleis and Lethbridge-Cejku (2007) reported significant disparities between African Americans and other racial counterparts, related in terms of their overall health. Their study indicated that African Americans have higher incidents of hypertension, diabetes, and obesity when compared to European Americans and Hispanic Americans.

Anger and adolescents

Anger is a dominant issue during adolescence, most likely because of the dramatic physical, psychological, and social changes that characterize this phase of development (Wilde, 1996). Blanchard-Fields and Coates (2008) found that adolescents reported they experience more anger than adults, in the context of everyday problems. A meta-analysis by Mahon, Yarcheski, Yarcheski, and Hanks (2010) identified several predictors of anger in adolescents and determined the magnitude of the relationship between each **predictor** and **anger.** Among the twelve prominent identified **predictors** for **anger**, several **predictors** such as exposure to violence, anxiety, and depression had the highest average effect sizes, moderate to substantial average effect sizes. The authors conclude that the identification of the most powerful predictors of anger during adolescence adds to the understanding of factors that play a significant role in adolescent anger.

In relation to prominent predictors of anger, according to the National Survey of Children's Exposure to Violence (2009) more than 60 percent of children from birth to 17

years of age in the United States were either directly or indirectly victimized within a one-year period. Specifically, about 36% of youth were exposed to an assault with no weapon or injury, 10% experienced child maltreatment, about 15 % witnessed an assault with a weapon and/or an injury, and 6% experienced direct sexual victimization. In addition, research by Merikangas et al. (2010), a nationally representative face-to-face survey of 10,123 adolescents aged 13 to 18 years in the United States, examined the lifetime prevalence rates of DSM-IV mental disorders. They found that nearly one in three adolescents (31.9%) met criteria for an anxiety disorder and that mood disorders affected 14.3% of the total sample, corresponding to 11.7% who met criteria for Major Depressive Disorder or dysthymia.

The topic of anger within the adolescent population is important due to its negative psychological and physiological effects. Anger has harmful effects on general well-being and manifest psychosomatically through the expression of various symptoms, such as headaches, loss of appetite, upset stomach, difficulty getting up in the morning, and complaints of pains and ailments (Mahon, Yarcheski, & Yarcheski, 2000). Additionally, anger has been found to be associated with high-risk behaviors such as drug and alcohol usage and an increased likelihood of suicide attempts (Daniel et al., 2009; Nichols, Mahadeo, Bryant, & Botvin, 2008). Furthermore, research by Hessler and Katz (2010) examined associations between emotional competence and adolescent risky behavior. In addition, these associations were examined for the emotion of anger concurrently during adolescence, and longitudinally from middle childhood to adolescence. Results suggested that children with poor emotional awareness and

regulation had a higher likelihood of using hard drugs and pointed to anger as an important emotion.

Anger and African American adolescents

More specifically, the topic of anger within the African American adolescent population is important due to their disproportionate exposure to racial discrimination, violence, and poverty (Williams et al., 2003), which are associated with predictors of anger among adolescents (Mahon et al., 2010). In particular, African American adolescents may be most vulnerable to the distressing effects of racial discrimination because this is a time when they begin to "solidify their identity and establish a place for themselves within society" (Caldwell, Kohn-Wood, Schmeelk-Cone, Chavous, & Zimmerman, 2004, p. 92). Research by Greene, Way and Pahl (2006) examined results from a 3-year longitudinal study of the growth patterns and correlates of perceived discrimination by adults and by peers among a racially diverse group of adolescents. They found that African American adolescents reported the steepest increase over time in levels of perceived discrimination by peers and by adults.

Numerous research articles have highlighted the negative effects of exposure to racial discrimination among African American adolescents such as components of psychological well-being and substance use. Research by Seaton, Caldwell, Sellers and Jackson (2010) examined the association between perceived discrimination and psychological well-being indicators (depressive symptoms, self-esteem, and life satisfaction) in a nationally representative sample of African American youth. The results indicated that perceived discrimination was linked to increased depressive symptoms and decreased self-esteem and life satisfaction. Research by Wong, Eccles, and Sameroff

(2003) found that experiences of racial discrimination at school from one's teachers and peers predicted declines in grades, academic ability self-concepts, academic task values, mental health (increases in depression and anger, decreases in self-esteem and psychological resiliency), and increases in the proportion of one's friends who are not interested in school and who have problem behaviors.

Furthermore, research by Gibbons et al. (2012) found that experience with discrimination was associated with reduced self-control, which then predicted increased substance use among African American adolescents. The researchers state this reduced self-control may leave these adolescents with less capability of monitoring and/or inhibiting their anger. Further analyses indicated anger as a mediator of this discrimination to use relation; in other words, more anger and reduced self- control led to increased substance use and/or substance cognitions (even for those who were not regular users). The authors state the results indicate a reduction in the ability to resist the urge to use substances and an increased interest in using substances to mute the anger.

According to Nyborg and Curry (2003) exposure to racial discrimination increases the probability that African American adolescents will engage in delinquent and risky behaviors, especially acts of violence and increase in drinking behavior and be at risk for negative psychological effects (Nyborg & Curry, 2003). Furthermore, research by Terrell et al. (2006) explored whether a relationship exists between anger among African American adolescents that has been provoked by racial discrimination and alcohol consumption. The results indicated that racial discrimination anger scores were found to be predictive of the amount of alcohol consumed by the participants. In addition, research by Guthrie, Young, Williams, Boyd, and Kintner (2002) examined the

relationship between racial discrimination and a specific health risk, cigarette smoking. They found that experiencing discrimination and racial discrimination was highly correlated with cigarette smoking among adolescent girls. Furthermore, removing the effects of stress significantly reduced the relationship between racial discrimination and smoking, indicating that racial discrimination is related to smoking because of its stressful nature. These results highlights previous research indicating that perceived racial or ethnic discrimination as one aspect of racism and a class of stressors that could have consequences for health and for understanding disparities in health (Mays et al., 2007; Williams & Mohammed, 2009).

Existing Anger Measures

State-Trait Anger Expression Inventory-2 Child and Adolescent (STAXI-2 C/A) is a 35-item self-report measure based on the adult version of the instrument, the STAXI-2, that measures state and trait anger along with anger expression and control in ages 9-18 years (Brunner & Spielberger, 2009). The STAXI-2 C/A contains 5 subscales: trait anger, state trait anger, anger expression-in (AX-I), anger expression-out (AX-O), and anger-control (AC) with coefficient alphas of .94, .88, .84, .74, and .89, respectively. Higher scores on the trait-anger suggest frequent experience of angry feelings; high state-anger scores suggest experience of relatively intense angry feelings at time of testing; high AX-I scores suggest a tendency to suppress intense angry feelings; anger AX-O scores suggest tendency to express angry feelings via aggressive behavior; and high AC scores suggest expending a great deal of energy on calming down and reducing anger as soon as possible (Brunner & Spielberger, 2009).

The Adolescent Anger Rating Scale (AARS) is a 16-item self-report questionnaire designed to measure distinct types of anger (Burney & Kromrey, 2001). In the AARS, there are three subscales: instrumental anger, reactive anger, and anger control. Instrumental anger subscale is characterized by anger patterns that are planned over a period of time. Higher scores are reflective of one's predisposition to respond in intensive violent and malicious attacks on people, places, or objects. Reactive anger is defined as overt anger, or an immediate angry response displayed in response to a perceived negative, threatening, or fear-provoking event. Higher scores indicate one's predisposition to respond to anger-provoking situations with more frequent and intense anger outbursts. The anger control subscale is characterized by proactive behavior to resolve emotional reactions and impulsive behaviors when confronted with anger-provoking situations. Higher scores are reflective of control over one's anger responses. Factorial and construct validity of the AARS have been demonstrated with a normative sample of 4187 males and females, 11 to 19 years old and representing a diverse group of racial and ethnic backgrounds. Coefficient alphas were .83, .70, and .80, respectively, for Instrumental, Reactive, and Anger Control and demonstrated adequate validity (Burney & Kromrey, 2001).

The Novaco Anger Scale and Provocation Inventory (NAS-PI) is a 60-item self-report measures that assesses how particular individuals experience anger (Novaco, 2003). The NAS includes 48 items that measure three domains of anger: cognitive, arousal and behavioral. The sum of the 48 items contained in these subscales comprises the NAS Total score for anger disposition. The NAS has demonstrated good internal reliability and test–retest reliability (Novaco 2003). The Provocation Inventory (PI) is an

anger reaction inventory that was developed to accompany the NAS. It provides an index of anger intensity and generality across a range of potentially provocative situations. The PI has been independently validated and has good psychometric properties (Novaco, 2003). It has demonstrated adequate internal consistency reliability with various ethnic groups (Culhane & Morera, 2010).

The Anger Regulation and Expression Scale (ARES) is a 75-item, self-report measure that assesses tendencies towards inward and outward expressions of anger, along with the range and duration of anger experiences (DiGiuseppe & Tafrate, 2011). It contains three scales which include internalizing, externalizing, and extent of anger. The ARES has been designed specifically for children and adolescents aged 10 to 17 years. The ARES yields scores that assess aspects of anger that contributes to poor functioning and maladjustment. Higher scores on the internalizing subscale indicates that youth feels anger regardless of whether they express it externally; high scores on the externalizing subscale indicates that the youth is expressing anger externally; and higher scores on the extent subscale indicates that anger reactions are potentially persistent and wide spread. ARES has produced alphas that range from .97-.99, .95-.97, .96-.97, .87-.94, respectively for total score, internalizing, externalizing, and extent clusters (DiGiuseppe & Tafrate, 2011).

Several limitations with utilization of existing anger scales include: length, cost, and availability. My Level of Anger Scale (LAS) is measure that assesses the experience and expression of angry feelings over an identified amount of time (providing respondents with a guiding frame of reference), is self-explanatory, easy to use, time-conserving, which is an ideal research instrument for use when subject time is limited or multiple

measures are being administered. In addition, the LAS is normed with the adolescent population and will be readily available at no cost as a means of providing a service for researchers and providers.

Based on review of the anger literature, a continual focus on etiology, contributing factors, and expression of anger within the African American population is vital. Anger has been identified as one of the most frequently experienced negative emotions (Averill, 1983), a contributing feature to psychological distress (Landrine & Klonoff, 1996), and negative physiological responses (Pleis & Lethbridge-Cejku, 2007). Furthermore, examining ethnicity in relation to anger, in an attempt to uncover vulnerable individuals, is vital to understanding this emotion in relation to broader contextual factors (Finney et al., 2002). Specifically, research has identified factors that contribute to the experience of anger among African Americans such as powerlessness, denied opportunities, and perceived racism, rooted in historical and contemporary discrimination and oppressive realities (Simons et al., 2006; Stevenson, 1997). In addition, anger is a dominant issue during adolescence, most likely because of the dramatic physical, psychological, and social changes that characterize this phase of development (Wilde, 1996). More specifically, the topic of anger within the African American adolescent population is important due to their disproportionate exposure to racial discrimination, violence, and poverty (Williams et al., 2003), which are associated with predictors of anger among adolescents (Mahon et al., 2010) and various negative physiological and psychological outcomes (Gibbons et al., 2012; Terrell et al., 2006).

Emotions in the Context of Social Support

Emotional support is characterized as expressions of values for another's own worth and experiences and acceptance despite any difficulties or personal faults, and informational support is defined as helping an individual define, understand, and cope with problematic events (Cohen & Wills, 1985). Cohen and Wills (1985) suggest that emotional and informational support may be functional components most universally needed in response to a variety of stressful events. Emotional and informational support is thought to affect mental and physical health through its influence on emotions, cognitions, and behaviors (Cohen, 1988). In the case of mental health, social support is thought to maintain regulation of these response systems (e.g., emotions) and prevent extreme responses associated with dysfunction (Cohen, 1988).

Emotional regulation is defined as "extrinsic and intrinsic processes responsible for monitoring, evaluating, and modifying emotional reactions …to accomplish one's goal" (Thompson, 1994, p.26- 27). Emotion regulation has also been defined as "the processes by which individuals influence which emotions they have, when they have them, and how they experience and express these emotions" (Gross, 1998, p.275). Inherent in the definition of emotion regulation are aspects of emotional regulation strategies "because a considerable amount of emotional regulation occurs through the interventions of others" (Thompson, 1994, p. 26). Interventions ranging from "selective reinforcement and modeling of expressions of emotion to emotion-focused discourse, channel emotional behavior in directions that meet the expectations of the culture" (Thompson, 1994, p.26). The ability to manage one's emotions, through emotional regulation strategies, is "central to the socialization process and its outcomes"

(Thompson, 1994, p. 26). These interpersonal relationships are important not just because they have "mutual, long-term effects on the arousal and management of emotions" but also because of the "emotional dimensions of the relationship themselves", the "social expectations that they engender", and they influence the "interpretation of emotionally arousing situations and the coping resources that are available" (Thompson, 1994, p.42).

An essential objective in the development of emotion regulation is for children and adolescents to learn ways in which to manage emotions in socially and contextually appropriate ways (Thompson, 1994). A review of the literature by Morris, Silk, Steinberg, Myers, Robinson (2007) examined associations between components of the family context and children and adolescents' emotion regulation. They authors argue that children and adolescents learn about emotion regulation through observational learning, modeling and social referencing. The modeling hypothesis suggests that "parents' own emotional profiles and interactions implicitly teach children which emotions are acceptable and expected in the family environment, and how to manage the experience of those emotions" (p. 363).

Furthermore, children and adolescents learn that certain situations provoke emotions, and they observe the reactions of others in order to know how they should react in similar situations (Denham, Mitchell-Copeland, Strandberg, Auerbach & Blair, 1997). Some parent–child emotional interactions are likely to be particularly salient. For example, when parents often display high levels of anger toward children in frustrating situations, children are less likely to observe and learn effective emotion responses. In addition, parents' overall expressivity may affect children and adolescent's modeling of emotion regulation; if parents display a wide range of emotions freely, children learn

about the appropriateness of different emotions across different situations, as well as about a variety of emotional responses (Denham et al., 1997).

Research has examined the association between emotion regulation and numerous outcome variables. Deficits in general emotion-regulation abilities are thought to increase negative affect, decrease positive affect, and reduce emotion-related self-efficacy, thus prompting dysfunctional behavior as a means of avoiding negative emotions (Berking et al., 2008). More specifically, the role of emotion regulation in development has linked difficulty in regulating negative emotions such as anger and sadness to emotional and behavioral problems (Eisenberg et al., 2001; Silk, Steinberg, and Morris, 2003). In addition, lack of emotion regulation has been linked to eating disorders among the female population, generalized anxiety disorder, and post traumatic stress symptom severity (Harrison, Sullivan, Tchanturia, & Treasure, 2010; Salters-Pedneault, Roemer, Tull, Rucker, & Mennin, 2006; Tull, Barrett, McMillan, Roemer, 2007).

