LITERATURE REVIEW ON

WOMEN'S ANGER AND OTHER EMOTIONS

February 1995
Judy Crump, M.Div.
R.R. #2 Musquodoboit Harbour, Nova Scotia

For
Correctional Service of Canada
Ottawa, Canada

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INTRODUCTION

A comprehensive search of the literature, primarily North American, on women's anger and other emotions has been undertaken in the disciplines of psychology, psychiatry, sociology, criminology, social work and education. Several themes have emerged from this search, not least of which is an understanding of the complexity of this human emotion. Many factors influence the causes, presentation and effects of women's anger. There exist numerous myths, culturally sanctioned and perpetuated in popular literature, with few empirical studies conducted to support these views. Research on anger has largely been conducted by men on male populations with women receiving only cursory attention. Studies have predominately been undertaken in clinical settings with clients who have had serious problems expressing anger appropriately or in university environments with students receiving academic credit for their participation (Schill & Wang, 1990; O'Laughlin & Schill, 1994). Psychologist Harriet Goldhor Lerner, psychiatrist Teresa Bernardez-Bonesatti, and psychologist Carol Tavris were among the first to specifically examine women's anger in the 1970's and early 1980's. The first large scale descriptive study of women's anger conducted with women in their natural settings as they enact social roles was conducted by Thomas et al. in 1993.

POSITIVE FUNCTIONS OF ANGER

While the manifestations of anger can often be problematic, and "for centuries anger was considered a sin, a weakness, or a madness and was to be avoided or contained" (Thomas, 1990), the literature is in agreement that anger can perform a valuable function for women. Anger serves primarily as a messenger (Potter-Efron & Potter-Efron, 1991), providing a clue that something is not right (Lerner, 1985; Potter-Efron & Potter-Efron, 1991; Denham & Bultemeier, 1993). Anger can serve as a teacher (Estés, 1992; Denham & Bultemeier, 1993), imparting the awareness that "all emotion, even rage, carries knowledge, insight, what some call enlightenment" (p. 352). Women, through their anger can learn to identify problems (Lerner, 1990), mobilize their energy to respond to a perceived threat (Person, 1993), and discern how to change, develop and protect themselves (Estés, 1992, Thomas, 1993c). In this sense, anger directed againstocietal or personal injustice is a source of power (Bishop, 1994).

Thomas (1993c) points out that there are situations in which the expression of anger actually promotes health. Women with cancer who express their anger are found to live longer than those who express no anger. Valentis and Devane (1994), in their interviews with women, encountered rage as a survival tool and a grounding technique by which women become centred and reconnected to themselves. As Saylor and Denham (1993) note, "as uncomfortable as anger is for many of us, it can be preferable to anxiety, as it lays the blame outside ourselves" (p. 98).

CONCEPTUAL THEORIES OF EMOTION

Thomas (1990, 1991, 1993b) reviews the theoretical literature on emotion, noting there is little specifically yet written about women's anger that describes sufficiently the particular experience of women. Thomas examines twentieth century theories that continue to be emphasized in contemporary treatment modalities. The dominant theory, interpreted somewhat differently by William James, Sigmund Freud, and C.G. Lange was termed the *hydraulic model* by philosopher Robert Solomon in 1976. The human psyche is viewed as "a caldron of pressures demanding their release in action and expression" (Solomon, quoted in Thomas, 1991, p. 32). Carl Jung modified this notion with the introduction of complexes in the unconscious mind that function like independent personalities to influence action. In challenging the involuntary nature of emotion the hydraulic model demonstrates, Solomon perceived emotions as judgements about past and present situations. Persons respond to injustices acted upon them. Rather than responding out of an instinctual drive, judgements are made by the individual about a perceived violation of a moral or ideal. Maintaining "it is obvious that we make ourselves angry" (Solomon, quoted in Thomas 1993b, p. 25), and emphasizing individual action in creating emotion, Solomon's views reflect the cognitive behavioural theories of emotion becoming popular at the time. Thomas (1990) notes most modern behavioural theorists "emphasize the need to consider cognition on anger formulation" (p. 208).

The hydraulic model of emotion gave rise to the *ventilationist* approach to anger (Thomas 1990; 1991). Maintaining that suppressed anger is unhealthy, theorists encouraged its discharge to promote health. It is noted empirical studies have not supported this belief (Tavris, 1982; Lerner, 1985; Lerner, in Kirmer, 1990; Thomas, 1990; Thomas, 1991). In fact, there is evidence to believe the expression of anger produces

both negative health consequences and increased anger and hostility (Meyer, 1988; Thomas, 1990, 1991; Droppleman & Wilt, 1993). Lerner (1985) maintains that "venting anger may serve to maintain, and even rigidify, the old rules and patterns in a relationship, thus ensuring that change does not occur" (p.4). Crockett (1986) concurs, suggesting venting anger may further incite people to find further rationales for their anger rather than focusing on solutions. In advocating the venting of rage "in containment" (p. 355), Estés (1992) suggests to do otherwise is "like throwing a lighted match onto gasoline" (p. 355).

As Tavris (1982) notes, the ventilation perspective is apparent in contemporary literature, not only among psychologists, but also among the general population as well. Valentis and Devane (1994), drawing from mythology, literature, and film, as well as interviews with women and psychotherapists, in presenting a developmental perspective, trace the genesis of anger to the "seething rage" (p. 18) of the infant at birth. In addition to the rage experienced in the separation from the warmth and security of the mother's womb, are "narcissistic wounds" (p. 20), either actual or perceived injuries experienced that invalidate autonomy and self esteem which form the primary triggers of childhood rage. Linking anger to the experience of trauma in early development, Valentis and Devane contend the rage response becomes buried in the subconscious and "is primed to operate according to these early patterns" (p. 21). In later life a woman's therapeutic task is to "evacuate the site of the primary wound until the hurt is finally acknowledged and released" (p. 21).

In critiquing the hydraulic and ventilationist theories, Thomas (1991) proposes a new model for the conceptualization of women's anger that presently guides research in the Women's Mental Health Research Group at the University of Tennessee at Knoxville. The model includes three categories: *appraisal concepts*, self-perceptions such as perceived stress, values, and self-esteem a woman has that affect such factors as depression or health status, *modifying factors*, sociodemographic characteristics, her propensity to become angry (trait anger, described as a relatively stable personality characteristic), health habits, and role responsibilities that modify her self perception, and *outcome variables* such as depression, anger expression modes, excessive eating or smoking. The model is cyclical, with one factor influencing another. For example, "the burdens of fulfilling multiple role responsibilities influence both perceptions of stress and self esteem and outcome variables like general physical health status or depression" (p. 45). A woman's perceived level of stress becomes a principal factor in

this model, as stress potentially leads to "unhealthy anger expression modes, depressive illness, or other adverse consequences" (p. 44). The model recognizes however, that modifying factors may intervene to effect an outcome that is more beneficial. The model recognizes social context and the diversity of race, economics, and though not explicitly stated, sexual orientation as factors affecting the expression of women's anger, an analysis not apparent in previous theoretical approaches.

A brief explication of contemporary theories of emotion and their relation to anger is outlined below.

1. PSYCHOANALYTIC ORIENTATIONS

Emphasizing hidden, unconscious motivational forces that underlie and influence behaviour, psychoanalytic approaches explore the unconscious to make perceptions available to the client at a conscious level. Approaches are insight oriented, believing if individuals understand their anger they will be able to resolve it.

Psychoanalytic approaches further view emotions "to be drive-related; repression of these powerful drives is deemed unhealthy" (Rapaport, cited in Thomas, 1990, p. 205). Psychological or psychosomatic illness is believed to develop if emotions are not discharged. Thomas quotes a 1987 psychiatric nursing text:

> [T]here is a need for the discharge of the tension. It is possible to suppress the overt expression of anger, but sooner or later, perhaps in a very different form, the tension will be released. The chronically angry person may develop a duodenal ulcer, become depressed, or explode inappropriately at a minor mishap ....Direct expression of anger at the time that it occurs and toward the immediate cause is the healthiest and most satisfying way of releasing the tension.
> (Stuart & Sundeen, quoted in Thomas, 1990 pp. 205-206)

The debate regarding the perceived benefits of the expression of anger, noted above, is prevalent in the literature.

