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# The Angry Black Woman: The Impact of Pejorative Stereotypes on Psychotherapy with Black Women

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In the aftermath of slavery and the resulting social, economic, and political effects, Black women have become the victims of negative stereotyping in mainstream American culture. Such stereotypes include the myth of the angry Black woman that characterizes these women as aggressive, ill tempered, illogical, overbearing, hostile, and ignorant without provocation. Symptoms presented by Black women during mental health treatment may reinforce this myth. However, many of the negative characteristics of the angry Black woman developed in response to external stressors and historical factors. Black women also have a unique experience with and expressions of anger that shape the presenting symptoms interpreted by the mental health clinician. This myth and corresponding negative stereotypes significantly affect Black women intrapsychically, interpersonally, and are likely to influence the efficacy of mental health treatment. Understanding and treatment of Black women in a mental health context should be influenced by the cultural norms and sociopolitical dynamics affecting these clients. Successful mental health treatment requires cultural competence and clinicians who are well prepared to navigate the inherent complexities of culture with clients. Awareness of the angry Black woman mythology, including its genesis, manifestations, and the unique experiences of Black women, may raise the standards of cultural competence for clinicians and provide more successful treatment outcomes in working with this population. A case example illustrates the assiduity essential to practicing in a culturally competent manner. A client is presented from a traditional psychotherapeutic perspective and then viewed through a lens that integrates psychotherapeutic practice with conscious awareness of the mythology and stereotypes impacting Black women. Implications for culturally relevant practice are discussed.

*Keywords:* Black women, stereotypes, anger, psychotherapy, cultural competence

## INTRODUCTION

Although slavery as a formal institution ended almost a 150 years ago, ethnic minorities continue to face a social and economic environment of inequality that invariably takes a toll on mental health. Many minorities present in health and mental health settings with medical concerns and comorbid depression (Primm et al., 2009). Further, people of color are underrepresented in research, less likely to receive mental health treatment, and when they do obtain such treatment, they receive poorer quality of care (Primm et al., 2009). Despite the inequities that perpetuate a climate of disparity for Black Americans, the field of psychotherapy continues to blame Black clients for

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their lack of treatment success rather than view them through the context of their environment. Researchers and clinicians have at times considered Black clients to be poor candidates for therapy due to lack of insight, poor impulse control, paranoia, lack of verbal expression, and insufficient psychological mindedness (Nayman, 1983; Primm et al., 2009; West, 1995).

Race is present in psychotherapy in ways that parallel its insidiousness in society (Liggin & Kay, 1999). Culture influences mental health treatment in many ways, including identification and manifestation of symptoms, verbal and nonverbal communication, help-seeking behavior, stigma, and shame associated with illness or treatment. These cultural factors also influence the client's attitudes, adherence, and response to treatment. According to Wilson (2001), Black men and women share the common experience of inadequate mental health service delivery but have disparate experiences due to gender stereotyping. Research affirms that race and gender-specific stereotypes have implications for diagnosis, treatment, and therapeutic outcomes for Blacks and women (American Psychological Association, 1985; Jackson, 1983; West, 1995). Mental health practitioners are also vulnerable to the impact of stereotypes. Because media and popular culture perpetuates stereotypes in ways that foster the notion that these myths are accurate representations of certain groups, these stereotypes are likely to influence the professional's perception of their clients (Edwards, 1993; Sims-Wood, 1988; West, 1995).

The "angry Black woman" mythology presumes all Black women to be irate, irrational, hostile, and negative despite the circumstances. The stereotype is well known in informal settings but has a lack of representation in professional literature. Angry Black women are typically described as aggressive, unfeminine, undesirable, overbearing, attitudinal, bitter, mean, and hell raising (Malveaux, 1989; Morgan & Bennett, 2006). Black women described as tart tongued, neck rolling, and loud mouthed are archetypes perpetuated in the media (Jones, 2004). Chapman (2001) further identifies several "attitudes" held by Black women, including rage, control, desperation, materialism, shame, and cynicism that reinforce the stereotype. The angry Black woman stereotype is pervasive and parasitic; it affects Black women's self-esteem and how they are viewed by others (Morgan & Bennett, 2006).

The development of symptoms and behaviors such as anger, hostility, and/or aggression are often attributable to an array of underlying cultural and historical factors which may serve as a trap for the unwary mental health clinician who is not prepared to navigate through these dynamics of culture. Black women fearing the label of *Angry Black Woman* may suppress disclosures of anger and minimize its impact in their lives. Clients are then affected on multiple levels: feeling unsafe and unprotected as a result of oppression and stereotyping, having anxiety linked with feelings associated with the stereotypes, and anticipating anxiety associated with projections of future stereotyping (Gregory, 2010). As a result, clients may feel unsafe in the treatment environment and left with feelings of helplessness, hopelessness, and self-hate. Clinicians unaware of the potency of the angry Black woman mythology may miss or misinterpret data, symptoms, and observations of Black women; as a result, assessment, diagnostic formulation, and treatment for this population may be compromised. Nayman (1983) suggests that the consequence may be misdiagnosis, inappropriate service delivery, and premature termination of treatment (p. 33).