For example, research by Berking et al. (2011) investigated whether emotion-regulation skills were associated with alcohol dependence and whether these skills predicted alcohol use during and after treatment for alcohol dependence. Researchers found that pretreatment emotion-regulation skills predicted alcohol use during treatment, and posttreatment emotion-regulation skills predicted alcohol use at follow-up, even when controlling for other predictors potentially related to emotion regulation. Furthermore, individuals in the alcohol dependence sample reported significantly larger deficits in emotion-regulation skills than did those in a control sample. The authors concluded that the enhancement of general emotion-regulation skills, especially the

ability to tolerate negative emotions, appears to be an important target in the treatment of alcohol dependence.

Theories on emotion regulation have been synthesized and expanded to produce skill-based models of emotion regulation (Berking, 2010, as cited in Berking et al., 2011). Empirical studies have shown that all skills included in the adaptive coping with emotions (ACE) model are significantly associated with various indicators of mental health in various populations such as emotional adjustment (Berking, Orth, Wupperman, Meier, & Caspar, 2008). According to the ACE model:

> effective emotion regulation can be conceptualized as the situation-adapted interplay of the abilities to (a) be aware of emotions, (b) identify and label emotions, (c) correctly interpret emotion-related body sensations, (d) understand the prompts of emotions, (e) actively modify negative emotions to feel better, (f) accept negative emotions when necessary, (g) tolerate negative emotions when they cannot be changed, (h) confront distressing situations in order to attain important goals, and (i) compassionately support oneself in emotionally distressing situations, in order to counterbalance potential short-term negative effects that engagement in the other skills may have on one's emotions (p. 308).

In addition, researchers have examined the role of emotion regulation skills as a target and addition to treatment within existing psychotherapy interventions (Berking et al., 2008; Mikolajczak, Petrides and Hurry, 2009). Research by Berking et al., (2008) found that specific aspects of emotion regulation as particularly important for current mental health and treatment outcomes. They concluded that the incorporation of interventions that directly target general emotion-regulation skills may improve the

effectiveness of psychotherapeutic interventions. Specifically, among the adolescent population, research by Mikolajczak and colleagues (2009) emphasized the potential value of incorporating emotion regulation skills into existing psychotherapeutic interventions, such as treatment of adolescent self-harm patients.

Emotional regulation and adolescents

During adolescents, an understanding of how other important contextual factors such as peers, culture and neighborhood affect emotion regulation is important because of the prominence of the additional social context in adolescents' lives (Silk et al., 2003). Adolescents often look toward peers in order to gain information about how to respond to social and emotional situations, social referencing (Silk et al., 2003). In addition, adolescents develop a "sense of self that includes notions about their emotional and interpersonal style, as well as their preferred methods of emotion regulation" (Gross & Munoz, 1995, p.154). Among adolescents, lack of emotion regulation skills has been linked to various negative outcomes such as increased risk for non-suicidal self-injury among girls, deliberate self-harm and depressive symptoms, and problem behavior (Adrian et al., 2011; Silk et al., 2003). In addition, research by Sim and Zeman (2006) found that increased levels of negative affect, greater difficulties with emotional awareness, and more difficulty coping constructively with negative emotion were reported by adolescent females with higher levels of disordered eating.

An adolescent's perceived capacity to control emotional arousal and to adaptively cope with anger reflects an important aspect of emotion regulation (Zeman, Shipman, & Suveg, 2002). Research by Shortt, Stoolmiller, Smith-Shine, Eddy, and Sheeber (2010) found that mothers' emotion coaching of anger was related to better anger regulation,

which was, in turn related to less externalizing behavior. Furthermore, research by Houltberg, Henry, and Morris (2012) found that *perceptions of family cohesion and adaptability were indirectly associated with anger regulation through a positive association with parental support.*

Emotional regulation and African Americans

More specifically, the topic of emotion regulation within the African American population is important due to this population's disproportionate exposure to violence, poverty, and racism (Williams, Neighbors, & Jackson, 2003) which has been associated with various negative emotions and emotion dysregulation (Schulz et al., 2006; Steffen et al., 2003). For example, research by Schwartz and Proctor (2000) suggest that violence exposure is linked to multiple levels of behavioral and social maladjustment. In particular, they found that violent victimization was associated with negative social outcomes through the mediation of emotion dysregulation. In addition, research by Peters (2006) found that the experience of racism contributes to the development of negative psychological outcomes and individual who possess lesser skills in emotional regulation experience greater levels of chronic stress emotions (Peters, 2006). For example, research by Scott and House (2005) found that among African American youth, greater self-reports of distress, in relation to discriminatory experiences, were related to greater use of internalizing and externalizing coping strategies and greater self-reports of perceived control over discriminatory experiences were related to greater use of seeking social support and problem-solving coping strategies. This research highlights the importance of support and the acquisition of emotion regulation strategies in an attempt to promote successful coping with perceived racial discrimination. Furthermore, research by Gross

and John (2003) found that minority status, such as African Americans, is associated with greater use of suppression to regulate emotion, which is associated with experiencing and expressing lesser positive emotion and experiencing greater negative emotion, worse interpersonal functioning and related negatively to well-being.

Existing Measures of Emotions in the Context of Social Support

Communication-Based Emotional Support Scale (CBESS) is a 13-item self-report measures that assess the communication of emotional support in romantic relationships (Weber & Patterson, 1996). Higher scores on the CBESS indicate positive perceptions of relational solidarity and quality. The CSESS has demonstrated high reliability (.93) and evidence of internal, face, and convergent validity. The sample consisted of university undergraduate students and "no data exists concerning the racial composition of the subjects, the sample is over representative of Caucasians" (Weber & Patterson, 1996, p.71).

The Inventory of Socially Supportive Behaviors Scale (ISSB) is a 40-item scale that assesses what individuals actually do by way of providing support (Barrera, Sandler, & Ramsey, 1981). Respondents report the frequency with which they were the recipients of supportive actions such as tangible forms of assistance such as the provision of good and services as well as well as intangible forms such as guidance and expressions of esteem. The ISSB has demonstrated adequate internal consistency reliability of .93 and .94 among undergraduate psychology students (Barrera et al., 1981).

The Multidimensional Scale of Perceived Social Support Scale (MSPSS) is a 12-items scale that assesses ones perceived levels of social support (Zimet, Dahlem, Zimet & Farley, 1988). The scale also includes questions about perceived emotional support. The

items divide into factor groups relating to the source of the social support, namely family, friends, or significant other. Higher scores indicate higher level of perceived social support. The MSPSS has demonstrated good internal consistent, coefficient alpha of .88, and moderate construct validity with university undergraduates enrolled in an introductory psychology course (Zimet et al., 1988). It has demonstrated strong psychometric properties with diverse populations such as: university students at an urban college (Dahlem, Zimet, & Walker, 1991), urban, African-American adolescents (Canty-Mitchell & Zimet, 2000), pregnant women, adolescents living in Europe with their families, and pediatric residents (Zimet, Powell, Farley, Werkman, & Berkoff, 1990).

The Perceived Emotional Personal Support *Scale* (PEPSS) is a self-report measure that assesses perceived emotional support among adolescents (Slavin, 1991). Participants are instructed to list three important people in each of three relationship categories: family members, non-family adults, and friends/coworkers. Respondents then indicate the type of relationship, gender, and first initial of each person listed. Using a four-point Likert scale, ranging from “hardly at all” to “very much,” respondents answered questions about each person in the areas of personal concern, emotional closeness, concerns of supportive person, and satisfaction with support. The PEPSS has produced reliability coefficients of .83, .89, and .91 for family, adult, and friend subscales, respectively and demonstrated adequate validity with racially diverse high school students from working, upper, and middle class families (Slavin, 1991).

The Perceived Emotional Support Scale (PES) is a 16-item self-report questionnaire that assesses the perception of receiving encouragement, compassion, and other forms of emotional support from close others. This scale was originally developed

by Sarason, Shearin, Pierce, and Sarason (1987) and subsequently modified by Hisada, Senda, and Minoguchi (1989). Participants are asked to think about a close person in their lives and then indicate the extent to which they perceive emotional support on a scale from 1 (definitely no) to 5 (definitely yes). In a study with 64 European American, Filipino, and Japanese college students coefficient alphas of .91, .92, and .91 were produced for Americans, Filipinos, and Japanese, respectively (Uchida, Kitayama, Mesquita, Reyes, & Morling, 2008).

Some of the limitations with the utilization of existing social support scales include: assessment of emotional and informational support for emotions in general, assessment of other types of support (e.g., instrumental and diffuse) which limit its usability due to these other forms of support lacking the ability to be responsive to a wide range of stressful events (Cohen & Wills, 1985), specification of the type of relationship (e.g., romantic), and not being normed with the adolescent population or more specifically the African American, adolescent population. My scale, Anger and Support Scale (AAS) is a measure specifically tailored to the assessment of anger, includes types of support that are likely to be responsive to a wide range of stressful events (Cohen & Wills, 1985) such as emotional and informational support, does not specify the type of relationship (which will not limit its use) and is normed with an the African-American, adolescent population. Also, the AAS is self-explanatory, easy to use, will be readily available at no cost, and time-conserving which is an ideal research instrument for use when subject time is limited or multiple measures are being administered.

A continual focus on emotion regulation (though social support) is important because acquiring the skills necessary for successful emotional regulation “constitutes a

profound developmental achievement" (Gross & Munoz, 1995, p.154). Based on the review of the emotion regulation literature, it is clear that emotional regulation is influenced by one's context (Gross & John, 2003) and has a significant impact on psychological and physiological functioning (Berking et al., 2011; Harrison et al., 2010; Silk et al., 2003). Among the adolescent population, emotion regulation is acquired and honed through interactions within interpersonal relationships (Thompson, 1994) and is essential to adaptively cope with anger (Shortt et al., 2010; Zeman et al., 2002). The continual exploration of emotion regulation acquisition, through interpersonal relationships, is essential to the experience and expressing of emotions, interpersonal functioning and overall well-being of the African American adolescent population (Gross & John, 2003).

Moreover, a considerable amount of research has found a relationship between forgiveness and the emotion of anger (Hansen et al., 2009; Seybold et al., 2001) and anger and emotional support (Houltberg et al., 2012; Shortt et al., 2010). In addition, research highlights the association between forgiveness, anger, and emotion regulation and other psychological construction, such as depression (Freedman & Enright, 1996; Gross & Munoz, 1995; Reed & Enright, 2006). My hypotheses include: (1) LAS will have a positive, moderately strong correlation with The Anger Expression Scale for Children (AESC-M); (2) AAS will have a positive, moderately strong correlation with anger control subscale within the AESC-C; (3) the TTFS will have a positive, moderately strong correlation with the Tendency to Forgive Scale (TFS); (4) a moderate correlation will exist amongst the LAS, AAS, and TTFS ; (5) the LAS, AAS, and TTFS will have a somewhat (i.e., a small) correlation with the Center for Epidemiological Studies

Depression Scale (CES-D); and (6) no differences in total scores on the LAS, AAS, and TTFS will be found for gender, age, grade, neighborhood, and income.

Chapter III

Methods

Participants

The participants were recruited from three Milwaukee-area high schools, 9th-12th grades. Each school participates in the Parent Choice Program, which allows students who reside in the city of Milwaukee to attend a private school. The main author met with each school administrator to explain the purpose and methods of the study. Student participants were volunteers recruited through in-class announcements provided by classroom teachers. Students were provided with a Parental Consent Form (Appendix G) by classroom teachers and instructed to take it home and obtain signatures and return the form if parents failed to consent. No incentives, monetary or otherwise, were offered to the participants.

Study #1. This sample consisted of 90 African American high school students selected by the school administrators from the larger school population. Of these participants, 50% were male and 65% resided in the inner-city. The mean age of participants was 16.08 with a standard deviation of 1.15. Table 1 provides additional demographic information of this sample. This sample was used in preliminary item analysis.

Study #2. This sample, those remaining after the study #1 sample was chosen, consisted of 220 African American high school students. Of these participants, 49% were male and 69% resided in the inner-city. The mean age of participants was 15.74 with a standard deviation of 1.14. Table 1 provides additional demographic information of this sample. This sample was used in tests of reliability and validity.

Procedure

Study #1. On the day of study #1, students were provided with a print copy and read the Parental Consent Form by the main author. Students were given the opportunity to ask questions and assent before instructed to complete the questionnaires. The questionnaires were completed during non-instructional class periods, study hall or silent reading periods. If students failed to assent they remained in the same room and worked on other coursework. Participants responded to the questionnaires using a Scantron form. Participants were given an identification number to keep their identity confidential. During study #1, participants completed the following self-report questionnaires, designed for this study (Appendix H): Demographic Questionnaire, Level of Anger Scale (LAS), Anger and Support Scale (AAS), Tendency to Forgive Scale (TTFS).

The LAS contained 18-items and was designed to measure a participant's perceived level of anger (Appendix A). The AAS contained 12-items and was designed to measure a participant's perceived level of support surrounding emotion expression (Appendix C). The TTFS contained 18-items and was designed to measure a participant's perceived level of forgiveness (Appendix E). Each scale was developed after examining relevant literature in the area.

Study #2. On the day of study #2, approximately two weeks after study #1, students were provided with a print copy and read the Parental Consent Form by the main author. Students were given the opportunity to ask questions and assent before instructed to complete the questionnaires. The questionnaires were completed during non-instructional class periods, study hall or silent reading periods. If students failed to assent they remained in the same room and worked on other coursework. Participants responded

to the questionnaires using a Scantron form. Participants were given an identification number to keep their identity confidential. During study #2, student completed the following self-report questionnaires (Appendix I): the modified LAS, AAS, and TTFS, Demographic Questionnaire, The Anger Expression Scale for Children (AESC), Trait Forgiveness Scale (TFS), and Center for Epidemiological Studies Depression Scale.

Measures

Demographic Questionnaire. The demographic questionnaire for this study was developed to assess variables that may contribute to identifiable differences in scale scores (Appendix J). The 6-item questionnaire consisted of demographic variables such as gender, age, grade level, type of neighborhood, socioeconomic status (SES). Gender was assessed by having students self-report whether they identify themselves as male, female, or other. Age and grade level were assessed by having students indicate how old they are and their grade level at the time of the completion of the questionnaire items. Type of neighborhood was assessed by having students indicate the type of neighborhood they felt most accurately represents their community (inner-city, suburb, rural, and other). SES was assessed by having student participants indicate the SES they felt most accurately represented their family (not enough money, just enough money but struggle sometimes, enough money, a lot of money, do not know); adopted and modified from Hendrickson et al. (2009). The ethnicity variable was included on the demographic questionnaire to ensure the sample was exclusively African American. Ethnicity was assessed by having students indicate the ethnic group they felt most accurately represents them (White/Caucasian, Asian/Pacific islander, Black/African-American, Latino/a, and other). Students who did not self-report as African American were not included in either

sample; however all student participants who completed the questionnaires were included in both samples.