2. BEHAVIOURAL ORIENTATIONS

Behavioural theorists hold that it is necessary to consider thought processes in anger formulations. Anger is considered to be a judgement, a "learned response to

environmental stimuli" (Skinner, cited in Thomas, 1990, p. 208). Experiments have demonstrated that individuals duplicate behaviour that is rewarded. A child learns that anger works when a temper tantrum results in a positive outcome. Thomas (1990) cites the 1985 research by Novaco that maintains that the impetus to anger comes from internal thought processes. Novaco maintains "there is no direct relationship between external events and anger. The arousal of anger is a cognitively mediated process" (Novaco, quoted in Thomas, 1990, p. 208). Treatment approaches focus on "relaxation or humour counterconditioning (based on the premise that anger and relaxation or humour are incompatible responses to stimuli); social skills and assertion training; instrumental conditioning; and cognitive-behavioral modalities" (p. 208). Studies reporting significant support for the usefulness of these various methods in anger reduction are noted below.

3. Sociocultural Theories

Emphasizing the interpersonal nature of anger, this perspective suggests anger results to ward off anxiety that develops when expectations of others are not met (Sullivan, cited in Thomas, 1990). Such theories recognize that emotional patterns are learned within a cultural context and individuals develop gender specific expressions of emotion. Significant also is a focus on environmental factors contributing to emotional content and expressed behaviour (Bernard, 1990; Greenspan, 1993; Gwynn, 1993; Singer, Bussey, Song, & Lunghofer, 1995; Sommers, in press). Averill's 1982 research demonstrated that "anger is a highly interpersonal emotion that cannot be understood without consideration of the social context" (quoted in Thomas, 1993b, p. 30).

4. Humanistic Orientations

Humanistic orientations view emotion "neither as an expression of instincts nor as a learned response" (Thomas, 1990, p. 211), but as "orienting information" (Thomas, 1993b, p. 27) that provides individuals with necessary evidence upon which to make decisions. Anger, thus might signal that one's rights have been violated. A therapeutic intervention would assist persons in increasing awareness of emotion, and the consequent incentive to change. Thomas (1993b) notes the ability to fully experience feelings has been shown to "be predictive of positive psychotherapy outcomes" (Rogers, cited in Thomas, p. 27).

5. Psychobiological Theories

The psychobiological perspective recognizes the basis of evolutionary theory that "aggressive behaviour is a product of natural selection...and all animals, including humans, have the innate ability to elicit this fundamental trait" (Fishbein, 1992, p. 101). Inborn differences in biological processes in females and males account for differing aggressive behaviour patterns. This perspective perceives that "[i]n general, human males are inherently more aggressive due to the influence of biochemical mechanisms" (p. 101). Acknowledging that both biological and sociocultural conditions influence aggressive response, research focuses on "the roles of (a) neurological systems responsible for the inhibition of extreme behaviors and emotions, (b) the ability to learn from modeling and experience, and (c) availability of family and community resources and support mechanisms" (p. 102).

6. Feminist Theories

Feminism may be defined as "...a form of oppositional knowledge, aimed at disrupting accepted notions of women's behavior and women's proper place, and challenging customary categories and meanings that constitute our knowledge of gender" (Marecek & Hare-Mustin, quoted in White & Kowalski, 1994, p. 488). Inherent in this definition is an analysis of power differences in a culture that considers men to be more aggressive (White & Kowalski, 1994, pp. 492-493) than women. Feminist theory challenges the notion that anger and aggressive acts in women are labelled deviant, pathological, and unfeminine, a labelling that White and Kowalski maintain perpetuates power differences.

MYTHS ABOUT WOMEN'S ANGER

In the 1993 study edited by Sandra P. Thomas, several myths about women's anger are exposed. It is pointed out that because women's anger has been neglected by researchers, there is a lack of empirical evidence to refute the "myths, folk wisdom, and misinformation" (p. 4) that prevail.

Among the most common myths and untested theories noted by Thomas is the conclusion that women have difficulty acknowledging and expressing their anger. This myth is given significant attention and refuted by Tavris (1982) who contends that while women *feel* anger differently than men, "neither sex has the advantage in being

able to "identify" anger when they feel it or in releasing it once it is felt" (p. 185). Any real difficulty women have in acknowledging and expressing anger is attributed to *status* and power discrepancy rather than gender differences (Tavris, 1982; Crawford, Kippax, Onyx, Gault, & Benton, 1992). One study examining sex and sex-role identity with the expression of anger finds that sex is not a factor in anger expression or the tendency to suppress anger (Kopper & Epperson, 1991). A recent analysis of the theoretical perspectives regarding the female and male experience of anger determines as anger as a function of gender has not been adequately tested, it is not clear how women and men differ, if at all, in their experience and expression of anger (Sharkin, 1993).

Various reasons are presented in the literature for the repression of anger in women. Basic among these is the fear that its expression will cause retaliation (Lerner, 1985; Jack, 1991; Crawford et al., 1992; Campbell, 1993), deny the nurturing aspect of women's socialization (Bernardez-Bonesatti, 1978) or drive away the love and closeness women seek (Bernardez-Bonesatti, 1978; Lerner, 1985; Jack, 1991; Wilt, 1993). Lerner (1985) suggests women fear their own anger because, in signalling that something is wrong, it calls for the necessity of change. Jack (1991) notes this requirement to act threatens the established order of women's lives and thus is encountered as fearful. Women are further inhibited from the expression of anger by the requirement to live out the behaviours of the "good woman" (Jack, 1991), and the "nice lady" (Lerner, 1985) rather than being perceived as unfeminine or the "bitch" (Tavris, 1982; Lerner, 1985).

Bernardez-Bonesatti (1978) contends our society permits women the expression of anger in defense of those more vulnerable than themselves but discourages them from expressing anger on their own behalf. This admonition is rooted in the infantile notion of the omnipotent mother, a belief carried by both men and women into adulthood that women's power unleashed is considered devastating (p. 215).

Due to perceived cultural demands or environmental factors, anger often becomes misnamed as selfishness (Jack, 1991), hurt (Tavris, 1982; Valentis & Devane, 1993), sadness, and worry (Tavris, 1982), or transformed into self-righteous attempts to control (Kraus, 1991) or other socially acceptable forms "such as headaches, insomnia, ulcers, back pain, and obesity, that are often treated as though no preexisting condition existed" (Munhall, 1993, pp. 487-488). Munhall notes the critical implications of the transformation of anger into socially acceptable forms. When the acceptable condition

is treated while the underlying anger remains unresolved, inevitably the acceptable condition returns.

Greenspan (1993) notes the inherent sexism in the diagnostic labels widely used for female psychiatric patients. Borderline Personality Disorder, one of the most "demeaning categories in the entire psychiatric lexicon" (p. XXIX), was depicted in the then current *Diagnostic and Statistical Manual-III-R* by intense and frequent displays of anger. Greenspan suggests angry women are easy prey for this diagnosis.

Thomas (1993c) identifies the further myths that women use passive-aggressive forms of anger expression, such as pouting, whining, manipulating, backbiting, or gossiping and that the ultimate consequence of denied or suppressed anger is depression. This latter assumption is evident in much of the literature and is discussed in greater detail below. Related to this latter assumption is the belief that venting or discharging anger is necessarily curative. Consistently refuted in the literature (Tavris, 1982; Lerner, 1985; Lerner, in Kirmer, 1990; Thomas, 1990; Thomas, 1991), this myth will also receive more attention below.