## SURVIVAL MECHANISMS

Many characteristics of the angry Black woman stereotype, including hostility, rage, aggressiveness, and bitterness may be reflective of survival skills developed by Black women in the face of social, economic, and political oppression. This trifecta of oppression is all encompassing and creates a pervasive environment of injustice. A climate of constant danger or threat can significantly affect neural arousal and subsequent processing (Siegel, 1999). Anger originates in the amygdala, within the limbic system of the brain. A primary function of the amygdala is to

coordinate information received from the senses with memory; sensory input is then appraised in accordance with memory and past experience, often resulting in an emotional response (Drubach, 2000). The amygdala is particularly responsive to social interaction (Siegel, 1999). Certain stimuli can become associated in memory with a threat or feeling of danger. McRae (2003) indicates that women of color experience racism on an almost daily basis, therefore, racism constitutes a consistent social stressor for Black women. Institutional racism in particular, expressed through prejudicial attitudes and discriminatory behavior, provides the most debilitating impact on all facets of a Black woman's life (Nayman, 1983). Racism, discrimination, and oppression stimulate intense feelings regarding issues of power, authority, and privilege and signify a threat to safety, equality, and well-being. Within this paradigm, the association of racism as a constant stressor with fears of danger, lack of acceptance, or shame may result in hyperarousal of Black women, eliciting a fight response that may be perceived as anger or aggression. Further, social injustice may activate survival behaviors that reinforce the angry Black woman stereotype.

According to Bilodeau (1992), the most basic function of anger is survival. Bilodeau also describes anger as the emotion that provides the incentive and strength to struggle against the elements. Black women have a long history of anger being synonymous with strength in inciting social change. Women such as Harriet Tubman, Sojourner Truth, Ida B. Wells, and Rosa Parks channeled their anger about social injustice into justified and organized activism (Malveaux, 1989). In addition, anger defines social behavior and protects societal values by determining when an angry response is warranted and how it should be expressed (Bilodeau, 1992). However, there is societal incongruence when anger has positive connotations within the Black community related to strength and survival but is perceived as aggressive and frightening by the dominant culture. The implications of this perspective are prodigious when the dominant culture defines social norms and may benefit from oppression. Oppression, discrimination, and social inequality contribute to a façade that negatively categorizes culturally sanctioned, appropriately assertive responses as a violation of norms.

### INSURMOUNTABLE HISTORICAL STANDARDS

Historically, society has set social standards regarding the expectations for appropriate gender-specific behavior. In the 19th century, White patriarchy posited the criterion that womanhood and femininity included characteristics of virtue (sexual purity), domesticity, piety, and religious faithfulness (Higginbotham, 1993). Black women were enslaved and sexually brutalized. As a result, they were excluded from the standard of virtue. The physically exhausting and labor-intensive nature of slavery also excluded Black women from meeting the prevailing standards of domesticity. Piety and religious faithfulness were the only standards of womanhood that Black women were able to fulfill (Morgan & Bennett, 2006). Additionally, slavery inherently ascribed Black women the roles of caretakers and strong workers, reflecting responsibility in response to survival needs (McRae, 2003). Thus, the "good" Black woman is characterized by religious faithfulness, strength, and impassivity. Nelson (1997) describes this archetypical pious Black woman as stoic, all-suffering, discrete, silent, invisible, and socially graceful. In this context, Black women who express anger or discontent are unattractive, unladylike, and unacceptable (Nelson, 1997). Lerner (1997) adds that the direct expression of anger makes women unfeminine, unmaternal, sexually unattractive, and unlovable and condemns them as shrews, witches, hags, man haters, and castrators.

These insurmountable historical standards for femininity juxtaposed with the atrocities of slavery, racism, and discrimination present a conundrum for Black women who desire authenticity or acceptance. Black women who exhibit anger as a result of social injustice may be responding assertively and authentically but are perceived as unfeminine and unacceptable. Black women

who remain silent may obtain acceptance for their stoicism, but if they are internally incongruent, their self-worth is negatively affected. As a result, archetypical polarities are created between the angry Black woman and the stoic, nurturing, silent Black woman. According to A. J. Thomas et al. (2004), these polarities are often stereotyped as “Sapphire” and “Mammy.” These authors used a Stereotypical Roles for Black Women Scale (SRBWS) to study how the four common stereotypes of Black women (Jezebel, Sapphire, Mammy, and Superwoman) affect their self-esteem and internalization of stereotypes. Their research indicated a correlation between low self-esteem of Black women and internalization of the stereotypes of Mammy and Sapphire (Thomas et al., 2004). The Sapphire syndrome characterizes Black women as brutish, domineering, matriarchal, and castrating and serves to degrade the dignity and inherent value of Black women (Nayman, 1983). Sapphire appears to be a precursor to the angry Black woman and contributes to pervasive denigrating and pejorative stereotypes of Black females. A paucity of research and professional literature exists regarding the impact of these stereotypes on psychotherapy and mental health treatment. However, West (1995) indicates that psychosomatic conditions, depression, hypertension, and low self-esteem can develop when anger is unexpressed or internalized.