The Level of Anger Scale (LAS). The LAS tested in this study measures participant's perceived level of anger (i.e. "I often feel mad") within the past 3 weeks. The preliminary questionnaire consisted of 18 items. Participants rated each item using a 5-point Likert-type scales, with 1= strongly disagree to 5= strongly agree. The items from the preliminary (18-item) version of the LAS are listed in Appendix A. Appendix B lists items from the final 13-item version of the LAS. Higher scores on the LAS indicate a higher level of perceived anger.

Anger and Support Scale (AAS). The AAS tested in this study measures the participant's perceived level of support surrounding anger (i.e. "I have a person I can talk to when I get angry") within the past 3 weeks. The preliminary questionnaire consisted of 12 items. Participants rated each item using a 5-point Likert-type scale, with 1= strongly disagree to 5= strongly agree. The items from the preliminary (12-item) version of the AAS are listed in Appendix C. Appendix D lists items from the final 6-item version of the AAS. Higher score on the AAS indicate a higher level of perceived level of support surrounding anger.

Tendency to Forgive Scale (TTFS). The TTFS tested in this study measures a participant's perceived general level of forgiveness (i.e. "I forgive when I can") within the last 3 weeks. The preliminary questionnaire consisted of 18 items. Participants rated each item using a 5-point Likert-type scale, with 1= strongly disagree to 5= strongly agree. The items from the preliminary 18-item version of the TTFS are listed in

Appendix E. Appendix F lists items from the final 10-item version of the TTFS. Higher scores on the TTFS indicate a higher level of perceived unforgiveness.

The Anger Expression Scale for Children (AESC). The AESC (Steele, Legerski, Nelson, & Phipps, 2009), a 26-item scale, measures a participants' expression of anger; trait anger (10 items), anger expression (6 items), anger in (4 items), and anger control (6 items). The AESC is designed for use among children and adolescents aged 7 through 17 and demonstrate an estimated grade reading level of 2.1. Respondents rate each AESC item using a 4-point Likert-type scale, with 1= almost never to 4= almost always (Appendix K). Some sample items from the AESC include "I lose my temper easily" and "I stay well behaved." Higher scores on the AESC indicate greater endorsement of the items. In this study the trait anger, anger expression, and anger in subscales will be combined to create a 20-item, main subscale (AESC-M). The anger control subscale will be utilized as a separate 6-item, control subscale (AESC-C). Both components of the original 26-item AESC will be utilized separately in demographic, reliability, and validity analyses within study #2.

Steele and colleagues' (2009) validation of the AESC utilized samples of healthy children, children with cancer, and children with chronic illnesses. Cronbach's alpha was calculated using a combined data set. Results indicated internal consistency estimates for all four subscales: trait anger, .84; anger expression, .69; anger in, .71; and anger control .79. These internal consistency estimates were found among a diverse sample (about 55% female and 14% identifying as African American). The AESC produced moderate and significant positive correlations between Trait Anger and Anger Expression subscales and child-reported anger (Children's Inventory of Anger) and hostility (Cook-Medley

Hostility Scale) and parent-reported aggression (Behavior Assessment Scale for Children-Parent Report Form) and hostility (Children's Hostility Inventory). Conversely, significant negative associations were found between Anger Control and most indices of anger, hostility, and aggression.

Trait Forgiveness Scale (TFS). The TFS (Berry, Worthington, O'Connor, Parrott, & Wade, 2005), a 10-item scale, measures trait forgiveness (Appendix L) and was adapted from a longer scale employed in previous research (Berry & Worthington, 2001). Respondents rate each TFS item using a 5-point Likert-type scale, with 1= strongly disagree to 5= strongly agree. Some sample items from the TFS include "I can usually forgive and forget an insult" and "There are some things for which I could never forgive even a loved one." Higher scores on the TFS indicate higher trait forgivingness; for this study, the questions were reversed ordered and higher scores on the TFS indicate lower trait forgiveness. The coefficient alpha reliability ranges from .74 to .80 among college-aged samples (Berry et al., 2005).

Center for Epidemiological Studies Depression Scale (CES-D). The CES-D (Radloff, 1977) is a 20-item scale that measures depressive symptomatology (Appendix M). Respondents rate each CES-D item using a 4-point Likert-type scale, with 1= not at all to 4= a lot. Some sample items from the CES-D include "I was bothered by things that usually don't bother me" and "I felt like crying." Higher scores on the CES-D indicate higher depressive symptomatology. The CES-D has been found to be an acceptable and reliable measure for use with the adolescent and young adult population (Ratloff, 1991) and CES-D's factor structure has also been validated with African Americans (Nguyen, Kitner-Triolo, Evans, & Zonderman, 2004). The reliabilities for the total CES-D score

have ranged from .89 to .90 (Breslau, 1985; Radloff, 1977) and were similar across ethnic groups (Roberts, 1980).

Analysis

The purpose of this study was to evaluate the initial development and psychometric properties of three, independent instruments designed to measure perceived level of anger, perceived level of emotional support, and perceived level of forgiveness among African American adolescents. To assess the LAS, AAS, and TTFS more effectively, the sample was divided into two sections.

Study #1. This sample was utilized in preliminary item analyses utilizing SPSS statistical software. The item-total correlations were calculated to evaluate the item performance of each scale (DeVellis, 2003). Internal reliability analyses were performed first using all of the items of each scale and subsequent, individual reliability analysis were ran removing one item that would result in a higher internal reliability for each scale. The finalized scales were then subjected to the study #2 sample.

Study #2. An internal reliability analysis was conducted to obtain the coefficient alpha value for each individual scale, LAS, AAS, and TTFS utilizing SPSS statistical software. This analysis allows for the examination the homogeneity of the items within each scale and its connections with the latent variable (DeVellis, 2003). In addition, item-total correlation and item behavior analyses were calculated to evaluate the item performance of each scale. Furthermore, each scale utilized in this study (AESC, TFS, and CES-D) to measure the variables, were examined for reliability compared to what has been previously identified in the literature.

Validity.

Content validity. An adaptation of the procedures and guidelines for scale construction obtained from published literature guided the multi-step scale development procedures for initial development and psychometric testing of the LAS, AAS, and TTFS used in this study (DeVellis, 2003). An initial item pool of items for each scale was generated by a review of the literature. Initial content validity was supported by having the initial item pool for each scale reviewed by two psychology professors and a graduate student, who were considered experts in the area of anger and forgiveness with the adolescent population based on self-expressed interest, clinical experience with this population, and research publications, for relevance to the domain of interest to maximize item appropriateness (DeVellis, 2003). These consultants were asked to (a) assess each item for clarity, (b) identify the extent to which each item represents each of the constructs, (c) provide suggestions for additional items that may be relevant to anger, support and forgiveness, and (d) provide feedback for the type of Likert scale that would be appropriate (two different types were provided to reviewers). Scale items were revised based on feedback from the reviewers.

Construct validity. The correlations between the LAS and AESC; AAS and AESC, control subscale; TTFS and TFS; between the LAS, AAS, and TTFS and CES-D, separately; and amongst the LAS, AAS, and TTFS were performed to examine the extent to which the correlations match the predicted pattern/hypotheses and provide some evidence of how well each measure "behaves" like the variable it is supposed to measure (DeVellis, 2003, p.53). Correlations between corresponding measures are expected to be significantly greater than the correlations between alternative measures; this would

indicate that the corresponding measures converged and diverged from alternative measures. Convergent validity coefficients must be greater than divergent validity coefficients (Sullivan & Feldman, 1979). Furthermore, a series of statistical comparisons were performed to identify whether significant differences exist between moderately strong, moderate, and small correlations using Fisher's z for dependent correlations coefficients (Cohen & Cohen, 1983). In addition, separate analyses of variances (ANOVAS) were conducted to test if differences existed in total scores on LAS, AAS, and TTFS and the self-reported gender, age, grade level, type of neighborhood, and family income variables. Finally, Tukey's post-hoc analyses were utilized based on the ANOVA results.

Chapter IV

Results

This section describes the data collected and the statistical procedures used to analyze it. To assess the LAS, AAS, and TTFS more effectively, the sample was divided into two sections, study #1 and study #2.

Demographic Statistics

The demographics for study #1 and study #2 samples were reviewed and compared to examine possible differences between each sample. The study #1 sample consisted of 90 participants who were 50% male, had a mean age of 16.08, lived predominately in inner-city neighborhoods (65.6%), and were underclassmen (55.6%, ninth-and tenth-graders), and about 50% reported family income as 'enough' (47.8%). The study #2 sample consisted of 220 participants, 48.6% male, who had a mean age of 15.74, lived predominately in the inner-city (69.1%), and were underclassmen (63.2%, ninth- and tenth-graders), and about 25% reported family income as 'enough' (25.9%). Table 1 displays detailed demographic information of participants by sample.

In addition, further analysis of the demographic statistics between study #1 and study #2 sample indicated significant differences between the two samples for age $t(308)=2.37$, $p<.05$, suggesting age of the study #1 participants (mean = 16.08) was significantly higher than the age of the study #2 sample participants (mean =15.74). While this is a statistically significant difference, as the difference in average age between the two samples was less than half a year difference, this difference is not a clinically significant difference. Additionally differences were found for family income $t(308)=3.744$, $p<.05$, suggesting the proportion of study #1 participants reporting their

family income as 'enough' (47.8%) was significantly higher than study #2 participants (25.9%). However, no significant differences were found between the samples in terms of the distribution of gender t(308)=.224, p>.05; grade distribution of underclassmen t(308)=1.245, p>05; and place of residence t(308)=.600, p>.05.

Table 1

Demographic Information of Participants by Sample

	Study #1 (n= 90)	Study #2 (n = 220)
Mean age (SD)	16.08 (1.15)	15.74(1.14)
Gender		
Male (%)	50.0	48.6
Grade (%)		
9	25.6	22.7
10	30.0	40.5
11	27.8	25.5
12	16.7	11.4
Neighborhood (%)		
Inner-city	65.6	69.1
Suburbs	14.4	15.5
Rural	4.4	3.6
Other	15.6	11.8
Family Income (%)		
Not enough	6.7	12.7
Just enough, struggle	26.7	47.3
Enough	47.8	25.9
A lot	8.9	5.9
Do not know	10.0	8.2

Study #1 Results

For each independent scale (LAS, AAS, and TTFS), a total-scale initial internal reliability analysis was performed. Next, individual items were examined and deleted one at a time, performing a reliability analysis after the removal of each item, based on the new change in Cronbach's alpha and suggestions from previous research (DeVellis, 2003). Reliability analyses were performed to estimate the internal consistency of responses for each measure. In addition, for each independent scale, an item-total correlation for each item was calculated to evaluate an item's performance and items that did not correlate at .30 or higher were eliminated from each independent scale (DeVellis, 2003; Steele et al., 2009). Each finalized scale was then subjected to the study #2 participants.

LAS. The LAS was designed to examine a participant's perceived level of anger. The preliminary LAS consisted of 18 items (Appendix A). Table 2 displays the change in Cronbach's alpha and item-total correlations for the five items ultimately deleted from the LAS. The first item removed was item 18. A subsequent reliability analysis was performed without item 18 and based upon the reliability results, item 4 was then removed. Successive reliability analyses were performed, using the process above, and items 18, 4, 10, 5, and 6 were removed, respectively, resulting in a final 13-item LAS (Appendix B). The final 13-item scale produced an overall strong reliability ($\alpha = .876$) suggesting a strong degree of internal consistency among the items on the scale. The corrected item-total correlation, for the 13-item scale (Table 3), revealed that items ranged from .442 to .715, suggesting an existing correlation between the items and the rest of the measure.

Table 2

Item-total Correlation and Reliability for preliminary LAS

Item #	Corrected item-total correlation	Cronbach's alpha if item deleted
18	.113	.873
4	.344	.873
10	.314	.874
5	.319	.875
6	.309	.876

Table 3

Item-total Correlation for final 13-item LAS

Original Item #	Corrected item-total correlation
1	.651
2	.514
3	.520
7	.532
8	.516
9	.697
11	.715
12	.512
13	.572
14	.452
15	.442
16	.514
17	.585

AAS. The AAS was designed to examine a participant's perceived level of support. The preliminary AAS consisted of 12 items (Appendix C). Table 4 displays the change in Cronbach's alpha and item-total correlation for the six items ultimately deleted from the AAS. The first item removed was item 9. A subsequent reliability analysis was performed without item 9 and based upon the results item 10 was removed. Successive reliability analyses were performed, using the process above, and items 9, 10, 12, 1, 4, and 11 were removed, respectively, resulting in a final 6-item AAS (Appendix D). The final 6-item scale produced an overall strong reliability (α= .851), suggesting a strong degree of internal consistency among the items on the scale. The corrected item-total correlation, for the 6-item scale (Table 4), revealed items ranged from .579 to .706, suggesting an existing correlation between the items and the rest of the measure

Table 4

Item-total Correlation and Reliability for preliminary AAS

Item #	Corrected item-total correlation	Cronbach's alpha if item deleted
9	-.375	.586
10	-.329	.672
12	-.288	.744
1	-.016	.786
4	.127	.817
11	.221	.851

Table 5

Item-total Correlation for final 6-item AAS

Original Item #	Corrected item-total correlations
2	.706
3	.653
5	.579
6	.653
7	.587
8	.638

TTFS. The TTFS was designed to examine a participant's perceived level of forgiveness. The preliminary TTFS consisted of 18 items (Appendix E). Table 6 displays the change in Cronbach's alpha and item-total correlations for the eight items ultimately deleted from the TTFS. The first item removed was item 12. A subsequent reliability analysis was performed without item 12 and based upon the reliability results item 5 was removed. Successive reliability analyses were performed, using the process above, and items 12, 5, 18, 17, 15, 2, 3, and 14 were removed, respectively, resulting in a final 10-item AAS (Appendix F). The final 10-item scale produced an overall strong reliability (α= .867), suggesting a strong degree of internal consistency among the items on the scale. The corrected item-total correlation, for the 10-item scale (Table 7), revealed items ranged from .367 to .672, suggesting an existing correlation between the items and the rest of the measure.