White and Kowalski (1994) suggest the pervasive belief that women are not as aggressive as men is another myth to be deconstructed. They suggest that aggression among women has been ignored because it has been defined narrowly in terms of physical aggression. As a result of much female aggression having "gone unnoticed and thus unnamed....female physical aggression seems more unexpected, becomes labeled irrational, and is denied legitimacy" (p. 488). White and Kowalski cite four comprehensive reviews of the literature that argue "that the conclusion that men are always more aggressive than women cannot be substantiated" (p. 489). Two recent books (Bjorkqvist & Niemela, 1992, reviewed by Richardson, 1994; Haug, Benton, Brain, Oliver & Moss, 1992, reviewed by Pellis, 1994) cited by White and Kowalski concur, although Pellis' review of Haug et al. suggests that though "the book does succeed in shaking us loose from any enduring power of the standard sex stereotype....some chapters are poorly disguised political rhetoric, merely presenting new unexamined stereotypes that do little to promote the scientific analysis of either aggression or sex differences" (p. 469). Richardson's review strikes a similar note, maintaining that "recognizing that females are capable of aggression does not necessarily imply that they are *as* aggressive as males....Indeed, there is considerable and consistent scientific evidence, both in this book and elsewhere, to suggest that there

are some very real differences in the directness, frequency, and harmfulness of male and female aggression" (p. 400). Though White and Kowalski do not disagree, in their feminist analysis they suggest that maintaining the myth of the nonaggressive woman "sustains male power" (p. 493) by rendering women as weak, helpless, and in need of male protection. "By deconstructing the myth of the nonaggressive woman, the trap of gendered dualism (male/female: powerful/weak: perpetrator/victim) is recognized and the advantages of the myth to men is diminished" (p. 504). In suggesting available data does not clearly answer the question of who is more aggressive, White and Kowalski promote attention to women's aggression in and of itself (cf. also Bjorkqvist & Niemela, reviewed by Richardson), paying specific attention to the cultural, social, and psychological circumstances surrounding it (p. 504).

The increasingly held assumption that the effects of premenstrual syndrome (PMS) explain outbursts of anger among women is debated in the literature. In a review of the literature, Harry and Balcer (1987) note the lack of scientific knowledge regarding any association between any phases of the menstrual cycle and crime. Maintaining there is no evidence linking fluctuations in reproductive hormones to criminal behaviour, they advise that evidence concerning menstruation and crime should not be admissible in criminal trials. Campbell (1993) similarly suggests the assumption of any link is premature, citing methodological flaws and circumstantial evidence in the research. It is further noted that as researchers include two out of every four weeks in the vulnerability period, with no apparent reason given, it is "little wonder, then that 46 percent of criminally convicted women wound up committing their crimes during a period of time that spans half their cycle" (Dalton, cited in Campbell, p.157). Though studies are becoming more systematic, the suggestion of a relationship remains controversial with some suggesting there is a subgroup of women who are susceptible to hormonal fluctuations that leave them prone to increased anxiety and hostility during the premenstrual phase (Fishbein, 1992).

RELATED EMOTIONS

Theorists and clinicians are not always clear in distinguishing anger from hostility and aggression, sometimes using the terms interchangeably. Given the confusion that prevails in much of the literature, Thomas (1993c) maintains the importance of establishing such distinctions. Thomas defines *anger* as "a strong feeling of distress or

displeasure in response to a specific provocation of some kind", as distinct from *hostility*, which "implies a more pervasive and enduring antagonistic mental attitude". Person (1993) agrees, citing hostile behaviour as anger either previously unexpressed or anger that had been expressed and had failed to effect a desired change. *Aggression* is distinct from anger in being defined as "any behavior directed toward another person (or a person's property) with the intent to do harm, even if the aggressor was unsuccessful" (White & Kowalski, 1994, p. 487). Thomas (1993c) contends theorists error in placing anger and aggression on a continuum, implying that if anger remains unchecked it will escalate to aggressive acts. This assumption ignores the fact that "aggressive behavior can exist in the absence of anger and vice versa" (p.13; Lewis, 1993; Person, 1993). The definition Campbell (1993) puts forth recognizes the continuum that Thomas rejects. Campbell traces a chronology of women's aggression that begins with anger, initially accompanied by restraint and self control, moves through a mounting frustration if the provocation continues, and erupts in aggression when the frustration becomes intolerable. She thus views women's aggression as emerging from "their inability to check the disruptive and frightening force of their own anger" (p. 1). Thomas, whose study was conducted concurrently with Campbell's work, maintains research evidence does not substantiate this view.

In relating the experiences of shame and guilt to anger and self-reported aggression, Tangney, Wagner, Fletcher, and Gramzow (1992), reporting two studies of college undergraduates, note that psychologists have often failed to make a distinction between these two powerful emotions. While they both involve negative affect, the focus of the affect differs. Guilt emerges with an act or failure to act. Personal behaviour is thus evaluated somewhat externally, apart from the self. Shame is described as much more devastating, with the object of concern being the entire self. "The `bad thing' is experienced as a reflection of a `bad self'" (p. 670), with a resultant shrinking sense of worthlessness, of feeling small and powerless. In a search of the literature, Tangney et al. contend there is a consistent understanding that guilt leads to empathy, and motivates individuals to desire to confess, apologize, make amends, or repair, whereas shame activates a wish to hide, shrink, or disappear. The authors suggest that an initial sense of shame fosters a subsequent anger, a humiliated fury, as an attempt to provide temporary relief from the debilitating experience of shame. As shame typically involves a real or imagined disapproving other (p. 673), this fury is easily directed toward others. This study does not delineate the sex ratio of subjects and thus does not draw comparisons of male and female samples.

A significant link is cited in the clinical literature between adults shamed as children and anger and judgement toward the qualities in others they feel ashamed of in themselves (Middleton-Moz (1990). This reflects the shift from shame to rage noted above and confirmed by Nathanson (1992) who suggests "the most prominent stimulus to anger is humiliation" (p. 105).

Valentis and Devane (1994), in their analysis of the roots of female *rage*, make no clear distinction between this emotion and anger. The root cause of female rage is identified as "anguish turned to shame" (p. 17), and is described as a basic instinct along with fear, aggression, and sexual desire. The authors maintain rage is "carried deep within the human genetic program" (p. 19), and emerges as a defense against a perceived or real threat to the self, that may be experienced as the terrifying threat of annihilation. Rage is experienced by women as a total mind and body experience that blocks out all other emotions, and may trigger unconscious memories of key humiliating incidents.

Parrott and Smith (1993), in two experiments, empirically investigated the distinctions between envy and jealousy. Though long regarded as distinct emotions, they contend the two have recently been confused in the literature. *Envy* traditionally involves comparing poorly with others and emerges when another has what one lacks. It is associated with feelings of inferiority, longing, resentment, and ill will sometimes accompanied by guilt. *Jealousy* necessarily occurs in the context of relationships, involving three persons. Involved is the fear of losing an important relationship to a rival. Emotions associated are fear of loss, anxiety, suspiciousness, and anger about betrayal.

1. Self-Esteem and Anger

Self-esteem and anger in the literature are inextricably linked. One theorist claims "our emotions, to put the matter bluntly, are nothing other than our attempts to establish and defend our self-esteem" (Solomon, quoted in Saylor & Denham, 1993, p. 98). In a search of the literature, Saylor and Denham observe a majority of theorists suggest that persons with low self-esteem tend to become angry more easily than persons with high self- esteem. Two differing views emerge in explanation. Thomas (1991) suggests that when self-esteem is low women may interpret events in a manner that produces anger. Saylor and Denham reference a 1989 study by C.A. Hockett suggesting "*anger* caus[es] low self-esteem rather than low self-esteem being a predisposition to anger" (p. 99).

Saylor and Denham further note a complicating factor in assessing the anger self-esteem linkage in women, an assessment shared by Bernardez-Bonesatti (1978). Many women have been taught that anger is an unacceptable emotion. Its expression therefore produces a diminished sense of self-esteem. The possibility of a vicious cycle is apparent, low self-esteem predisposing women to become angry which leads in turn to lower self-esteem.