### EXPERIENCE AND EXPRESSION OF ANGER

Anger is a universal emotion (Gentry, 2007). However, the expression and communication of emotions is influenced by gender and cultural norms (Cox et al., 2004). When compared with Whites, African Americans have been found to experience higher psychological distress and more negative emotions in daily life (Mabry & Kiecolt, 2005; Mirowsky & Ross, 2003; Vega & Rumbaut, 1991). Additionally, African Americans as a group continue to experience racial discrimination and remain at a socioeconomic disadvantage (Mabry & Kiecolt, 2005; Mirowsky & Ross, 2003; Taylor & Turner, 2002; Thomas & Gonzalez-Prendes, 2009). For Black women, powerlessness may contribute to the experience and expression of anger. According to Thomas and Gonzalez-Prendes (2009), Black women are at a higher risk of internalizing powerlessness due to racial and gender oppression as well as limited or denied access to resources. These authors affirm that powerlessness is an internal experience as well as an external reality that may be cultivated in gender-role socialization that creates an unreasonable cultural expectation of strength for Black women. Thus, when there is an expectation of strength that is met by the disempowering reality of racism, sexism, and discrimination, Black women may suffer internally (such as health problems, depression, stress), externally (such as impaired relationships), or may internalize the incongruence as an intrapersonal deficit. Liggan and Kay (1999) describe this dynamic as a conflict between racial pride and an underlying self image as inferior or primitive. The result is often negative ethnic identity, characterized as using the majority groups’ standards as a means to judge, accept, or reject oneself (Smith, 1991).

### INTRAPSYCHIC AND INTERPERSONAL IMPACTS

Stereotyping all Black women as angry, despite significant variations in their backgrounds and individual experiences, results in fundamental distortions and misinterpretations of their actual emotional experiences (Morgan & Bennett, 2006, p. 488). The myth of the angry Black woman presumes that certain characteristics are applicable to the character and emotional experiences of Black women and encourages the misinterpretation of their communication styles, emotional expressions, and responses to stress. Morgan and Bennett (2006) identify these stereotypes as a cultural ideology rather than a social or psychological reality, and state that they serve to “silence

and dehumanize Black women by blaming them for experiences of racism and sexism that affect them in personal and political ways” (p. 486).

Further, the myth of the angry Black woman carries significant implications for how Black women are understood, engaged, and treated in a therapeutic context. Nayman (1983) posits that Black women may approach psychotherapy with some degree of apprehension due to historic underutilization of mental health services by minorities and related fundamental suspicions about the efficacy and motives of therapy and relevance to their lives. The author further asserts that this apprehension may manifest in treatment as either aggressiveness or exaggerated unassertiveness reflective of a reluctance to confront or acknowledge anger, both influenced by the Sapphire syndrome and hindering the capacity for spontaneous expression of authentic feelings. Although anger can be clarifying and cathartic if utilized effectively, it can also initiate or exacerbate mental health symptoms if it is denied and swallowed in the interests of survival (Williams, 2001). In a therapy setting, being or feeling silenced or dehumanized is counterintuitive to the therapeutic alliance and process, which may result in unsuccessful treatment outcomes.

Successful treatment with Black women must include awareness of the internal and interpersonal impact of destructive stereotypes assiduously integrated with the client’s treatment goal(s). Liggan and Kay (1999) state that it is the acknowledgment of race and racial conflicts that is critical to the success of psychotherapy. These authors assert that existential approaches may allow clinicians to recognize the influence of culture and ethnicity within the fabric of each client’s problems as well as employ strategies to minimize the perception of ethnocentrism or institutionalized racism. West (1995) asserts that optimal treatment with Black women includes encouragement in manifesting and confronting anger as well as development of culturally appropriate assertiveness strategies to increase awareness of the impact of internalized stereotypes on the expression of emotionality. Psychotherapy offers an intimate setting to confront difficult content while addressing interpersonal struggles. Because patients often re-create in therapy the same interpersonal problems that exist in their outside world, focus on the therapeutic relationship in the here-and-now can be a powerful clinical tool to address symptomatology within a cultural and sociopolitical context (Yalom, 1989).