Table 6

Item-total Correlation and Reliability for preliminary TTFS

Item #	Corrected item-total correlation	Cronbach's alpha if item deleted
12	-.187	.770
5	-.181	.796
18	-.044	.818
17	-.145	.842
15	-.080	.859
2	.176	.867
3	.371	.867
14	.385	.867

Table 7

Item-total Correlation for final 10-item TTFS

Original Item #	Corrected item-total correlation
1	.657
4	.577
6	.628
7	.574
8	.589
9	.518
10	.606
11	.672
13	.625
16	.367

Study #2-Modified Measures

The modified LAS, AAS, and TTFS scales then were subjected to the 220 study #2 participants. Each scale's mean, standard deviation (SD), range, reliability, item-total correlation, and response frequencies were calculated to examine item and total scale performance of each measure.

Level of Anger Scale (LAS). The LAS measures a participant's perceived level of anger. Participants respond to each item using a 5-point Likert-type scale, with 1= strongly disagree to 5= strongly agree. Higher scores on the LAS indicate a higher level of perceived anger. From study #2, scores ranged from 13 to 65 (mean=38.84, SD=13.26). The overall internal consistency of the 13-item LAS produced an overall strong reliability (α= .935), suggesting a high degree of internal consistency among the items on the scale. Item-total correlations for items on the LAS ranged from .61 to .77, suggesting an existing correlation between the items and the rest of the measure.

A review of response frequencies across categories (individual Likert anchor points) suggested participant responses to the LAS generally had a slight negative skew (skewness of -.071) with a relatively flat distribution (kurtosis -1.32), suggesting more *strongly agree* and *mildly agree* (43% cumulative) values were selected as compared to *strongly disagree and mildly disagree* (37% cumulative) and relative symmetry across anchor points. More specifically, out of a total of 2,860 responses from the study #2 participant sample, *strongly disagree* was endorsed 557 times (19%), *mildly disagree* was endorsed 541 times (18%), *agree/disagree* was endorsed 504 times (17%), *mildly agree* was endorsed 725 times (25%), and *strongly agree* was endorsed 533 times (18%).

Anger and Support Scale (AAS). The AAS measures a participant's perceived level of support surrounding feelings of anger. Participants respond to each item using a 5-point Likert-type scale, with 1= strongly disagree to 5= strongly agree. Higher scores on the AAS indicate a higher level of perceived level of support. With a possible range of 6 to 30, the mean AAS score was 16.98 with a SD of 6.36. The overall internal consistency of the 6-item AAS produced an overall strong reliability (α= .857), suggesting a high degree of internal consistency among the items on the scale. Item-total correlations ranged from .59 to .68, suggesting an existing correlation between the items and the rest of the measure.

A review of response frequencies across categories (individual Likert anchor points) suggested participant responses to the AAS generally had a slight positive skew (skewness of .233) with a relatively flat distribution (kurtosis -1.14), suggesting more *strongly disagree* and *mildly disagree* (46% cumulative) values were selected as compared to *strongly agree and mildly agree* (33% cumulative) and relative symmetry across anchor points. More specifically, out of a total of 2,860 responses from the study #2 participant sample, *strongly disagree* was endorsed 600 times (21%), *mildly disagree* was endorsed 715 times (25%), *agree/disagree* was endorsed 533 times (18%), *mildly agree* was endorsed 500 times (17%), and *strongly agree* was endorsed 457 times (16%).

Tendency to Forgive Scale (TTFS). The TTFS measures a participant's perceived level of forgiveness. Participants respond to each item using a 5-point Likert-type scale, with 1= strongly disagree to 5= strongly agree. Higher scores on the TTFS indicate a higher level of unforgiveness. The mean score was 30.07 with a SD of 9.51 and range of 10 to 50. The overall internal consistency of the 10-item TTFS scale produced

an overall strong reliability (α= .892), suggesting a high degree of internal consistency among the items on the scale. Item-total correlations on the TTFS ranged from .54 to .70, suggesting an existing correlation between the items and the rest of the measure.

A review of response frequencies across categories (individual Likert anchor points) suggested that participant responses to the TTFS generally had a slight negative skew (skewness of -.017) with a relatively flat distribution (kurtosis -1.31), suggesting *strongly agree and mildly agree* (41% cumulative) values were selected as compared to *strongly disagree and mildly disagree* (37% cumulative) and relative symmetry across anchor points. More specifically, out of a total of 2,860 responses from the study #2 participant sample, *strongly disagree* was endorsed 519 times (18%), *mildly disagree* was endorsed 564 times (19%), *agree/disagree* was endorsed 591 times (21%), *mildly agree* was endorsed 748 times (26%), and *strongly agree* was endorsed 438 times (15%).

Study #2-Convergent and Divergent Validity Measures

The AESC-M, AESC-C, TFS, and CES-D scales were administered to the 220 study #2 participants. Each scale's mean, SD, and range were calculated to examine item and total scale performance of each measure. In addition, the internal consistency was calculated to examine the scale's performance and relationship with previous literature.

The Anger Expression Scale for Children, main subscale (AESC-M). The AESC-M is a 20-item measure that contains the trait anger, anger expression, and anger-in subscales. Respondents rate each item using a 4-point Likert-type scale, with 1= almost never to 4= almost always. Higher scores on the AESC-M indicate greater endorsement of those items. The mean score, with a range of 20 to 80, was 51.18 with a SD of 10.33. The overall internal consistency of the 20-item AESC-M produced an

overall strong reliability (α= .836), suggesting a high degree of internal consistency among the items on the scale. Specifically, the subscales trait anger, anger expression, and anger in produced overall strong reliabilities of .887, .856, .747 respectively, which is consistent with values identified in previous research; alpha values of .84, .69, .71, respectively (Steele et al., 2009).

The Anger Expression Scale for Children, anger control subscale (AESC-C). The AESC-C is a 6-item subscale within the AESC and measures anger control. Respondents rate each item using a 4-point Likert-type scale, with 1= almost never to 4= almost always. Higher scores on the AESC-C indicate greater endorsement of anger control. The mean score, with a range of 6 to 24, was 14.53 with a SD of 5.01. The overall internal consistency of the 6-item AESC-C produced an overall strong reliability (α= .842), suggesting a high degree of internal consistency among the items on the scale. This value is consistent with values identified in previous research (α= of .79 in Steele et al., 2009).

Trait Forgiveness Scale (TFS). The TFS is a 10-item scale that measures trait forgiveness. Respondents rate each TFS item using a 5-point Likert-type scale, with 1= strongly disagree to 5= strongly agree. Higher scores on the TFS indicate lower trait forgiveness. The mean score, with a range of 10 to 50, was 36.80 with a SD of 5.32. The overall internal consistency of the 10-item TFS produced an overall strong reliability (α= .718), suggesting a high degree of internal consistency among the items on the scale. This value is consistent with values identified in previous research; alpha values ranging from .74 to .80 (Berry et al., 2005).

Center for Epidemiological Studies Depression Scale (CES-D). The CES-D is a 20-item scale that measures depressive symptomatology. Respondents rate each CES-D item using a 4-point Likert-type scale, with 1= not at all to 4= a lot. Higher scores on the CES-D indicate higher depressive symptomatology. The mean score, with a range of 20 to 80, was 56.14 with a SD of 11.51. The overall internal consistency of the 20-item CES-D produced an overall strong reliability (α= .888), suggesting a high degree of internal consistency among the items on the scale. This value is consistent with values identified in previous research; alpha values that range from .89 to .90 (Breslau, 1985; Radloff, 1977).

External Validity-Convergent and divergent validity

Using data from the 220 study #2 participants, separate convergent and divergent validity coefficients were calculated for the LAS, AAS, and TTFS. These analyses were performed to examine the degree to which LAS, AAS, and TTFS appear to measure the same/different construct as the previously established corresponding measures. Table 8 displays the correlation coefficient of the study #2 measures-modified and convergent/divergent validity measures. In addition, a series of statistical comparisons were completed to identify whether significant differences existed between moderately strong, moderate, and somewhat (i.e., small) correlations among the 220 study #2 sample participants using Fisher's z for dependent correlation coefficients (Cohen & Cohen, 1983).

LAS. The LAS total score was correlated with the AESC-M total score, TTFS total score, AAS total score, and CES-D total score. The hypothesis that the LAS would be significantly and positively correlated with the AESC-M, TTFS, and CES-D was

supported (.766, .868, .761, respectively), suggesting high levels of perceived anger are related to relatively high levels of anger, unforgiveness, and depression symptomology as measured by the AESC-M, TTFS, and CES-D. In addition, it was expected the LAS would produce a significant, negative correlation with the AAS. Results demonstrated a negative, significant correlation with the AAS (-.542), suggesting high levels of perceived anger are related to relatively low levels of perceived support.

Furthermore, it was hypothesized the LAS would have the strongest (i.e., moderately strong) correlation with the AESC-M, moderate correlation with the TTFS/AAS, and small correlation with the CES-D. This prediction was less strongly as can be seen in Table 8. When comparing strength of these correlations to LAS total score, the TTFS correlated at a significantly higher degree than the AESC-M, $t(217)= 4.538$, $p<.05$. The AESC-M did not correlate with LAS to a significantly stronger degree than the CES-D, $t(217) = .179$, $p>.05$. Finally, the CES-D correlated with LAS to a significantly stronger degree than did the AAS, $t(217) = 8.700$, $p<.05$. These results suggest a moderately strong correlation with the TTFS, a moderate correlation with the AESC-M and CES-D, and a small correlation with the AAS.

TTFS. The TTFS total score was correlated with the TFS total score, LAS total score, AAS total score, and CES-D total score. The hypothesis that the TTFS would produce a positive, significant correlation with the TFS, LAS, and CES-D was supported (677, .868, and .786, respectively), suggesting high levels of perceived unforgiveness are related to relatively low levels of trait forgiveness and high levels of perceived anger and depression symptomology. The TTFS produced a negative, significant correlation (-.521)

with the AAS as predicted, suggesting high levels of perceived unforgiveness are related to relatively low levels of perceived support.

Furthermore, it was expected the TTFS would have the strongest correlation (i.e., moderately strong) with the TFS, moderate correlation with the LAS/AAS, and small correlation with the CES-D. These predictions were partially supported as seen in Table 8. T-tests were utilized to examine the relative strength of these various correlations the LAS did not correlate with TTFS at a significantly stronger degree than did the CES-D, $t(217)= 1.20$, $p>.05$. The CES-D correlated with the TTFS at a significantly stronger degree than the TFS, $t(217) = 3.766$, $p<.05$. Lastly, the TFS correlated with the TTFS at a significantly different degree than did the AAS, $t(217) = 7.465$, $p<.05$. These results suggest a moderately strong correlation between the LAS and CES-D, a moderate correlation with the TFS, and small correlation with AAS.

AAS. The AAS total score was correlated with the AESC-C total score, LAS total score, TTFS total score, and CES-D total score. It was expected the AAS would produce a positive, significant correlation with the AESC-C, which was supported (.583), suggesting high levels of perceived support are related to relatively high level of anger control. In addition, it was expected that the AAS would produce negative, significant correlations with the TTFS, LAS, and CES-D. The AAS did produce negative, significant correlations with these three measures (-.521, -.542, -.566, respectively), suggesting high levels of perceived support are related to relatively low levels of perceived unforgiveness, low levels of anger, and low levels of depression symptomology.

Furthermore, it was predicted the AAS would have the strongest (i.e., moderately strong) correlation with the AESC-C, moderate correlation with the LAS/TTFS, and

small correlation with the CES-D. These hypotheses were partially supported as seen in Table 8. In examining the strength of these associations, results demonstrated the AESC-C correlated with the AAS at a significantly different degree than the CES-D, t(217)= 12.080, p<.05. The CES-D did not correlate with AAS at a significantly different degree than did the LAS, t(217) = -.068, p>.05. The LAS did correlate with AAS at a significantly different degree than the TTFS, t(217) = -.722, p>.05. These results suggest a moderately strong correlation with the AESC-C, a moderate correlation with the CES-D and LAS, and a small correlation with the TTFS.

Table 8

Study #2 Correlation Matrixes

	LAS	TTFS	AAS	CES-D	TFS	AESC-C	AESC-M
LAS	1						
TTFS	.868*	1					
AAS	-.542*	-.521*	1				
CES-D	.761*	.786*	-.566*	1			
TFS	.660*	.677*	-.494*	.758*	1		
AESC-C	-.585*	-.629*	.583*	-.642*	-.692	1	
AESC-M	.766*	.763*	-.474*	.757*	.650*	-.505*	1

Note: LAS = Level of Anger, TTFS= Tendency to Forgive, AAS=Anger and Support, CES-D= Depression Symptomology, TFS= Trait Forgiveness, AESC-C= Anger Control, and AESC-M=Anger; *= p<.05

Construct Validity

Analyses of variance (ANOVAs) were used to further test the construct validity hypotheses using the 220 study #2 participants for each independent measure. It was expected that there would be no differences in total scores on the LAS, AAS, and TTFS across gender, age, grade, type of neighborhood, or income. Tables 9, 10, and 11 display the results of the separate analyses for each measure.

For gender, age, grade, and type of neighborhood no significant differences were found between total scores on the LAS, AAS, and TTFS. In addition, no significant differences were found in the AAS and TTFS scores for income. However, significant differences in LAS scores were found by income levels ($F= 3.24$, $p<.05$). Based on post-hoc analyses significant differences in LAS scores were found between income levels of 'a lot' and 'just enough, but struggle' ($t(219)=.024$, $p<.05$) and 'not enough' ($t(219)=.008$, $p<.05$). In addition, differences in LAS scores were found between income levels of 'enough' and 'just enough, but struggle' ($t(219)=.029$, $p<.05$) and 'not enough' ($t(219)=.010$, $p<.05$). These findings suggest those participants who self-reported family income as 'a lot' or 'enough' money reported a lower level of perceived anger than participants who self-reported their family income as 'not enough' or 'just enough, but struggle sometimes'.

Summary

The results of the current study suggest that with some initial adjustments, each scale (LAS, AAS, and TTFS) produced an overall strong reliability and tests of convergent and divergent validity yielded mixed results. Furthermore, no differences in total scores on the LAS, AAS, and TTFS were found for self-reported gender, age, grade,

and type of neighborhood. In regards to income, no significant differences were found for the AAS and TTFS. However, significant differences among the LAS were found for income. The last chapter will provide a discussion of the meaning of these findings, the limitations, and the future implications of the current study.