This cycle becomes apparent in a discussion of self-esteem and anger within the context of women's social development. Crawford, et al. (1992), in examining the relative differences in social power between men and women, suggest that men, expressing anger from a position of power as a means of attempting to ensure it, and directing their anger toward inferiors, become empowered in the process. Women's anger however, arising out of a sense of powerlessness "takes on an out-of-control, passionate, ineffective character" (p. 183). Their anger expressed is likely to provoke angry reactions in the more powerful at having their power challenged. Similarly Belenky, Clinchy, Goldberger and Tarule (1986), in examining women's ways of knowing that "have been neglected and denigrated by the dominant intellectual ethos of our time" (preface), address the relative powerlessness women have experienced, manifesting itself in the extreme "in denial of self and in dependence on external authority for direction" (p. 24). The expression of anger among persons without power who are "assessed against a standard that holds that women should be seen but not heard" (p. 45), and who risk fear of unfavourable social consequences brought about as a result, is likely to lead to the cycle noted above.

The debate regarding the ventilationist perspective noted above, appears in the literature on anger and self-esteem. The view that venting one's anger leads to increased self-esteem (Hockett, 1989, cited in Saylor & Denham) is consistently challenged (Tavris, 1982; Lerner, 1985; Saylor & Denham, 1993). Lerner, in conversation with Kirmer (1990), maintains therapists "place too much emphasis on just expressing feelings per se, as if emoting is curative" (p. 12). As she earlier maintained, venting alone does not solve the underlying problems and in fact can lead to lower self-esteem (Lerner, 1985). Studies conducted by Brown (cited in Tavris, 1989) and Saylor and Denham (1993) substantiate this claim. Lerner (1985) advocates that to develop a stronger sense of self, it is essential that women translate their anger into clear, nonblaming statements that establish boundaries.

Saylor and Denham (1993) confirm in their study that discussing anger in a nonblaming way is positively associated with self-esteem. They further find that higher self-esteem is related to less tendency to become angry, to dwell over anger producing events, and most significantly, to convert anger into physical symptoms. Interestingly, lower self-esteem was related both to venting anger and to keeping it in, although the relationship was stronger for venting. Findings were congruent in nonclinical, medical, and psychiatric groups in the sample.

2. Stress and Anger

The study conducted by Thomas and Donnellan (1993) is among the first to assess the relationship between high levels of life stress and increased anger in women. While prior studies affirm the relationship, it is noted these have predominately been conducted on college students or on men and may not be generalized to women. No previous studies have extensively addressed the relationship between specific modes of anger expression and stress. The study confirms that higher stress is associated with higher anger levels, and this anger is more likely to find expression in physical symptoms or vented outwardly in blaming statements than suppressed or discussed in constructive ways.

The study notes some association, though not significant, between social support and the experience of anger. There is indication that anger increases with "feeling unloved, smaller network size, interpersonal relationships of shorter length, and less frequent contact with one's network" (p. 121). Older women were more likely to suppress their anger, while younger women were more prone to vent outwardly. The busiest women, those carrying a three role combination of wife, mother, and worker were least prone to anger. Those most prone to be angry were never-married women, followed by homemakers. Married workers without children and divorced workers with children were tied in their propensity to be angry. Although the results in the study were consistent, because they were working with cross sectional data within a nonexperimental design, the authors were reluctant to conclude that stress causes anger or that higher anger creates more stress.

One of the major recommendations of this study is for further exploration of vicarious stress the women identified. When asked about their greatest stress, women responded most often by indicating the stresses of other people in their social network; "the burdens of others were taken on as the women's *own*" (p. 128). Cognitive restructuring

was recommended to health care providers to assist women to view stressors as "challenges to be mastered" (p. 128).

Women's aggression (as distinguished from anger) in the home related to domestic stresses such as budgeting, primary responsibility for child care, and social isolation of the nuclear family, is examined in one American survey that found women's aggression remains low until very high levels of stress are reached (Straus, cited in Campbell, 1993). The role of the home in diminishing women's usual self control is a further factor contributing to women's aggression (Campbell, 1993). Women who work outside the home and who experience the normal stress of the workplace compounded by patronizing comments and sexual harassment, fearing possible dismissal, are rarely able to openly express their frustration. Socialized to exert internal control over their anger in public places, their frustration erupts in the less inhibited environment at home (Campbell, 1993). The exacerbated level of stress women experience in nonsupportive homes and battering relationships is further addressed below.

Lerner (1985) documents predictable styles of managing anger when anxiety and stress is high. Anger may often be turned into tears, hurt, self-doubt, silent submission, or nonproductive blaming. Women may become distancing, under, or overfunctioning.

Crawford et al. (1992) specifically address anger accompanied by crying, suggesting it is representative of the "impotence and powerlessness" (p. 174) felt when a woman is victimized by injustice. Tears accompany anger when there is a power differential between a women and the object of her anger, when "action is denied us [because] the forces which frustrate us are too powerful" (p.174). Often misinterpreted as a sign of sorrow, crying is "a signal of the righteousness of [women's] anger along with the strength of the hurt" (p. 176). In suggesting that anger is the expression of women's frustration and powerlessness, Crawford et al. maintain that "[a] person with power does not need to be angry" (p. 182), suggesting that women's anger will be significantly lessened when it is acknowledged and recognized as legitimate.

3. Anger and Health

While present research is conclusive that anger increases with higher stress, further research is required regarding anger and women's health (Thomas & Atakan, 1993). Negative affect has been associated with the development of a wide range of diseases (Bleiker, van der Ploeg, Mook, & Kleijn, 1993), though many of the studies have not

included women (Modrcin-McCarthy, & Tollett, 1993). For example, though extensively researched in men, few studies have focused on cardiovascular disease among women (Emerson & Harrison, 1990; Information Morning, 1995), with recent research disproving the prevailing belief that this is a primarily male disease (Baker, Dearborn, Hastings, & Hamberger, 1984; Information Morning, CBC Radio, Halifax, January 26, 1995)). Women who do not acknowledge anger, or who are prone to high levels of anger, in addition to cardiovascular illness (Emerson & Harrison, 1990), are vulnerable to headaches (Epstein & Kaplan, 1983; Munhall, 1992), stomachaches (Epstein & Kaplan, 1983), asthma, arthritis (Friedman Booth-Kewley, cited in Modrcin-McCarthy & Tollett, 1993), elevated blood pressure Modrcin-McCarthy & Tollett, 1993), insomnia, ulcers, back pain and obesity (Munhall, 1992). Rates of diagnosed breast cancer are found to be higher both in women who have openly expressed their anger only once or twice in their lives and in those who display frequent temper outbursts as compared to women who display less extreme expressions of their anger (Greer & Morris, cited in Thomas, 1993a). The transformation of anger into "socially accepted pathology" (Munhall, 1992, p. 488) that is treated while the anger remains unrecognized is noted above.

In addition to denial or suppression of anger, the expression of anger outwardly is associated with psychosomatic symptoms. The inappropriate expression of anger in behaviours such as obscenity, rudeness, or condescension, in addition to increasing hostility, is identified as a risk factor for coronary heart disease (Musante, MacDougall, Dembroski, & Costa, cited in Modrcin-McCarthy & Tollett, 1993).

The question of how anger actually relates to health is explored in research regarding anger and health habits among women (Johnson-Saylor, cited in Modrcin-McCarthy & Tollett, 1993; Modrcin-McCarthy & Tollett, 1993). Both studies found an association between poor health habits and anger expression. Johnson-Saylor found healthy behaviours to decrease as hostility increased. Modrcin-McCarthy & Tollett discovered that women who held anger in or expressed it somatically through body pain also practised poor health habits (p. 166). The authors cite a 1992 study by Pope, Wiebe, and Smith, that suggested "hostile persons directed their hostility onto themselves as well as others, thereby contributing to lack of self-care" (p. 166). Modrcin-McCarthy and Tollett further postulate that individuals believe they have little control over their ability to influence their health and/or their expression of anger. They are indeed, as the title of their article suggests, unhealthy, unfit, and too angry to care. In addition to

physical exercise, promoting the expression of anger through discussion is suggested as the most valuable recommendation for the improvement of health among women (Modrcin-McCarthy & Tollett, 1993).