## CASE EXAMPLE

The client was a 35-year-old African American female, who worked as an educational counselor and was enrolled in school to obtain a master’s degree in psychology. She was divorced with two children, a 16-year-old daughter and a 14-year-old son. She reported dating three men concurrently. At intake, she reported severe symptoms of depression, anxiety, and abuse flashbacks. She reported two incidents that were the major source of her flashbacks: sexual abuse by her live-in cousin from age 7 to 12 and sexual harassment at work in which a coworker began to escalate his advances to her, including fondling her at work. The latter incident, exacerbated by her experiencing her work environment as racist and unsupportive, prompted her to take a leave of absence from school and work. This client also reported difficulties with intimate relationships, indicating hypersexual behavior in her sexual relationships with little satiation. She reported dysphoric mood and had blunted affect. She stated that she had several years of ineffective psychotherapy. The client indicated that her primary goals for treatment were (a) to address the impact abuse has had on her life and (b) to explore obstacles to maintaining a healthy, intimate relationship with one person.

A traditional psychotherapeutic lens may identify several presenting problems reported by this client, including depression, anxiety, trauma (sexual abuse and sexual harassment), and relational difficulties. Typical generalized treatment goals may focus on alleviating symptoms of depression and anxiety, and engagement in trauma-focused interventions to combat the sexual and interpersonal symptoms induced by her complex traumas.

However, a perspective that integrates traditional psychotherapeutic practice with cultural competence and the awareness of the impact of the angry Black woman myth and corresponding stereotypes may incorporate additional treatment foci. Specifically, questions, comments, and exploration related to the myth, anger, and its impact on the client's life were presented to the client, including questions that identify and contextualize anger such as:

- What are your thoughts or associations with anger?
- Is there anger associated with the abuse you have experienced?
- What is your experience with feeling and expressing anger?
- Can you recall the last time you were angry?
- When does your anger come up and how does it look?
- Do you have any association with anger as a “good” or “bad” emotion?
- What emotions were acceptable and unacceptable in your primary family of origin?
- What emotions are acceptable or unacceptable to you now?

Questions that explore awareness, experience, and impact of Angry Black Woman mythology and stereotypes such as:

- Are you aware there are stereotypes about Black women being angry?
- What do you think about the angry Black woman stereotypes?

Validating comments such as:

- You have a lot to be angry about.
- I'm sure you have good reasons to be angry.

Interpersonal comments and questions such as:

- Is the therapeutic environment a safe place to be angry?
- How would your anger look if it were to come up here with me?
- What is your experience of and comfort level with these questions?

The questions utilized in this case allowed the client to increase her awareness of the role of anger in her interpersonal relationships and treatment experiences. Questions to identify and contextualize anger as well as thoughts about angry Black women mythology were introduced during the first two sessions. The client identified awareness of the stereotypes associated with Black females and expressed fears of being perceived as an angry Black woman. During the third session, we began to explore the impact of her abuse, which the client identified as a treatment goal. When provided with validation, the client, who was previously blunted in affect, began to cry and openly sobbed for several minutes. She was also able to identify with significant affect that she had been suppressing her anger for “a long time” in an effort to bury her abuse history. She stated that she was fearful of the consequences of discharging her rage. She identified the work harassment incident as the beginning of the realization that she was unable to continue to contain her anger. The client further utilized therapy to explore the role anger had in relationships with her children and intimate partners and develop strategies to express her anger while fostering healthy intimacy.

Although the client presented with relatively specific treatment goals, she was unable to achieve them in previous therapy. She was aware of the stereotypes associated with angry Black women and actively avoided the label by suppressing her anger in her personal life and psychotherapy. Although anger is an appropriate response to trauma, the client internalized her anger

as a characterological defect. Identifying the significance of anger, normalizing her anger as an appropriate response, and providing a safe environment to identify the impact of damaging stereotypes allowed her to effectively integrate her anger into her treatment plan. As a result, goal attainment was achieved within 20 sessions. This client's experience is unique to her history and symptoms; however, confronting social norms and stereotypes surrounding appropriate expression or suppression of anger is often critical to the effective treatment of Black women burdened by the myth and its pejorative associations.

## CONCLUSION

The myth of the angry Black woman results in stereotypes that may be internalized by Black women and are likely to manifest in psychotherapeutic settings. Clinicians unaware of the angry Black woman mythology may misinterpret symptoms and clinical observations of Black women, which may contribute to misdiagnosis and ineffective treatment. In a treatment setting, perception, reception, and communication are topics that require a level of interpersonal safety to explore. Culturally competent treatment may counter the vicissitudes of the intrapsychic and interpersonal impact of the angry Black woman myth by allowing it to be present in the room. As a result, the archaic illusion of color-blind therapy can be ameliorated and the psychological stress of being Black in America can be integrated into the biopsychosocial spiritual narrative of Black female clients. Only then can Black women be safe enough to be angry without fear of being characterized as angry Black women.

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