Table 9

Analysis of Variance of variables for LAS

Predictor Variable	n	M	SD	F	df	p
Gender				3.69	1, 217	.056
Male	107	37.08	12.92			
Female	112	40.51	13.42			
Age				.45	4, 214	.776
14	33	41.45	12.86			
15	65	38.02	13.26			
16	63	38.03	13.89			
17	43	39.19	13.29			
18 or older	15	39.00	12.20			
Grade				.89	3, 215	.445
9	50	39.38	12.14			
10	89	38.21	13.58			
11	55	37.65	14.12			
12	25	42.56	12.30			
Neighborhood				.93	3, 215	.425
Inner-city	152	39.19	13.50			
Suburb	33	36.33	11.13			
Rural	8	44.50	8.26			
Other	26	38.19	15.31			
Income				3.24	4, 214	.013
Not Enough	28	43.57	13.35			
Enough, but Str	104	40.51	13.38			
Enough	57	35.79	13.52			
A lot	13	31085	8.89			
Do not know	17	36.35	10.31			

Table 10

Analysis of Variance of variables for AAS

Predictor Variable	n	M	SD	F	df	p
Gender				.16	1, 218	.687
Male	107	16.80	6.35			
Female	113	17.15	6.39			
Age				.87	4, 215	.483
14	33	16.61	6.65			
15	65	17.10	6.08			
16	64	17.59	6.15			
17	43	17.12	7.15			
18 or older	15	14.27	5.39			
Grade				1.49	3, 216	.217
9	50	17.52	6.09			
10	89	17.38	6.35			
11	56	16.96	6.81			
12	25	14.52	5.62			
Neighborhood				.88	3, 216	.452
Inner-city	152	16.74	6.47			
Suburb	34	18.59	5.42			
Rural	8	16.13	7.55			
Other	26	16.58	6.49			
Income				2.04	4, 215	.091
Not Enough	28	14.39	5.65			
Enough, but Str	104	16.96	6.78			
Enough	57	17.26	5.75			
A lot	13	17.92	5.81			
Do not know	18	19.56	6.35			

Table 11

Analysis of Variance of variables for TTFS

Predictor Variable	n	M	SD	F	df	p
Gender				1.77	1, 218	.184
Male	107	29.19	9.28			
Female	113	30.90	9.69			
Age				.46	4, 215	.766
14	33	31.52	10.21			
15	65	29.75	9.36			
16	64	30.33	9.52			
17	43	29.91	10.11			
18 or older	15	27.67	7.06			
Grade				2.06	3, 216	.107
9	50	30.62	9.21			
10	89	30.12	9.47			
11	56	27.98	9.52			
12	25	33.48	9.61			
Neighborhood				.38	3, 216	.765
Inner-city	152	30.49	9.83			
Suburb	34	29.09	7.94			
Rural	8	27.88	7.97			
Other	26	29.58	10.14			
Income				1.71	4, 215	.148
Not Enough	28	33.64	9.62			
Enough, but Str	104	30.48	10.12			
Enough	57	28.67	9.49			
A lot	13	28.08	7.18			
Do not know	18	28.06	5.31			

Chapter V

Discussion

This section includes an overview of the study and a discussion of the results including hypotheses, implications, and limitations.

Overview

The role of forgiveness, anger, and emotional support, among the adolescent population, continues to receive significant interest among the research community (Hessler & Katz, 2010; Harrison et al., 2010; Mahon et al., 2010; Worthington et al., 2010). Moreover, a considerable amount of research has found a relationship between forgiveness and anger (Hansen et al., 2009; Seybold et al., 2001) and anger and emotional support (Angerer, 2000; Arslan, 2009). Previous research has suggested that levels of anger, forgiveness, and emotional support play a large role in the lives of adolescents (Colletta, 1981; Daniel et al., 2009; Freedman & Knupp, 2003; Mahon et al, 2000; Nichols et al., 2008). Further, the importance of anger, forgiveness, and emotional support has been examined in relation to a multitude of constructs, suggesting its impact on the well-being of adolescents (*Al-Mabuk & Downs, 1996; Ayres & Leaper, 2012*).

The purpose of this study was to develop and validate a measure of perceived level of anger, support, and forgiveness among African-American adolescents. Although current measures of perceived levels of anger, support, and forgiveness have been validated with adolescents, they have not exclusively examined these constructs among the African-American, adolescent population within a short-term, specified amount of time (e.g., last 3 weeks). In addition, these measures were specifically created to be

utilized in future research to capture the relational dimension between level of perceived anger, forgiveness, and support within the African-American, adolescent population.

In order to examine the psychometric properties of each measure, the study was divided into 2 independent samples. In study #1, preliminary item analyses were examined for each measure. Utilizing a sample of 90 African-American high school students, participants were asked to respond to several different questionnaires that identified the constructs of forgiveness, anger, and support. The collected data was analyzed utilizing SPSS software allowing for reliability and item-correlations to be examined. The results of this examination suggested with some initial adjustments, each scale showed strong psychometric properties. These results were confirmed by internal consistency estimates for the LAS, AAS, and TTFS of .876, .851, and .867, respectively, suggesting homogeneity of the items within each scale. The finalized scales were then subjected to the study #2 participants.

In study #2, the remaining 220 African-American high school students' responses to several questionnaires were used in tests of reliability and validity. The results of this examination displayed overall strong psychometric properties of the three new measures. These results were confirmed by internal consistency estimates for the LAS, AAS, and TTFS of .935, .857, and .892, respectively, again suggesting homogeneity of the items within each scale. These results are consistent with established measures used in this study (e.g., AESC and TFS). Furthermore, measures utilized for validity analyses (e.g., AESC-M, AESC-C, TFS, and CES-D) also produced overall strong reliability. These results confirmed previous conclusions in the literature (Berry et al., 2005; Breslau, 1985; Radloff, 1977; Steele et al., 2009).

Hypotheses

Hypothesis #1. It was expected that the LAS would produce a positive, significant correlation with the AESC-M. As predicted, the LAS and AESC-M were significantly, positively related, suggesting the two constructs are related and that high scores on the LAS (indicating high levels of perceived anger) are associated with relatively high scores on the AESC-M (indicating high levels of anger). In addition, it suggests the LAS measured the theorized psychological construct (anger) it purports to measure.

However, contrary to other predictions, in relation to other measures, the LAS did not produce the strongest correlation/relationship with the AESC-M. The LAS produced the strongest relationship with the TTFS measure. These results suggest the LAS did not converge with another measure of anger and diverge with measures of trait forgiveness, depression symptomology, and anger support as strongly as hoped. The relationship between the LAS and TTFS could be attributed to the definition of forgiveness. The definition used in the present work was an attempt to synthesize the major themes found in the relevant literature. As such, forgiveness was broadly defined and may tap into more constructs than expected; forgiveness is defined as a psychological construct and a coping strategy in-and-of-itself (North, 1987; Worthington & Scherer, 2004)

Also, a stronger relationship between the LAS and CES-D was produced than was predicted. This can be understood by examining recent research among adolescents that suggest depression and anger manifest themselves in similar presentations and can be viewed as distress (Baskin, Quintana, & Slaten, 2013). In addition, research has highlighted the association between aspects of depression (e.g., hopelessness and poorer

self-concept) and anger in which anger fully mediates and attributes to depression symptomology due to chronic stressors such as racism and discrimination (LaMar, 2010; Nyborg & Curry, 2003; Peters, 2006).

Hypothesis #2. It was expected the AAS would produce a positive, significant correlation with the AESC-C. This hypothesis was supported, indicating high scores on the AAS (indicating high levels of perceived support surrounding anger) are associated with relatively high scores on the AESC-C (indicating high levels of anger control). In addition, in relation to other measures, the AAS produced the strongest correlation/relationship with the AESC-C as predicted. This relationship is consistent with previous research highlighting the relationship between perceived emotional support and emotional control/regulation (Adrian et al., 2011; Cohen, 1988). Also, the strength of this relationship, in relation to other measures, suggests one can more accurately predict reported level of anger control from knowledge of perceived level of anger support.

However, the AAS produced subsequent significant, zero-order correlations with the CES-D, LAS and TTFS, with the CES-D producing a higher correlation than expected. These results suggest the anger support measure (AAS) had a stronger relationship to depression symptomology (CES-D) than level of anger (LAS) and level of forgiveness (TTFS). Although the CES-D produced a stronger relationship than the LAS, no significant difference was found between the CES-D and LAS. This suggests one can accurately predict level of depression symptomology and level of anger from level of anger support more than from level of forgiveness. As stated above, these results can be explained by research suggesting depression and anger manifest in similar presentations and can be viewed as distress (Baskin, Quintana, & Slaten, 2013)

In addition, research has shown associations between aspects of depression and anger, in which anger has been shown to fully mediate and/or attributes to depression symptomology due to chronic stressors such as racism and discrimination (LaMar, 2010; Nyborg & Curry, 2003; Peters, 2006). Furthermore, research has shown that although emotional support may be aimed at providing support in one domain, it is a functional component used to respond to a variety of stressful events assisting with the maintenance of emotions and prevention of extreme responses such as anger and depression symptomology (Cohen, 1985; Cohen, 1988; Silk, et al., 2003).

Hypothesis #3. It was expected the TTFS would produce a positive, significant correlation with the TFS. In support of this prediction, the TTFS and TFS did produce a positive significant correlation, suggesting both measures are measuring similar constructs and that high scores on the TTFS (indicating low levels of perceived forgiveness) are associated with relatively high scores on the TFS (indicating low levels of trait forgiveness). In addition, it suggests the TTFS measures the theorized psychological construct (forgiveness) it was designed to measure.

However, in relation to other measures, the TTFS did not produce the strongest correlation/relationship to the TFS, contrary to my prediction. These results suggest that the TTFS did not converge with another measure of trait forgiveness and diverge with measures of anger, depression symptomology, and anger support as strongly as predicted. The relationship between the TTFS and preceding measures could be contributed to the definition of forgiveness; it was broadly defined for the development of measures in this study and may tap into more constructs than expected (Thompson et al., 2005).

Hypothesis #4. Based upon research which has found a relationship between forgiveness and anger (Hansen, Enright, Baskin, & Klatt, 2009; Seybold et al., 2001) and anger and emotional support (Houltberg et al., 2012; Shortt et al., 2010) it was hypothesized the LAS would be significantly correlated with the TTFS and AAS. As predicted, significant correlations were found among the LAS, AAS, and TTFS, suggesting the constructs are related. The LAS and TTFS produced a positive significant correlation, suggesting high levels on the LAS (indicating high levels of anger) are associated with relatively high levels of TTFS (indicating high levels of unforgiveness). In addition, the LAS and AAS were negatively, significantly correlated, suggesting high scores on the LAS (indicating high levels of perceived level of anger) are associated with relatively low scores on the AAS (indicating low levels of perceived anger support). The AAS and TTFS, meanwhile, were also negatively, significantly correlated suggesting low scores on the AAS (indicating low levels of perceived anger support) are paired with relatively high scores on the TTFS (indicating high levels of perceived unforgiveness).

Hypothesis #5. It was expected that significant, somewhat (i.e., "small") correlations would exist independently between the LAS, AAS, and TTFS and CES-D. Research highlights the association between forgiveness, anger, and support and other psychological constructs, such as depression (Freedman & Enright, 1996; Gross & Munoz, 1995; Mahon et al., 2010; Reed & Enright, 2006). As predicted, the LAS, TTFS, and AAS independently produced significant correlations with the CES-D (.761, .786, -.566, respectively), suggesting a relationship between perceived level of anger, support, and forgiveness and level of depressive symptomology. More specifically, high scores on the CES-D (indicating high levels of depression symptomology) were associated with

relatively high scores on the LAS and TTFS (indicating high levels of perceived anger and unforgiveness) and low scores on the AAS (indicating low levels of perceived anger support).

However, contrary to predictions, none of the measures produced a somewhat (i.e., "small") correlation with the CES-D in relation to the other measures; each produced stronger relationships than expected. The TTFS produced a moderately strong correlation with the CES-D, and the LAS and AAS produced moderate correlations with the CES-D. As stated above, these correlations can be attributed to the forgiveness definition (Thompson, et al., 2005) and to research demonstrating depression and anger manifest themselves in similar presentations and can be viewed as distress (Baskin, Quintana, & Slaten, 2013). Also, based upon the relationship of the AAS with other measures, the AAS measure may tap into more theoretical ideas behind anger control than one's level of anger. Anger control can be seen as an emotion regulation technique that would suggest an inverse relationship with depression symptomology (the ability to regulate another emotion-depression). Research has suggested that emotional support is thought to maintain regulation of these response systems (e.g., emotions) and prevent extreme responses associated with dysfunction (Cohen, 1988).

Hypothesis #6. It was expected no significant differences in total scores on the LAS, AAS, and TTFS would be found for gender, age, grade, neighborhood, and income. Overall, the results of the hypothesis were supported with exception of income. In support of this hypothesis, no significant differences were found between total scores on the LAS, AAS, and TTFS for gender, age, grade, and type of neighborhood. In addition, no significant differences were found for the AAS and TTFS for income. This is likely a

result of to the unifying characteristics among the participants (e.g., race/ethnicity, developmental level, and family income); the sample was exclusively African-American adolescents with the overwhelming majority qualifying for free/reduced lunch due to family's income. One's minority status, developmental level, and SES are thought to be significant, influential factors in an individual's everyday experiences such as exposure to stressors (e.g., racial discrimination), access to resources, psychological and physiological health outcomes (Bradley & Corwyn, 2002; Dahl, 2004; Forman et al., 1997; Shonkoff & Phillips, 2000). In addition, this combination of factors can influence how one responds to these everyday experiences (Gross & John, 2003; Jones et al., 1992).

However, significant differences in LAS total score were found based on reported income level. Participants who self-reported family income as 'a lot' or 'enough' money reported a lower level of perceived anger than participants who self-reported their family income as 'enough, but struggles sometimes' or 'not enough'. These observations highlight the impact of income on level of perceived anger. These findings are contrary to predictions that no significant differences would be found for LAS total scores among the sample and to previous research which has highlighted the equal prevalence of potential anger predictors (e.g., racial discrimination, exposure to violence) among the African-American population regardless of family income (Crouch et al., 2000; Williams et al., 2003). Furthermore, according to the participating schools' administrators, between 83-99% of their student body qualifies for reduced/free lunch due to family income (Scott, Weber, & Verridan, personal communication, December 2012). These results could highlight the importance of examining the participant's perception of their family income

in relation to their actual/documented income and potential overall effects of one's perceived income to perceived levels of anger and the anger experience among the African-American adolescent population.