One further study of some interest relating to anger and health issues among women, (Siblerud, Motl, & Kienholz, 1994) suggests the mercury in silver dental fillings, by affecting the neurotransmitters in the brain, may be an etiological factor in increased anger, depression and anxiety. Women with dental amalgams, having notably more mercury vapour in the oral cavity than those without, had significantly higher scores in their propensity to express anger without provocation, and their frequency of anger expression.

4. Depression and Anger

The long standing belief begun with Freud (Droppleman & Wilt, 1993), that depression is anger turned inward, is strongly questioned in much of the literature (Tavris, 1982; Tavris, 1989; Thomas, 1991; Droppleman & Wilt, 1993). The related assumption that releasing anger produces clinical improvement is similarly discredited (Tavris, 1982; Lerner, 1985; Gershon, Cromer, & Klerman, cited in Thomas, 1990; Lerner, in Kirmer, 1990; Thomas & Atakan 1990; Thomas, 1990; Thomas, 1991; Nathanson, 1992; Moreno, Fuhriman, & Selby, 1993). It is documented in fact, that women who inappropriately express their anger are more likely to be depressed (Thomas & Atakan, 1990), or their depression deepens as a result (Tavris, 1989; Droppleman & Wilt, 1993). In a study involving male and female subjects, Moreno, et al. (1993) note that "anger may mask underlying depression" (p. 521), and in suggesting that hostility in depressed persons may be a predictor of suicide, cautions clinicians to pay strict attention to anger and hostility when assessing for suicide risk among clients.

While Greenspan (1993) holds the conventional belief that depression is anger turned inward, maintaining "traditional experts in chronic depression do recognize that the major dynamic here is anger which has been displaced...and directed at the self" (p. 190), she notes that such displacement is "an inevitable aspect of female identity in patriarchal society" (p. 190). Women's increased tendency to depression (Notman, 1989; Bleiker, et al., 1993; Campbell, 1993) is noted in part as a consequence of female development that "prescribe(s) passivity" and allows for "relatively fewer pathways for...active mastery" (Notman, 1989, p. 230) of aggression.

From a developmental perspective, Jack (1991) maintains "psychologists who are listening to women from a developmental perspective, a clinical orientation, or a psychoanalytic viewpoint all agree women's orientation to relationships is the central component of female identity and emotional activity" (p 3) Jack argues if such relatedness[1] is primary for women, "it becomes clear why a person will go to any lengths, including altering the self, to establish and maintain intimate ties". (p. 11) The link between the altering of self in relationship and the expression of anger is best expressed by Harriet Goldor Lerner in her 1987 article entitled *Female depression: Self-sacrifice and self-betrayal in relationships.* In it she writes, "Feelings of depression, low self-esteem, self-betrayal, and even self-hatred are inevitable when women fight but continue to submit to unfair circumstances, when they complain but participate in relationships that betray their own beliefs, values, and personal goals, or when they find themselves fulfilling society's stereotype of the bitchy, nagging, bitter, or destructive woman" (cited in Jack, 1991, p. 230).

There is suggestion that the ability to discuss anger rationally decreases the likelihood of depression (Droppleman & Wilt, 1993), but the correlation was so small in this study the authors are reluctant to infer a causal relationship. In a 1989 study conducted by Riley, Triber, and Woods, women suffering from Post Traumatic Stress Disorder (PTSD) and women who are depressed were found to be less likely to discuss their anger than women who had not experienced such trauma (cited in Droppleman & Wilt, 1993). Droppleman and Wilt confirm in their study "the more depressed women were, the more they were likely to report physical symptoms when angry" (p. 221), as well as the previously held conclusion that dwelling on angry thoughts amplifies depression. They conclude their analysis on a positive note by advising that though the anger-depression linkage among women is "often overlooked and inadequately treated" (p. 232), women can use the experience to move beyond blockages in their functioning and further their growth.

5. Anger and Self Harming Behaviour

Anger is implicated in various forms of self harming behaviour among women. The powerlessness women feel finds expression in self mutilation (Bass & Davis, 1988; Courtois, 1988; Favazza & Conterio, 1989; Herman, 1992; Greenspan, 1993), unhealthy eating behaviour (Woodman, 1980; Pendleton, Moll, Tisdale, & Marler, 1990; Smith,

[1] See also Belenky, et al.(1986) and Gilligan (1982) for research on women from a developmental perspective.

Hillard, Walsh, Kubacki, & Morgan, 1991; Arnow, Kenardy, & Agras, 1992; Russell & Shirk, 1993), substance abuse (Gustafson, 1991; Potter-Efron & Potter-Efron, 1991; Grover & Thomas, 1993; Seabrook, 1993), and suicidal gestures (Grumet, 1988; Grossman, 1992; Greenspan, 1993).

a. Self Mutilation

Self mutilation, often inaccurately interpreted as a suicidal gesture (Herman, 1992), is a specific response to anxiety that offers temporary relief from emotional pain (Favazza & Conterio, 1989). Associated with earlier childhood abuse (Courtois, 1988; Favazzz & Conterio, 1989; Herman, 1992), self-injury is associated with an "impotent rage" (Courtois, 1988, p. 303) that becomes directed at the self rather than the abuser. It becomes for some "a way to anesthetize the part of their body that is being abused by distracting themselves with another type of pain" (Courtois, 1988, p. 303). For others it becomes an internalization of the abuser's hostility as the survivor continues to abuse herself (Bass & Davis, 1988). A third motivation to self-injury is to provide a feeling of calm that rapidly decreases tension surrounding memories of abuse (Courtois, 1988; Favazza & Conterio, 1989; Herman, 1992). Herman documents the accounts of survivors who report injuring themselves to prove they exist (p. 109), and thus paradoxically regards self-injury as a from of self-protection rather than a suicide attempt.

Favazza & Conterio (1989) report a large number of women who self-mutilate also have an "eating disorder" (p. 283) and are alcoholics. The authors further found that no form of therapy was particularly helpful to subjects in their study.

b. Eating Behaviour

In a review of the literature, Russell and Shirk, (1993) found that although several studies have examined the link between overeating and emotions, few have examined anger in particular or concentrated specifically on women (p. 177). Their intensive study of 535 subjects found eating to be a response to almost every emotion, with "injustice, resentment, discrimination and rejection" (p. 181) common factors that triggered eating. Food was identified as the "drug of choice" (p. 184) for many women in the sample. Their study concludes that anger as a contributing factor in obesity in women is a subject warranting further research so appropriate treatment can be designed.

Although the current literature search found no other studies that specifically address the relationship between women's anger and eating behaviour, anger was mentioned among other factors affecting eating and non eating. In their study of binge eating in 20 female subjects, Arnow et al. (1992) discovered negative emotions to be present both before and after bingeing. Any relief from feelings of anger, anxiety, or sadness that bingeing offered was extremely temporary. In her study of eating patterns and personality traits among twenty obese women, Woodman (1980) observed eating in repressed anger to be present in all twenty subjects. Woodman, in a Jungian approach, theorises that obesity and anorexia nervosa reflect "the progressive loss of the feminine in our culture" (p. 23) that has caused women to reject their own bodies. Rage was rarely expressed among the obese women studied. All twenty women reported feeling "caged" (p. 34), propelled by "compulsive drives waiting to burst out" (p. 32). Experiencing herself as a social outcast from a very early age, the obese woman harbours fears of rejection along with a "compensating anger and desire for power" (p. 32).

Ellyn Kaschak (1992) places her discussion about women's eating patterns within the context of her analysis of women's position in a male dominated society and considers the "so-called eating disorders - anorexia, bulimia, and bulimarexia...to be the extreme end point of normal feminine development" (p.190). This view is substantiated by Brown and Jasper (1993), and a decade earlier by Tavris (1982), who suggests "most dieters would do better to become angry not with their parents, but at a society that has made an enemy of their bodies" (p. 101). In a discussion of the theory that sex-role conflict contributes to the prevalence of eating disorders among contemporary women, Pendleton et al. (1990) suggest that the conflict regarding "how aggressive/independent vs. how passive/dependent a woman ought to be" (p. 816) is not specific to bulimic women but appears in women who seek psychiatric treatment for a large range of disorders. Their examination fails to delineate factors leading to the development of bulimia separate from other forms of psychiatric presentation.