These results are parallel to the findings produced between study #1 and study #2 data in relation to the LAS. Although differences existed between study #1 and study #2, creating a study #1 sample that was slightly older and a reported higher family income as 'enough', no differences existed between the samples for AAS responses and TTFS responses. However, significant differences did exist between the samples for LAS responses, indicating study #1 sample mean responses to the LAS were significantly lower than study #2 sample. This suggests the slightly older, higher report of family income as 'enough' study #1 sample participants reported lower levels of perceived anger. These observations also highlight the potential impact of age and income on one's level of perceived anger.

Implications and Limitations

The initial development and validation suggest each measure can be used with African-American adolescents to measure levels of perceived anger, forgiveness, and anger support. Each measure was developed and tested according to psychometric principles of test construction. Initial development started with an extensive base of items extracted from the psychological literature. Item reduction was achieved through the use of an expert panel, correlation and reliability analyses. A final 13-item LAS, 10-item TTFS, and 6-item AAS emerged. Psychometric reliability and validation testing was accomplished with a sample of African-American adolescents. The initial development and validation of these measures can add to the body of knowledge and extend that body

of work by investigating the relational dimension among the constructs with this distinct population.

The validity for anger research is indicated by correlations with trait forgiveness, depressive symptomology, and anger support. In addition, previous research has examined the role of gender, age/grade, income, and neighborhood in relation to one's experience and expression of anger (Stevenson, 1997; Yarcheski, Mahon, & Yarcheski, 2002). This study suggested that one's level of anger is equally reported within this majority urban, adolescent, African-American sample only for gender, age/grade, and neighborhood, but not for family income. In relation to the anger experience and expression, family income (i.e., factors associated with income that may influence the anger experience and expression) should be considered when creating anger interventions/programs for this population.

The validity for forgiveness research is indicated by correlations with trait anger, depressive symptomology, and anger support. In addition, previous research has examined the role of gender, age/grade, (i.e., developmental level), income, and neighborhood in relation to forgiveness (Enright et al., 1989; Hui & Ho, 2004; Konstam, Holmes, & Levine, 2003; Miller, Worthington, & McDaniel, 2008). The results of this study suggest that forgiveness tendency is equally reported within this majority urban, adolescent, African-American sample. Although these demographic factors should be considered when creating forgiveness interventions/programs, this study suggests that separate, distinctive interventions (e.g., intervention created separately for males and females) may not be warranted for this specific population.

The validity for anger support research is indicated by correlations with trait anger and forgiveness and depressive symptomology. In addition, previous research has examined the role of gender, age/grade, income, and neighborhood in relation to one's access and social support seeking behaviors (Cattell, 2001; Gross & Munoz, 1995; Silk et al., 2003; Slavin & Rainer, 1990). Current results suggest that one's level of anger support is equally reported within this majority urban, adolescent, African-American sample. Although these demographic factors should be considered when creating social support interventions/programs, separate interventions (e.g., intervention created separately for older and younger adolescents) may not be warranted for this specific population.

Results of the study suggest that levels of perceived anger, forgiveness, and support are vital constructs to explore among the African American population. This is confirmed by the overall pattern of responses that emerged across the three Milwaukee-area high school participants. This sample's response style to the LAS and TTFS produced an overall slightly negative skew suggesting a tendency to report higher levels of anger and unforgiveness. In addition, the sample's responses to the AAS produced an overall positive skew suggesting a tendency to report a lower level of anger support. Despite the diverse sample (e.g., male, female, age and grade range, neighborhood, and income), the sample produced similar response patterns that highlight higher levels of anger, unforgiveness, and lack of support. These findings parallel previous research which has shown adolescents reported experience more anger than adults, in context of everyday problems (Blanchard-Fields & Coates, 2008), there are many factors that contribute to the experience of anger among African Americans (Brown et al., 2000;

Simons et al., 2006; Swim et al., 2003; Thomas & Gonzalez-Prendes, 2009), and associations exist between levels of anger and forgiveness and levels of anger and emotional support (Enright & Fitzgibbons, 2000; Silk et al., 2003).

Furthermore, the results of this study suggest the preceding constructs are related to one another and future researchers should continue to examine these relationships. These relationships were displayed in the high correlation between the level of forgiveness and level of anger measures. Future research should continue to test each measure in different context to see if over time the two variables remain separate constructs. Also, a consistent theme in relation to depressive symptomology and anger emerged, lending support to research showing these constructs manifest in similar presentations and can be viewed as distress (Baskin, Quintana, & Slaten, 2013) and an association exist between depression and anger (LaMar, 2010; Nyborg & Curry, 2003; Peters, 2006). Furthermore, researchers should continue to operationalize the concept of distress by examining potential contributing constructs (e.g., anger and depression symptomology) within the adolescent population. Also, a consistent theme in relation to forgiveness and anger emerged. Researchers should continue to operationalize the concept of forgiveness to examine how much forgiveness is coping, emotional, and/or spiritual. In relation to the African American population, future researchers should examine if African Americans tend to suppress the emotion anger and if this act of suppression is reflected in response patterns on anger measures. Also, future research should examine how and if African American traditions of spirituality endorse forgiveness.

These psychological constructs could be strategically combined into a single intervention to assist with developing better regulation of anger through emotional support and the acquisition of forgiveness concepts to affect one's level of anger, forgiveness, and depressive symptomology, and the possible resulting outcomes. The availability of each measure will aid in the opportunity for more providers to examine each construct and develop unique interventions to assist the African-American adolescents they service. This work provides a basis for refinement and further development of a relational dimension between anger, forgiveness, and emotion regulation through support.

There are, however, limitations to that basis. The first limitation involves the use of an inclusive category of adolescents versus a sample consisting of distinct adolescent age groups, older and young adolescents. Significant differences were found for the LAS between the study #1 and study #2 participants; the study #1 sample was slightly older. Future researchers could examine the LAS, AAS, and TTFS with distinct adolescent groups.

The second limitation is related to the reliability of each measure; test-retest reliability was not performed. Having access to the participants proved to be more challenging than expected due to scheduling conflicts and student activities. Future validation of each measure should include the temporal stability component of reliability to increase the overall psychometric properties of each measure.

The final limitation is related to the demographics of the sample; the sample consisted of exclusively African-American adolescents of whom a majority resided in an urban environment, which limits its external validity. Although the purpose of the study

was to focus on this distinct population, future researchers can validate each measure with additional, diverse populations.

Despite these limitations, each of these measures can be utilized to measure the perceived level of anger, anger support, and forgiveness among the African-American urban, adolescent population. Understanding these constructs is imperative to creating interventions/programming that will increase the overall psychological and physiological well-being of this population, not just as distinct entities, but also in how they are related and can be combined to achieve better understanding of contributory and protective factors for this population in research and practice.

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Appendix A

Original Level of Anger Scale

Directions: Think about how you have felt over the past 3 weeks, indicate the degree to which you agree or disagree with each statement below by using the following scale:

- A=Strongly Disagree (SD)
- B=Mildly Disagree (MD)
- C=Agree and Disagree equally (A/D)
- D=Mildly Agree (MA)
- E=Strongly Agree (SA)

		SD	MD	A/D	MA	SA
1.	I often feel mad.	A	B	C	D	E
2.	My parents think I get angry a lot.	A	B	C	D	E
3.	Among my friends, I get angrier than others.	A	B	C	D	E
4.	I wish I got mad less often.	A	B	C	D	E
5.	I feel happy most of the time.	A	B	C	D	E
6.	I have angry thoughts when I am with friends.	A	B	C	D	E
7.	I yell at others a lot.	A	B	C	D	E
8.	It is very easy for me to get frustrated.	A	B	C	D	E
9.	People always make me angry.	A	B	C	D	E
10.	My teachers think I get mad a lot.	A	B	C	D	E
11.	I have angry thoughts at home.	A	B	C	D	E
12.	I hit/destroy things when I get frustrated.	A	B	C	D	E
13.	I have angry thoughts when I am at school.	A	B	C	D	E
14.	People often say that I am mean to others.	A	B	C	D	E
15.	It is difficult for me to overlook other people's mistakes.	A	B	C	D	E
16.	Other people think I tend to overreact.	A	B	C	D	E
17.	I feel like I am about to explode from all the anger inside me.	A	B	C	D	E
18.	It takes a lot to get me upset.	A	B	C	D	E

Appendix B

Final Level of Anger Scale

Directions: Think about how you have felt over the past 3 weeks, indicate the degree to which you agree or disagree with each statement below by using the following scale:

- A=Strongly Disagree (SD)
- B=Mildly Disagree (MD)
- C=Agree and Disagree equally (A/D)
- D=Mildly Agree (MA)
- E=Strongly Agree (SA)

		SD	MD	A/D	MA	SA
1.	I often feel mad.	A	B	C	D	E
2.	My parents think I get angry a lot.	A	B	C	D	E
3.	Among my friends, I get angrier than others.	A	B	C	D	E
4.	I yell at others a lot.	A	B	C	D	E
5.	It is very easy for me to get frustrated.	A	B	C	D	E
6.	People always make me angry.	A	B	C	D	E
7.	I have angry thoughts at home.	A	B	C	D	E
8.	I hit/destroy things when I get frustrated.	A	B	C	D	E
9.	I have angry thoughts when I am at school.	A	B	C	D	E
10.	People often say that I am mean to others.	A	B	C	D	E
11.	It is difficult for me to overlook other people's mistakes.	A	B	C	D	E
12.	Other people think I tend to overreact.	A	B	C	D	E
13.	I feel like I am about to explode from all the anger inside me.	A	B	C	D	E

Appendix C

Original Anger and Support Scale

Directions: Think about how you have felt over the past 3 weeks, indicate the degree to which you agree or disagree with each statement below by using the following scale:

- A=Strongly Disagree (SD)
- B=Mildly Disagree (MD)
- C=Agree and Disagree equally (A/D)
- D=Mildly Agree (MA)
- E=Strongly Agree (SA)

		SD	MD	A/D	MA	SA
1.	It is hard for me to find a place to go when I am mad.	A	B	C	D	E
2.	I have people I can share my mad feelings with.	A	B	C	D	E
3.	When I talk to someone about my angry feelings, I feel safe.	A	B	C	D	E
4.	I feel like I have no support when I am mad.	A	B	C	D	E
5.	I have a person I can talk to when I get angry.	A	B	C	D	E
6.	I have someone who listens to me when I get frustrated.	A	B	C	D	E
7.	It is easy for me to share my angry feelings with others.	A	B	C	D	E
8.	I have someone who understands me when I get mad.	A	B	C	D	E
9.	No one allows me to be angry.	A	B	C	D	E
10.	I wish I had someone to talk to about my frustrations.	A	B	C	D	E
11.	I am able to hold in my anger in the moment because I can talk about them later.	A	B	C	D	E
12.	No one ever asks me about my angry feelings.	A	B	C	D	E

Appendix D

Final Anger and Support

Directions: Think about how you have felt over the past 3 weeks, indicate the degree to which you agree or disagree with each statement below by using the following scale:

- A=Strongly Disagree (SD)
- B=Mildly Disagree (MD)
- C=Agree and Disagree equally (A/D)
- D=Mildly Agree (MA)
- E=Strongly Agree (SA)

		SD	MD	A/D	MA	SA
1.	I have people I can share my mad feelings with.	A	B	C	D	E
2.	When I talk to someone about my angry feelings, I feel safe.	A	B	C	D	E
3.	I have a person I can talk to when I get angry.	A	B	C	D	E
4.	I have someone who listens to me when I get frustrated.	A	B	C	D	E
5.	It is easy for me to share my angry feelings with others.	A	B	C	D	E
6.	I have someone who understands me when I get mad.	A	B	C	D	E

Appendix E

Original Tendency to Forgive Scale

Directions: Think about how you have felt over the past 3 weeks, indicate the degree to which you agree or disagree with each statement below by using the following scale:

- A=Strongly Disagree (SD)
- B=Mildly Disagree (MD)
- C=Agree and Disagree equally (A/D)
- D=Mildly Agree (MA)
- E=Strongly Agree (SA)

		SD	MD	A/D	MA	SA
1.	I hold grudges.	A	B	C	D	E
2.	I forgive whenever I can.	A	B	C	D	E
3.	When someone says they are sorry, I am likely to remain mad.	A	B	C	D	E
4.	Some things you just cannot forgive.	A	B	C	D	E
5.	My friends have hurt me in the past, but I have forgiven them.	A	B	C	D	E
6.	It is hard for me to let hurtful things go.	A	B	C	D	E
7.	When someone hurts me, I often remind them of what they did.	A	B	C	D	E
8.	My parents think I stay angry at others for a long time.	A	B	C	D	E
9.	When someone hurts me, I have to get even.	A	B	C	D	E
10.	When someone hurts me, I keep track of how many times they have hurt me.	A	B	C	D	E
11.	When someone does something hurtful to me, memories of the hurt surface.	A	B	C	D	E
12.	When I encounter someone that has hurt me in the past, I feel a lot of anger.	A	B	C	D	E
13.	When bad things happen to people who have hurt me, I get happy.	A	B	C	D	E
14.	Others tell me to forgive, but I think they are wrong.	A	B	C	D	E
15.	You are supposed to forgive, but it is not a smart thing to do.	A	B	C	D	E
16.	Even after someone says they are sorry, I talk about what they did to me.	A	B	C	D	E
17.	I feel better when I forgive.	A	B	C	D	E
18.	When someone is forgiven, they are more likely to forgive others.	A	B	C	D	E

Appendix F

Final Tendency to Forgive Scale

Directions: Think about how you have felt over the past 3 weeks, indicate the degree to which you agree or disagree with each statement below by using the following scale:

- A=Strongly Disagree (SD)
- B=Mildly Disagree (MD)
- C=Agree and Disagree equally (A/D)
- D=Mildly Agree (MA)
- E=Strongly Agree (SA)

		SD	MD	A/D	MA	SA
1.	I hold grudges.	A	B	C	D	E
2.	Some things you just cannot forgive.	A	B	C	D	E
3.	It is hard for me to let hurtful things go.	A	B	C	D	E
4.	When someone hurts me, I often remind them of what they did.	A	B	C	D	E
5.	My parents think I stay angry at others for a long time.	A	B	C	D	E
6.	When someone hurts me, I have to get even.	A	B	C	D	E
7.	When someone hurts me, I keep track of how many times they have hurt me.	A	B	C	D	E
8.	When someone does something hurtful to me, memories of the hurt surface.	A	B	C	D	E
9.	When bad things happen to people who have hurt me, I get happy.	A	B	C	D	E
10.	Even after someone says they are sorry, I talk about what they did to me.	A	B	C	D	E

Appendix G

Parental Consent Form

UNIVERSITY OF WISCONSIN-MILWAUKEE

DEPARTMENT OF EDUCATIONAL PSYCHOLOGY

CONSENT TO PARTICIPATE IN RESEARCH

GUARDIAN/PARENTAL NOTICE OF CHILD PARTICIPATION

Your child has been chosen to participate in a research study that involves the completion of questionnaires. The participation in the research study is completely voluntary and your child's identity will be anonymous. A University of Wisconsin-Milwaukee doctoral graduate student from the Department of Educational Psychology will come to your child's classroom to distribute the one-time questionnaires. The purpose of this experience is to allow your child to anonymously share their thoughts on aspects of anger, support, and forgiveness. In addition, the purpose is to create questionnaires that are appropriate for the African American, adolescent population in an attempt to gain a better and accurate understanding of anger, support, and forgiveness within this population. The research encounter will involve the distribution of questionnaires where the doctoral student will acquire information pertaining to your child's background and personal experiences with anger, anger and support, forgiveness, ethnic identification, and recent feelings and thoughts.

The services offered have been arranged through the University of Wisconsin-Milwaukee. The services will be in the form of a one-time questionnaire, which will take place in your child's classroom and take approximately 45 minutes to complete. The questionnaires will ask questions surrounding your child's attitude and behaviors with anger, support regarding anger, forgiveness, ethnic identification, and recent feelings and thoughts.

Your child's identity will be kept completely confidential because the questionnaires will be anonymous; your child will <u>not</u> place their names on the questionnaires. The UWM doctoral student will be supervised by her advisor, Dr. Thomas Baskin. The information gathered from the questionnaires will be utilized in the doctoral student's dissertation. No data will be published that would individually identify your child or their school.

What happens to the information collected?

We may decide to present what we find to others, or publish our results in scientific journals or at scientific conferences. We will use the information collected to that point with your consent.

If you would like your child to participate please do not sign the form. On the day the questionnaires will be distributed, your child has the right to decline or terminate participation for any reason. The questionnaires will be completed during your child's study hall and if your child chooses to decline or terminate participation they will remain in the study hall and work on other academic coursework during this time.

Participant: What happens if I decide not to be in this study?

Your child's participation is entirely voluntary. You may choose for your child to take part in this study. If you decide to take part, you can change your mind later and withdraw your child's participation. Your decision will not change any present or future relationships with the University of Wisconsin-Milwaukee.

Before the completion of the questionnaires, your child will also be read this consent form and be given the chance to withdrawal from participation.

Sincerely,

Jaquaye Russell
School Counseling, MS and Counseling Psychology Doctoral Student

Who do I contact for questions about this study?

For more information about the study or the study procedures or to withdraw from participation, contact:

Jaquaye Russell
UWM Department of Educational Psychology
414-366-0611
Email: jlglover@uwm.edu

Who do I contact for questions about my rights or complaints towards my child's treatment as a research subject?

The Institutional Review Board may ask your name, but all complaints are kept in confidence.

Institutional Review Board, Human Research Protection Program
Department of University Safety and Assurances
University of Wisconsin – Milwaukee
P.O. Box 413
Milwaukee, WI 53201
(414) 229-3173

Research Subject's Consent to Participate in Research:

To voluntarily agree to take part in this study, you do not have to sign and return the form. If you choose to allow your child to take part in this study, you child may withdraw at any time. You are not giving up any of your legal rights by not signing this form.

However, if you chose to not allow your child to participate, you must sign and return the form. Your signature below indicates that you have read or had read this entire consent form, including the risks and benefits, and have had all of your questions answered.

Parental/Guardian Refusal to Consent:

_____

Printed Name of Parent/Guardian

_____ _____

Signature of Parent/Guardian Date

Principal Investigator (or Designee)

I have given this research subject information on the study that is accurate and sufficient for the subject to fully understand the nature, risks and benefits of the study.

_____ _____

Printed Name of Person Obtaining Consent Study Role

_____ _____

Signature of Person Obtaining Consent Date

Appendix H

Pilot Questionnaires

Scale #1

Directions: Indicate that answer choice that most closely represent you by using the following scales:

1. Ethnicity:

(A) White/Caucasian (B) Asian/Pacific Islander (C) Black/African American (D) Latino/a (E) Other

2. Gender:

(A) male (B) female (C) other

3. Age:

(A) 14 (B) 15 (C) 16 (D) 17 (E) 18 or older

4. Grade Level:

(A) 9^{th} (B) 10^{th} (C) 11^{th} (D) 12^{th}

5. Type of neighborhood, where you live

(A) inner-city (B) suburb (C) rural (D) other

6. Family income level:

(A) not enough money (B) just enough money, but struggle sometimes (C) enough money (D) a lot of money (E) do not know

Scale #2

Directions: Think about how you have felt over the past 3 weeks, indicate the degree to which you agree or disagree with each statement below by using the following scale:

- A=Strongly Disagree (SD)
- B=Mildly Disagree (MD)
- C=Agree and Disagree equally (A/D)
- D=Mildly Agree (MA)
- E=Strongly Agree (SA)

	SD	MD	A/D	MA	SA
7. I often feel mad.	A	B	C	D	E
8. My parents think I get angry a lot.	A	B	C	D	E
9. Among my friends, I get angrier than others.	A	B	C	D	E
10. I wish I got mad less often.	A	B	C	D	E
11. I feel happy most of the time.	A	B	C	D	E
12. I have angry thoughts when I am with friends.	A	B	C	D	E
13. I yell at others a lot.	A	B	C	D	E
14. It is very easy for me to get frustrated.	A	B	C	D	E
15. People always make me angry.	A	B	C	D	E
16. It is hard for me to find a place to go when I am mad.	A	B	C	D	E
17. I have people I can share my mad feelings with.	A	B	C	D	E
18. When I talk to someone about my angry feelings, I feel safe.	A	B	C	D	E
19. I feel like I have no support when I am mad.	A	B	C	D	E
20. I have a person I can talk to when I get angry.	A	B	C	D	E

	SD	MD	A/D	MA	SA
21. I have someone who listens to me when I get frustrated.	A	B	C	D	E
22. I hold grudges.	A	B	C	D	E
23. I forgive whenever I can.	A	B	C	D	E
24. When someone says they are sorry, I am likely to remain mad.	A	B	C	D	E
25. Some things you just cannot forgive.	A	B	C	D	E
26. My friends have hurt me in the past, but I have forgiven them.	A	B	C	D	E
27. It is hard for me to let hurtful things go.	A	B	C	D	E
28. When someone hurts me, I often remind them of what they did.	A	B	C	D	E
29. My parents think I stay angry at others for a long time.	A	B	C	D	E
30. When someone hurts me, I have to get even.	A	B	C	D	E

Scale #3

Directions: Think about how you have felt over the past 3 weeks, indicate the degree to which you agree or disagree with each statement below by using the following scale:

	SD	MD	A/D	MA	SA
31. My teachers think I get mad a lot.	A	B	C	D	E
32. I have angry thoughts at home.	A	B	C	D	E
33. I hit/destroy things when I get frustrated.	A	B	C	D	E
34. I have angry thoughts when I am at school.	A	B	C	D	E
35. People often say that I am mean to others.	A	B	C	D	E
36. It is difficult for me to overlook other people's mistakes.	A	B	C	D	E
37. Other people think I tend to overreact.	A	B	C	D	E
38. I feel like I am about to explode from all the anger inside me.	A	B	C	D	E
39. It takes a lot to get me upset.	A	B	C	D	E
40. It is easy for me to share my angry feelings with others.	A	B	C	D	E
41. I have someone who understands me when I get mad.	A	B	C	D	E
42. No one allows me to be angry.	A	B	C	D	E
43 .I wish I had someone to talk to about my frustrations.	A	B	C	D	E
44. I am able to hold in my anger in the moment because I can talk about them later.	A	B	C	D	E
45. No one ever asks me about my angry feelings.	A	B	C	D	E

	SD	MD	A/D	MA	SA
46. When someone hurts me, I keep track of how many times they have hurt me.	A	B	C	D	E
47. When someone does something hurtful to me, memories of the hurt surface.	A	B	C	D	E
48. When I encounter someone that has hurt me in the past, I feel a lot of anger.	A	B	C	D	E
49. When bad things happen to people who have hurt me, I get happy.	A	B	C	D	E
50. Others tell me to forgive, but I think they are wrong.	A	B	C	D	E
51. You are supposed to forgive, but it is not a smart thing to do.	A	B	C	D	E
52. Even after someone says they are sorry, I talk about what they did to me.	A	B	C	D	E
53. I feel better when I forgive.	A	B	C	D	E
54. When someone is forgiven, they are more likely to forgive others.	A	B	C	D	E

Appendix I

Main Study Questionnaires

Scale #1

Directions: Indicate that answer choice that most closely represent you by using the following scales:

1. Ethnicity:

(A) White/Caucasian (B) Asian/Pacific Islander (C) Black/African American (D) Latino/a (E) Other

2. Gender:

(A) male(B) female (C) other

3. Age:

(A) 14 (B) 15 (C) 16 (D) 17 (E) 18 or older

4. Grade Level:

(A) 9^{th} (B) 10^{th} (C) 11^{th} (D) 12^{th}

5. Type of neighborhood, where you live

(A) inner-city (B) suburb (C) rural (D) other

6. Family income level:

(A) not enough money (B) just enough money, but struggle sometimes (C) enough money

(D) a lot of money (E) do not know

Scale #2

Directions: Think about how you have felt over the past 3 weeks, indicate the degree to which you agree or disagree with each statement below by using the following scale:

- A=Strongly Disagree (SD)
- B=Mildly Disagree (MD)
- C=Agree and Disagree equally (A/D)
- D=Mildly Agree (MA)
- E=Strongly Agree (SA)

	SD	MD	A/D	MA	SA
7. I often feel mad.	A	B	C	D	E
8. My parents think I get angry a lot.	A	B	C	D	E
9. Among my friends, I get angrier than others.	A	B	C	D	E
10. I yell at others a lot.	A	B	C	D	E
11. It is very easy for me to get frustrated.	A	B	C	D	E
12. People always make me angry.	A	B	C	D	E
13. I have angry thoughts at home.	A	B	C	D	E
14. I have people I can share my mad feelings with.	A	B	C	D	E
15. When I talk to someone about my angry feelings, I feel safe.	A	B	C	D	E
16. I have a person I can talk to when I get angry.	A	B	C	D	E
17. I hold grudges.	A	B	C	D	E
18. Some things you just cannot forgive.	A	B	C	D	E
19. It is hard for me to let hurtful things go.	A	B	C	D	E
20. When someone hurts me, I often remind them of what they did.	A	B	C	D	E
21. My parents think I stay angry at others for a long time.	A	B	C	D	E

Scale #3

Directions: Think about how you have felt over the past 3 weeks, indicate the degree to which you agree or disagree with each statement below by using the following scale:

- A=Strongly Disagree (SD)
- B=Mildly Disagree (MD)
- C=Agree and Disagree equally (A/D)
- D=Mildly Agree (MA)
- E=Strongly Agree (SA)
-

	SD	MD	A/D	MA	SA
22. I hit/destroy things when I get frustrated.	A	B	C	D	E
23. I have angry thoughts when I am at school.	A	B	C	D	E
24. People often say that I am mean to others.	A	B	C	D	E
25. It is difficult for me to overlook other people's mistakes.	A	B	C	D	E
26. Other people think I tend to overreact.	A	B	C	D	E
27. I feel like I am about to explode from all the anger inside me.	A	B	C	D	E
28. I have someone who listens to me when I get frustrated.	A	B	C	D	E
29. It is easy for me to share my angry feelings with others.	A	B	C	D	E
30. I have someone who understands me when I get mad.	A	B	C	D	E
31. When someone hurts me, I have to get even.	A	B	C	D	E
32. When someone hurts me, I keep track of how many times they have hurt me.	A	B	C	D	E
33. When someone does something hurtful to me, memories of the hurt surface.	A	B	C	D	E
34. When bad things happen to people who have hurt me, I get happy.	A	B	C	D	E
35. Even after someone says they are sorry, I talk about what they did to me.	A	B	C	D	E

Scale #4

Below are a number of statements which children and adults sometimes use to describe themselves. Read each statement and circle the number that describes you best, or shows how you **usually** feel using the following scale:

- A=Almost Never (Never)
- B=Sometimes (Some)
- C=Often
- D=Almost Always (AA)

	Never	Some	Often	AA
36. I feel angry	A	B	C	D
37. I feel like yelling at someone	A	B	C	D
38. I get very impatient if I have to wait for something	A	B	C	D
39. I lose my temper easily	A	B	C	D
40. I feel like breaking things	A	B	C	D
41. I feel grouchy or irritable	A	B	C	D
42. I get in a bad mood when things don't go my way	A	B	C	D
43. I have a bad temper	A	B	C	D
44. I get very angry if my parent or teacher criticizes me	A	B	C	D
45. I get in a bad mood easily	A	B	C	D

Everyone feels angry from time to time, but people differ in how they act when they are angry. Below are some statements that people use to describe themselves and how they act **when they feel angry**. Read each statement carefully, and decide how often the statement applies to you **when you feel angry**:

	Never	Some	Often	AA
46. I slam door or stomp my feet	A	B	C	D
47. I keep it to myself	A	B	C	D
48. I control my temper	A	B	C	D
49. I let everybody know it	A	B	C	D
50. I try to be patient	A	B	C	D
51. I argue of fight back	A	B	C	D
52. I keep my cool	A	B	C	D
53. I hit things or people	A	B	C	D
54. I feel it inside, but I don't show it	A	B	C	D

55. I stay well behaved	A	B	C	D
56. I say mean or nasty things	A	B	C	D
57. I stay mad at people but keep it secret	A	B	C	D
58. I try to stay calm and settle the problem	A	B	C	D
59. I have a temper tantrum	A	B	C	D
60. I hold my anger in	A	B	C	D
61. I try to control my angry feelings	A	B	C	D

Scale #5

Directions: Indicate the degree to which you agree or disagree with each statement below by using the following scale:

- A=Strongly Disagree (SD)
- B=Mildly Disagree (MD)
- C=Agree and Disagree equally (A/D)
- D=Mildly Agree (MA)
- E=Strongly Agree (SA)

	SD	MD	A/D	MA	SA
62. People close to me probably think I hold a grudge too long.	A	B	C	D	E
63. I can forgive a friend for almost anything.	A	B	C	D	E
64. If someone treats me badly, I treat him or her the same.	A	B	C	D	E
65. I try to forgive others even when they don't feel guilty for what they did.	A	B	C	D	E
66. I can usually forgive and forget an insult.	A	B	C	D	E
67. I feel bitter about many of my relationships.	A	B	C	D	E
68. Even after I forgive someone, things often come back to me that I resent.	A	B	C	D	E
69. There are some things for which I could never forgive even a loved one.	A	B	C	D	E
70. I have always forgiven those who have hurt me.	A	B	C	D	E
71. I am a forgiving person.	A	B	C	D	E