In addition to the agreement that excessive eating is viewed among women as a means of control and regaining power (Woodman, 1980; Bass & Davis, 1988; Root, Fallon & Friedrich, cited in Smith et al., 1991), it is cited as a socially acceptable way to appease anger (Matsakis, cited in Russell & Shirk, 1992). Valentis and Devane (1994) suggest eating and noneating become the adolescent's way of expressing rage at parental neglect. "Eating is the one thing Mom can't make her do" (p. 82). Purging among

bulimics, from a psychoanalytic perspective, is interpreted as a self punishing act (Schwartz, cited in Smith et al., 1991). Smith et al. cite the 1983 study of Mintz who suggests "vomiting has long been considered a symbolic expression of rage" (p. 285). Although differences were not significant in their study, Smith et al. conclude that purgers were somewhat more likely to be depressed, angry, and self-absorbed, with a somewhat higher self-destructive potential than nonpurgers. The "physiological and tranquilizing" component of purging is reported by Valentis and Devane (1994) who suggest "purging is a protection against the self and its rage" (p. 84). The authors quote therapist Pam Killen's explanation that endorphins are released in vomiting that "soothe[s] that rage and act[s] as palliatives for murderous feelings" (p. 84).

The relationship between food abuse and prior physical or sexual assault is reported in the literature. Russell and Shirk (1993), refer to two studies (Root, 1989; Tice, 1991) suggesting this correlation. Root reported from 30% - 75% of women who had failed treatment for food and substance abuse had been previously assaulted while Tice reported a figure of 50%. Among other emotions, anger was cited as a problem exhibited among Root's subjects. Difficulty remaining in treatment was related to the surfacing of feelings that had been masked by the addictive behaviour. Tice reported intense anger and low self esteem among the obese and bulimic women studied, with the anger directed toward themselves, their abuser, and projected toward other men. Women identified eating as a way to deny the abuse or suppress feelings including anger, and some relied on their weight as a protection against further sexual advances. Clinical literature confirms the link between sexual and physical assault and abuse of food (Bass & Davis, 1988; Courtois, 1988; Luepnitz, 1988; Herman, 1992; McGillicuddy & Maze, 1993).

c. Substance Use

Prior to the past two decades which have seen a dramatic increase in research on substance abuse by women, research, predominantly conducted on male subjects either ignored women or viewed them as anomalies when results were inconsistent with that of men (Seabrook, 1993). Research on women's anger and substance abuse has received very little attention.

Seabrook determined in her study, which she deems exploratory given the scarcity of research in this area, "women who use alcohol express their anger in ways that are similar to the general population of women" (p. 207). Although this study does not

confirm any suggestion that women who use alcohol are angrier than other women, it does maintain a subgroup demonstrating unhealthy anger management may be at risk for future alcohol abuse. High risk drinkers showed a higher propensity to become angry, displayed more angry symptoms in their bodies such as headaches and shakiness, and tended to dwell on angry thoughts. These women were found to be less likely to engage in a discussion about their angry feelings in a healthy or productive way. High risk drinkers were found to have fewer social supports, a finding that contradicts results of Grover and Thomas (1993), who found no significant difference between the social supports of substance users and nonusers.

Women with anger symptoms (e.g., having a headache when angry) were found to drink more alcohol (Grover & Thomas, 1993) and use prescription drugs (Seabrook, 1993), suggesting cause for concern regarding the use of medication that masks underlying distress and the possibility of overdose and interactions of medication with alcohol. The suppression of anger chemically is considered both to be socially acceptable and fairly common in our society. No relationship was found between stress and use of alcohol, or between depression and drinking in the Seabrook study. A relationship was found however, between smoking and alcohol use, and a tendency for alcohol users to also use over the counter drugs. In a study testing aggression in women, use of alcohol in moderate dosage was not found to increase aggression when more than one response alternative was available (Gustafson, 1991).

ANGER AND ABUSE OF WOMEN

A study of women and anger must, of necessity involve a discussion of the social context within which women live their lives. As Greenspan (1993) notes, the diagnostic label Post Traumatic Stress Disorder (PTSD) is described as a "disorder" occurring when "the person has experienced an event that is outside the range of usual human experience and that would be markedly distressing to almost anyone..." (Desk Reference to the Diagnostic Criteria from the DSM-III-R, quoted in Greenspan, 1993, p. xxx). Greenspan contends this definition fails to recognize the physical and sexual trauma women endure is "very much *inside*" (p. xxx) the range of their usual experience. The high incidence of the violation, "cultural sexualization and devaluation" (Westkott, cited in Jack 1991 p. 15) of women constitutes a major component in their subsequent ability to cope with feelings of helplessness,

powerlessness, anger, shame, and rage (Courtois, 1988; Davis, 1990; Estés, 1992; Herman, 1992; Kinzl & Biebl, 1992; Campbell, 1993; Valentis & Devane, 1994).

The empirical studies of women and anger fail to address the social reality of the domestic stresses women face both in battering relationships and as a consequence of childhood and adult sexual abuse. This complete absence constitutes a serious limitation. The clinical literature solidly recognizes the intense anger of those violated. Estés (1992) writes: "Rage corrodes our trust that anything good can occur. Something has happened to hope. And behind the loss of hope is usually anger; behind anger, pain; behind pain, usually torture of one sort or another, sometimes recent, but more often from long ago" (p. 353). Women have been trained to contain this anger at violation, fearing the retaliation of those more powerful (Campbell, 1993). In her assessment of the aggression of women who kill their abusive husbands, Campbell maintains that women who live under situations of intolerable stress in battering relationships are driven to aggressive action, the intensity of which is such that it is common for them to have little memory of the event (Katz, cited in Campbell, 1993). Campbell notes "it is as if the anger has been so deeply buried and the accommodation to the husbands' violence so complete that it has erased any belief in the power of their own capacity to retaliate" (p. 123). Hilberman agrees, stating that "passivity and denial of anger do not imply that the battered woman is adjusting to or likes her situation. These are the last desperate defenses against the homicidal rage" (quoted in Grumet, 1988, p. 60).

In comparing female and male aggression in intimate relationships, White & Kowalski (1994) remind us that "the motives of women and men for aggression differ. In self-reports of reasons for spousal homicide, the most frequently cited reason among women is self-defense, whereas among men the most common justification is sexual jealousy and/or the wife threatening to terminate the relationship....Women who initiate acts of violence frequently do so in anticipation of an abusive attack from their partner" (p. 495).

While much is known about the sexual and physical victimization of women, little research has been conducted concerning women who are themselves aggressive (Campbell, 1993). This is reflected in an absence of "specific treatments for forensic patients" (Hodgins, Hébert, & Baraldi, 1986, p. 213).

Such research is essential so women's aggression in situations of extreme stress is understood. The very conditioning women have had in containing their rage leaves them at a disadvantage within the current legal system. A charge of voluntary manslaughter which recognizes the intent to kill is "partially justified because it is committed under provocation from the victim and in the heat of passion" (Campbell, 1993, p. 145), is often rejected in favour of a murder charge because there is usually a delay between the most recent provocation and the killing. In failing to recognize the years of brutalization she has endured and to which she has become resigned, her motive is judged as revenge rather provocation.[2] It is further noted that although the outcome of self-defense is acquittal, and even though 87% of convicted women (in the United States) believe they acted in self defense, many are still found guilty of murder or manslaughter (Gilleslie, cited in Campbell, 1993). The necessity of research concerning "women's distinct experience of anger and response" (Campbell, 1993, p. 151) is evident.

ANGER AMONG INCARCERATED WOMEN

Grossmann (1992), in a study of suicide among first nation women in custody, notes that both the role of the carceral environment and personal characteristics women bring with them when they enter an institution are factors to consider in understanding and possibly reducing suicide among these inmates. A similar analysis may be made regarding anger and its expression among incarcerated women. Sommers (in press) presents women's personal accounts of their lawbreaking behaviour in which women identify four explanations: "need; disconnection and the influence of others; visible anger; and fear" (p. 19). Faily and Roundtree, in a 1979 study of rule violations in a female prison population, confirmed that "[t]he characteristics, experiences, and behaviors of women criminals before incarceration does affect their behavior in prison to a great extent" (p. 86). The prevalence of past physical and sexual victimization (Grossmann, 1992; Elizabeth Fry Society, 1994; Katz & Hall, 1994; Singer et al., 1995), lack of social support, enforced separation from their children (Flowers, 1987; Elizabeth Fry Society, 1994; Katz & Hall, 1994), and high proportion of drug and alcohol use (Singer et al., 1995) are some of the factors signifying the distress present in women when they enter custody. These "psychological, economic, social, legal and historical" (Gwynn, 1993, p. 103), factors are compounded by the conditions women encounter in

[2] For an in depth analysis of battered women, murder, and the law see Campbell, 1993, pp. 144-152.

the "already-existent conflict-ridden" (Rucker, 1991), competitive environment of the prison setting that induces abuse of power and control (Katz & Hall, 1994), coercion, and mistrust. Suspicion and mistrust of security staff and inconsistent rule enforcement were noted as significant factors contributing to anger levels among incarcerated women (Rucker, 1991).

VISIBLE AND INVISIBLE MINORITIES

Research on anger has predominantly been conducted on convenient samples of white, usually middle-to-upper class university students (Thomas, 1993a). While Bernard (1990) does mention racial and ethnic discrimination as one of three social factors that "increase the likelihood of frequent or intense physiological arousal....[which] directly increases the likelihood of angry aggression" (p. 74), research conducted by Thomas et al. (1993) found no previous studies on the everyday experience of anger among black women (Thomas, 1993a, p. 58). Their study included African-American women and Chinese-American women.

Despite the unquestioning rationale for anger among black women, considering the extreme history of racism suffered and the reality that they continue to be disenfranchised, this study surprisingly found no differences among African-American and Caucasian-American women in propensity to be angry or in anger expression. Two explanations were considered for this finding. The population of black women surveyed were middle class, and thus were suspected to share in part similar advantages as white women. The higher level of religious involvement among the black women sampled was suggested as a further explanation. The black church was, and still is considered to be, a symbol of liberation and reassurance during times of crisis. The church offers black women a sense of power and strength that possibly enables them to manage conflict and anger (Boyd, cited in Thomas, 1993a). The author suggests results of this study may not be generalized to other black women and suggest the use of culturally sensitive interviewers and data collectors would enhance future research.

As emotional expression is downplayed in Chinese culture, it was expected that Chinese-American women would score higher than white women on suppression of anger. This assumption was not supported by the research. Findings in fact were the

opposite, with white women scoring higher on anger suppression. Chinese-American women of Taiwanese origin scored higher on trait anger (propensity to anger) and anger expression. Higher propensity to anger was perceived to be a result of "overwesternization" (p. 62), as women reject traditional values and teach their children to be like Americans, as well as a greater freedom to express emotions away from in-laws and extended family. Caution was expressed in generalizing these findings to other groups of women of Chinese origin, and a similar recommendation to utilize culturally sensitive interviewers in further research was suggested.

Apart from this study, a search of the literature revealed a complete absence of attention to the anger felt and expressed by visible and invisible minorities. Disabled women and lesbians were not mentioned in the literature. It is significant to note the categories of women selected for comparison in the Thomas and Donnellan (1993) study of stress and anger: "never-married workers, married workers with no children, divorced workers with children, unemployed married mothers, and employed married mothers" (p. 119). The categories selected reflect the silence in the totality of the literature on women and anger regarding the experience of lesbians. Considering the multiple losses and resultant stress lesbians encounter daily (O'Neill & Ritter, 1992), their absence as subjects in anger studies is significant.

ASSESSMENT INSTRUMENTS

Anger assessment instruments encountered in the literature are listed below with brief descriptions. Empirical studies that have included women in their samples have utilized the Minnesota Multiphasic Personality Inventory (Moll & Marler, 1990; Schill & Wang, 1990; O'Laughlin & Schill, 1994), the Speilberger Anger Expression Scale (Emerson & Harrison, 1990; Schill & Wang, 1990; Tangney, et al., 1992; O'Laughlin & Schill, 1994), Zelin, Adler, and Myerson's Anger Self Report Scale (Schill & Wang, 1990; O'Laughlin & Schill, 1994), the Cook & Medley Hostility Scale (Schill & Wang, 1990; O'Laughlin & Schill, 1994), the State-Trait Anger Scale (Thomas & Atakan, 1990; Potter-Efron & Potter Efron, 1991; Moreno, et al., 1993; Thomas, 1993d), the Framingham Anger Scales (Thomas & Atakan, 1990; Grover & Thomas, 1993; Thomas, 1993d), the Contrada Cognitive Anger Scale (Thomas, 1993), the Anger Situation Questionnaire (van Goozen, Frijda, Kindt, & van de Poll (1994), and the Hostility and Direction of Hostility Questionnaire (HDHQ) (Moreno, et al., 1993).

In one study of a Canadian federal and provincial inmate sample, the Anger Expression Scale was found to be satisfactory, but the conclusion was drawn that the State-Trait Anger Expression Scales should be used on this population with caution (Kroner & Reddon, 1992). It should be noted however, this study was conducted on a male sample and thus should not be generalized to a female population. Kroner and Reddon note the absence of research examining the role of anger in violent behaviour and "more broadly, in crime" (p. 398).

1. Anger Expression (AX) Scale

The Anger Expression Scale measures style and expression of anger and includes anger-in (the extent to which anger is experienced but not expressed) and anger-out (the external expression of anger) (Schill & Wang, 1990; Spielberger, Johnson, Russell, Crane, Jacobs, & Worden, cited in Thomas, 1993a). It also has a subscale for anger control.

2. Anger Inventory

Designed for women and men survivors of child sexual abuse to assist individuals to assess their current experience of anger and express it in the process of healing, this inventory consists of sentence completion and other writing exercises (Davis, 1990).

3. Buss-Durkee Hostility Inventory (BDHI)

Developed in 1957, this scale measures assault, indirect aggression, irritability, negativism, resentment, suspicion, and verbal expressions of anger. Though regarded as one of the most meticulously constructed measures of hostility, evidence of its validity was found to be "both fragmentary and limited" (Speilberger, Jacobs, Russell, & Crane, 1983). It was further rejected as an appropriate anger test by Braha (1987).

4. Contrada Cognitive Anger Scale

This 10-item measurement, designed by Contrada, Hill, Krantz, Durel, and Wright in 1986, scores tendency to engage in unhealthy thinking and dwell on angry incidents (cited in Thomas, 1993a). The tool includes a Somatic Anger Scale measuring physical symptoms in reaction to anger arousal.

5. COOK & MEDLEY HOSTILITY SCALE

The Cook & Medley Hostility Scale, developed in 1954 primarily measures "suspiciousness, resentment, frequent anger, and cynical distrust of others rather than overtly aggressive behaviour" (Smith & Frohm, cited in Schill & Wang, 1990).

6. FRAMINGHAM ANGER SCALES

The Framingham Anger Scales were developed in a study of coronary heart disease risk in Framingham, Massachusetts (Haynes, Levine, Scotch, Feinleib, & Kannel, cited in Thomas, 1993a), to assess how anger is expressed when it is felt. In addition to assessing internalization (anger-in), and externalization in an attacking or blaming way (anger-out), the Framingham scales measure somatization (physical symptoms), and discussion of anger (anger-discuss) (Grover & Thomas, 1993).

7. HOSTILITY AND DIRECTION OF HOSTILITY QUESTIONNAIRE (HDHQ)

The HDHQ (Foulds, Caine, & Creasy, cited in Moreno et al., 1993) includes 48 components of the MMPI (see below) and is purported to be the best known measure of hostility that has been derived from the Minnesota Multiphasic Personality Inventory (Foulds, Caine, & Creasy, cited in Speilberger, et al., 1983). It consists of four subscales: Intropunitiveness, Extrapunitiveness, Direction of Hostility, and General Hostility. Speilberger et al. conclude its validity may be restricted to neurotics and depressives, the populations with which it has been used.