Scale #6

Directions: Below is a list of the ways you might have felt or acted in the *past week*. Indicate the degree to which how *much* you have felt this way during the *past week* using the following scale:

- A=Not at All (Not)
- B=A Little (Little)
- C=Some
- D=A Lot

	Not	Little	Some	Alot
72. I was bothered by things that usually don't bother me.	A	B	C	D
73. I did not feel like eating, I wasn't very hungry.	A	B	C	D
74. I wasn't able to feel happy, even when my family or friends tried to help me feel better.	A	B	C	D
75. I felt like I was just as good as other kids.	A	B	C	D
76. I felt like I couldn't pay attention to what I was doing.	A	B	C	D

DURING THE PAST WEEK	Not	Little	Some	Alot
77. I felt down and unhappy.	A	B	C	D
78. I felt like I was too tired to do things.	A	B	C	D
79. I felt like something good was going to happen.	A	B	C	D
80. I felt like things I did before didn't work out right.	A	B	C	D
81. I felt scared.	A	B	C	D

DURING THE PAST WEEK	Not	Little	Some	Alot
82. I didn't sleep as well as I usually sleep.	A	B	C	D
83. I was happy.	A	B	C	D
84. I was more quiet than usual.	A	B	C	D
85. I felt lonely, like I didn't have any friends.	A	B	C	D
86. I felt like kids I know were not friendly or that they didn't want to be with me.	A	B	C	D

DURING THE PAST WEEK	Not	Little	Some	Alot
87. I had a good time.	A	B	C	D
88. I felt like crying.	A	B	C	D
89. I felt sad.	A	B	C	D
90. I felt people didn't like me.	A	B	C	D
91. It was hard to get started doing things.	A	B	C	D

Appendix J

Demographic Questionnaire

1. Ethnicity:

(A) White/Caucasian (B) Asian/Pacific Islander (C) Black/African American (D) Latino/a (E) Other

2. Gender:

(A) male(B) female (C) other

3. Age:

(A) 14 (B) 15 (C) 16 (D) 17 I 18 or older

4. Grade Level:

(A) 9^{th} (B) 10^{th} (C) 11^{th} (D) 12^{th}

5. Type of neighborhood, where you live

(A) inner-city (B) suburb (C) rural (D) other

6. Family income level:

(A) not enough money (B) just enough money, but struggle sometimes (C) enough money

(D) a lot of money I do not know

Appendix K

The Anger Expression Scale for Children

Below are a number of statements which children and adults sometimes use to describe themselves. Read each statement and circle the number that describes you best, or shows how you **usually** feel using the following scale:

- A=Almost Never (Never)
- B=Sometimes (Some)
- C=Often
- D=Almost Always (AA)

	Never	Some	Often	AA
1. I feel angry	A	B	C	D
2. I feel like yelling at someone	A	B	C	D
3. I get very impatient if I have to wait for something	A	B	C	D
4. I lose my temper easily	A	B	C	D
5. I feel like breaking things	A	B	C	D
6. I feel grouchy or irritable	A	B	C	D
7. I get in a bad mood when things don't go my way	A	B	C	D
8. I have a bad temper	A	B	C	D
9. I get very angry if my parent or teacher criticizes me	A	B	C	D
10. I get in a bad mood easily	A	B	C	D

Everyone feels angry from time to time, but people differ in how they act when they are angry. Below are some statements that people use to describe themselves and how they act **when they feel angry**. Read each statement carefully, and decide how often the statement applies to you **when you feel angry**:

	Never	Some	Often	AA
11. I slam door or stomp my feet	A	B	C	D
12. I keep it to myself	A	B	C	D
13. I control my temper	A	B	C	D
14. I let everybody know it	A	B	C	D
15. I try to be patient	A	B	C	D
16. I argue of fight back	A	B	C	D
17. I keep my cool	A	B	C	D

18. I hit things or people	A	B	C	D
19. I feel it inside, but I don't show it	A	B	C	D
20. I stay well behaved	A	B	C	D
21. I say mean or nasty things	A	B	C	D
22. I stay mad at people but keep it secret	A	B	C	D
23. I try to stay calm and settle the problem	A	B	C	D
24. I have a temper tantrum	A	B	C	D
25. I hold my anger in	A	B	C	D
26. I try to control my angry feelings	A	B	C	D

Appendix L

Tendency to Forgive Scale

Directions: Indicate the degree to which you agree or disagree with each statement below by using the following scale:

- A=Strongly Disagree (SD)
- B=Mildly Disagree (MD)
- C=Agree and Disagree equally (A/D)
- D=Mildly Agree (MA)
- E=Strongly Agree (SA)

	SD	MD	A/D	MA	SA
1. People close to me probably think I hold a grudge too long.	A	B	C	D	E
2. I can forgive a friend for almost anything.	A	B	C	D	E
3. If someone treats me badly, I treat him or her the same.	A	B	C	D	E
4. I try to forgive others even when they don't feel guilty for what they did.	A	B	C	D	E
5. I can usually forgive and forget an insult.	A	B	C	D	E
6. I feel bitter about many of my relationships.	A	B	C	D	E
7. Even after I forgive someone, things often come back to me that I resent.	A	B	C	D	E
8. There are some things for which I could never forgive even a loved one.	A	B	C	D	E
9. I have always forgiven those who have hurt me.	A	B	C	D	E
10. I am a forgiving person.	A	B	C	D	E

Appendix M

Center for Epidemiological Studies Depression Scale

Directions: Below is a list of the ways you might have felt or acted in the *past week*. Indicate the degree to which how *much* you have felt this way during the *past week* using the following scale:

- A=Not at All (Not)
- B=A Little (Little)
- C=Some
- D=A Lot

	Not	**Little**	**Some**	**Alot**
1. I was bothered by things that usually don't bother me.	A	B	C	D
2. I did not feel like eating, I wasn't very hungry.	A	B	C	D
3. I wasn't able to feel happy, even when my family or friends tried to help me feel better.	A	B	C	D
4. I felt like I was just as good as other kids.	A	B	C	D
5. I felt like I couldn't pay attention to what I was doing.	A	B	C	D

DURING THE PAST WEEK	**Not**	**Little**	**Some**	**Alot**
6. I felt down and unhappy.	A	B	C	D
7. I felt like I was too tired to do things.	A	B	C	D
8. I felt like something good was going to happen.	A	B	C	D
9. I felt like things I did before didn't work out right.	A	B	C	D
10. I felt scared.	A	B	C	D

DURING THE PAST WEEK	**Not**	**Little**	**Some**	**Alot**
11. I didn't sleep as well as I usually sleep.	A	B	C	D
12. I was happy.	A	B	C	D
13. I was more quiet than usual.	A	B	C	D
14. I felt lonely, like I didn't have any friends.	A	B	C	D
15. I felt like kids I know were not friendly or that they didn't want to be with me.	A	B	C	D

DURING THE PAST WEEK	Not	Little	Some	Alot
16. I had a good time.	A	B	C	D
17. I felt like crying.	A	B	C	D
18. I felt sad.	A	B	C	D
19. I felt people didn't like me.	A	B	C	D
20. It was hard to get started doing things.	A	B	C	D

CURRICULUM VITEA

Jaquaye L. Russell

Place of birth: Milwaukee, WI

Education

B.A., University of Wisconsin-Madison, May 2001
Major: Legal Studies

M.S., University of Wisconsin-Milwaukee, May 2008
Major: Educational Psychology, School Counseling

Ph.D., University of Wisconsin-Milwaukee, May 2013
Major: Educational Psychology, Counseling Psychology

Dissertation Title: Instrument Development: Youth Anger, Youth Forgiveness, and Youth Support

Awards/Honors

Advanced Opportunity Program Fellowship - UW- Milwaukee 2008- 2011

Clinical Experience

Lakeview Specialty Hospital and Rehabilitation August 2012-present
Psychology Pre-Doctoral Intern
Supervisor: Patricia Stanik, PhD
Provide psychological services to residents of the NeuroRehabilitation Center and Lakeview School which include intake assessments, individual, group, and family therapy, psychological assessments, and behavioral and treatment planning . The NeuroRehabilitation Center provides a continuum of post-acute care for individuals with neurobehavioral challenges with the adult population. The Lakeview School is a year-round residential and day program that provides services for children who experience significant behavioral and emotional difficulties secondary to neurologic and developmental conditions. Provide risk assessment, crisis intervention, and consultation with a multi-disciplinary staff including teachers, social workers, behavioral specialist and psychiatrists. Supervise education and residential staff and provide feedback on the application of clinical skills with residents.

St Rose Youth and Family Center September 2010-May 2011
Advanced Doctoral Practicum Student
Supervisor: Stephen Wester, Ph.D.
Assessed adolescent females in the areas of disruptive behavior disorders, depression, personality concerns, anxiety, and self-harm by giving a full psychological assessment battery. Administered WISC-IV, KBIT-II, Achenbach semi-structured clinical interview, MMPI-A, Rorschach, and trauma-related symptoms inventories. Completed integrative reports that included treatment recommendations for each assessed adolescent.

Children's Hospital of Wisconsin September 2009-May 2010
Doctoral Practicum Student
Supervisor: Andrea Begotka, Ph.D.
Worked with client's primary care doctor and other medical specialist to offer ongoing care in the Feeding, Swallowing and Nutrition Center in outpatient and inpatient programs and individual therapy in the general psychiatry clinic. Counseled a caseload of 5-8 clients weekly for primarily feeding and swallowing disorders and anxiety (panic disorder, GAD), depression, trauma, adjustment to an illness or life circumstance problem, and ADHD. Trained in utilizing behavior therapy and contingency management interventions. Provided family co-therapy for families of the children admitted to the inpatient treatment program.

Isaac Coggs Heritage Health Center September 2008-May 2009
Doctoral Practicum Student
Supervisor: Yvonne Bell-Gooden, Ph.D.
Counseled a caseload of 8-10 clients weekly for anxiety (panic disorder, GAD), depression, trauma, disruptive behavioral disorder, substance abuse, and ADHD. Co-facilitated therapy group for females with HIV/AIDS on issues of anger, forgiveness, coping, communication, and safety. Trained in utilizing behavior therapy, contingency management interventions, utilizing play therapy techniques, art therapy techniques, and parent-child interaction therapy.

Publications/Presentations
Baskin, T.W., Slaten, C.D., Sorenson, C., & Glover-Russell, J.L. (2010). Does youth psychotherapy provide academically related outcomes? A meta-analysis. *Journal of Counseling Psychology, 57,* 290-296.

Slaten, C.D., Sorenson, C., Glover, J.L., & Baskin, T.W. (2009, August). *Meta-Analysis of Youth Mental Health and Academic Outcomes*. Poster session presented at the American Psychological Association Conference, Toronto, CA.

Slaten, C.D., Sorenson, C., Glover, J.L., & Baskin, T.W. (2008, March). *Counseling Outcomes: Linking Mental Health and Academic Achievement.* Poster session presented at the International Counseling Psychology Conference, Chicago, IL.

Teaching Experience
Cardinal Stritch University
Department of Clinical Psychology
Associate Lecturer Spring 2012 & Spring 2013
Psychology 555: Theories and Techniques of Group Psychotherapy and Counseling
Instructed a 3-credit master's level course that focused on different group therapeutic strategies using classroom theory and laboratory learning experiences. Group therapy, family therapy, couples therapy, mental health consultation and education, and community psychology were covered with a focus on the development of a fundamental appreciation for the current state of research on group psychotherapy practice and

outcomes group with a focus on teaching empirically-support treatments (cognitive-behavioral therapy) utilizing didactic, in-class experiential, and assessment techniques for various disorders. The course also provided training on specific cognitive-behavioral protocols for various disorders, and also protocols on comorbidity, including other anxiety disorders and mood disorders.

Carroll University
Department of Psychology
Lecturer Summer & Winter 2012
Psychology 260: Health Psychology
Instructed a four-credit, undergraduate course based on the research of clinical, experimental social and health psychologists; this course examined how psychological, social, and biological factors affect health and illness. Topics included coping with stress and pain, psychoneuroimmunology, and living with chronic illness, such as diabetes, cardiovascular disease, or cancer. Emphasis was also placed on effective patient-clinician communication and on the modification of health-related behaviors. Constructed syllabi, lectures, exams, and assignments and utilized technology to post lectures and assignments as well as PowerPoint presentations for lectures.

University of Wisconsin-Milwaukee
Department of Educational Psychology
Associate Lecturer Fall 2011 & Spring 2012
Counseling 775: Supervised Practicum 1 in Community Counseling
Instructed a 3-credit master's level and provided lecture and out of class individual consultation for students. Curriculum focused on skill development. These skills included: working within a therapeutic alliance with a variety of clients from a variety of backgrounds, dealing with any number of issues; assessment, conceptualization, and intervention strategies; fully understanding and begin to integrate, the American Counseling Association Code of Ethics with regards to theory, research, and practice; and professional identity formation as a counselor.

University of Wisconsin-Milwaukee
Department of Educational Psychology
Associate Lecturer Spring 2011 & Fall 2011
Counseling 704: Multicultural Mental Health Guidelines and Ethics Overview
Instructed a 3-credit master's level course in an on-line format facilitating on-line discussions, drop box submissions, electronic feedback on papers/exams and posting of course readings and materials using Desire 2 Learn software (D2L). Adapted curriculum to meet varying student needs, interests, learning styles and special needs. Curriculum focused on introducing students to basic concepts in multicultural psychology and how they interact to shape the individual. Concepts such as oppression, power and privilege, social class, ethnic identity development, gender role socialization, discrimination, microaggressions, acculturation/assimilation, racism, ageism, ableism, and their manifestations were presented. Particular attention was given to how many of these factors influence worldview, contribute to marginalization, as well as to disparities in education, work and health.

Carroll University
Department of Psychology
Lecturer Fall 2010
Psychology 101: Introduction to Psychology
Taught undergraduate courses in psychology that met bi-weekly for the semester which fostered academic writing, critical thinking, oral communication, and understanding contemporary relevance. Constructed syllabi, lectures, exams, and assignments and utilized technology to post lectures and assignments as well as powerpoint presentations for lectures.

Professional Affiliations
American Psychological Association, *graduate affiliate*
Division 17 Society of Counseling Psychology
University of Wisconsin-Milwaukee Counseling Psychology Student Association
University of Wisconsin-Milwaukee Multicultural Graduate Student Alliance