8. MINNESOTA MULTIPHASIC PERSONALITY INVENTORY (MMPI)

This assessment instrument, named "the most widely researched objective personality questionnaire available" (Butcher, 1987, p. 161), was originally published in 1943 as an aid to psychological screening for professionals in the mental health fields and general medical practice. It is the most frequently administered psychological test with over 10,000 articles and books documenting its use.

9. MOSHER FORCED-CHOICE GUILT INVENTORY

An index of aggression anxiety (Mosher, 1966, cited in Tangney et al. 1992), that includes a Hostility-Guilt subscale.

10. MULTIDIMENSIONAL ANGER INVENTORY

The Multidimensional Anger Inventory (Siegel, cited in Kroner & Reddon, 1992) includes five categories: anger-arousal, range of anger-eliciting situations, hostile outlook, anger-in and anger-out.

11. THE ANGER SITUATION QUESTIONNAIRE

This scale was developed by van Goozen et al. (1994) to focus on the relationship between anger and anger-readiness, rather than overt aggressive behaviour. The ASQ consists of thirty three scenarios or vignettes. The respondent is asked to imagine herself in each situation and to indicate from a choice of five emotion labels, five intensity levels, and five action tendencies, "which emotion she would experience, how intense this emotion would be, and what she would feel inclined to do of she found herself in the situation" (p. 81).

12. THE AWARENESS AND EXPRESSION OF ANGER INDICATOR

This inventory appeared in the research only under testing for a 1987 Masters thesis, with further testing recommended at that time (Braha, 1987).

13. THE STATE-TRAIT ANGER SCALE

Psychologist Charles Speilberger was first to distinguish between state and trait anger. Anger defined as an emotional state is a transient condition varying in intensity. Trait anger involves one's general propensity to perceive situations as anger provoking and to respond with expressions of anger (Spielberger et al., 1983). Examining both aspects assumes that anger is both stable (trait anger) and variable over time (state anger) (Fuqua, Leonard, Masters, Smith, Campbell & Fischer, 1991). There has been significant work completed on examining the validity of this assessment tool and it has been widely used in many well known studies. It includes the subscales of Angry Temperament and Angry Reaction. This tool was developed following the assessment that most available anger scales cloud "the experience of anger with aggressive behavior and anger-provoking situations" (Speilberger et al., 1983).

14. SELF ASSESSMENT TOOL: HOW ENRAGED ARE YOU?

This is a questionnaire designed for personal use to assist women to assess their rage quotient (Valentis & Devane, 1994).

15. ZELIN, ADLER, AND MYERSON'S ANGER SELF-REPORT SCALE

This 1972 scale differentiates between awareness and expression of anger and includes the following subscales: awareness of anger, general expression of anger, physical expression, verbal expression, guilt, condemnation of anger, and mistrust and suspicion (projection of anger) (Schill & Wang, 1990). This scale was found to be infrequently used, and its validity drawn into question (Speilberger et al., 1983).

TREATMENT MODALITIES/PROGRAMMES

One of the identifying marks of a healthy individual is the ability to tolerate occasional hostility (Malmquist, cited in Meyer, 1988). Interventions designed to assist individuals in recognizing and managing their anger however, have "lagged significantly behind" (Deffenbacher & Stark, 1992, p. 158) treatments for emotional problems such as depression or anxiety. This reality, confirmed by Lopez and Thurman (1986), exists despite the popularity of the subject of anger in popular psychology and self-help books and the "importance of anger in the psychological, social, educational, vocational, and physical functioning of clients" (Deffenbacher & Stark, 1992, p. 158), and reflects the scarcity of research in this area.

The first controlled study of anger reduction was conducted in 1975 research (Novaco, cited in Deffenbacher & Stark, 1992) that assessed a programme of stress inoculation that combines relaxation and cognitive approaches. In a 1985 review of the literature, the same author noted that "until the era of behavioral and cognitive-behavioral therapy, there was virtually no empirical evaluations of anger interventions" (Novaco, cited in Thomas, 1990, p. 208) and, further, "until more controlled experimental studies are conducted, our confidence in available treatments should be tempered". (Novaco, quoted in Thomas, 1990, p. 212).

As noted above, the widespread belief that the purpose of the treatment of anger lies in assisting persons to acknowledge and ventilate hostile feelings is strongly challenged and noted as the basis of much of the mistreatment of anger among clinicians (Meyer, 1988). As Greenspan (1993) notes, anger expression in itself is not enough to empower individuals, suggesting it is "at best a half truth and a dangerous falsification" (p. 315) Gaylin (cited in Wilt, 1993) cautions therapists to attend to the interconnectedness of emotions, the complexity of which is often underestimated. Wilt cites an example of

feeling simultaneous rage and love for children when they place themselves in positions of danger. Treatment of anger includes "identification of adaptive, maladaptive, and ego-defending responses to anger, and implementation of specific treatment approaches" (Wilt, 1993, p. 234). There are times when women may need an initial treatment approach that assists in suppression of anger, followed by the introduction of calming techniques that allow for verbalization as an effective means of expression.

A search of the literature and a survey among therapists working in the field, revealed few programmes for treatment of anger and related emotions among women. Several identify anger as a small and usually brief component of the overall programme (eg. Carlson, n.d.; Saxe, 1993), or part of an ongoing therapy group (Campbell, 1989), but the paucity of specific treatment programmes reflects the scarcity of research conducted to date. No published studies report anger management programmes with female offenders prior to 1986 (Wilfley, Rodon, & Anderson, 1986). The following is a summary of programmes and treatment modalities identified in the search.

1. COGNITIVE-BEHAVIORAL

A series of studies were conducted to examine relaxation and cognitive treatments of anger, in response to Novaco's earlier research (Moon & Eisler, 1983; Hazaleus & Deffenbacher, 1986; Lopez & Thurman, 1986; Deffenbacher, Story, Stark, Hogg, & Brandon, 1987; Deffenbacher, Story, Brandon, Hogg, & Hazaleus, 1988; Deffenbacher & Stark, 1992). Each of the studies, with the exception of Moon and Eisler, was conducted on a combined female and male university sample. Moon and Eisler conducted their study using all male subjects. In addition to these studies, Perry (1991) reports the success of an individualised thirty nine week anger control programme running concurrently with a twelve week anger management training group in the treatment of a woman institutionalised after being convicted of arson.

Though conducted on nonclinical samples, research supports the effectiveness of cognitive and relaxation methods in anger reduction. Novaco's 1975 study compared a combined relaxation and cognitive treatment (stress inoculation) with relaxation and cognitive treatments alone. The study revealed that the combined treatment was preferable followed by a cognitive approach. The effects of relaxation were limited, owing, as proven later (Hazaleus & Deffenbacher, 1986) to poor intervention design. In their study, Hazaleus and Deffenbacher (1986) determined that both cognitive and

relaxation interventions were equally effective. In two studies (Deffenbacher et al., 1988; Deffenbacher & Stark, 1992) no differences were found in the effectiveness of cognitive and combined cognitive-relaxation treatments. The 1987 study by Deffenbacher et al. compared cognitive-relaxation and social skills interventions and determined that while both significantly reduced anger, cognitive-relaxation subjects responded more favourably to their treatment than did social skills subjects. Moon and Eisler (1983), in comparing stress inoculation training with social skills training and problem-solving training noted each "had significant effects in reducing the cognitive components of anger" (p. 503), but the effect was accomplished in different ways.

Those receiving cognitive treatment reduced their anger provoking thoughts but did not increase in their level of assertion. Those receiving problem-solving treatment increased in both areas, indicating they were better able to both reduce their angry thoughts and assert themselves. They, and subjects who received social skills training "displayed increases in socially skilled assertive behavior in the presence of anger-provoking stimuli" (p.505). It will be useful to summarize the methods of treatment examined.

Social Skills Training:
In an eight session group interaction, social skills were described, modeled, and role played by the group in dyads (Deffenbacher et al., 1987). Homework was assigned between sessions. Sessions focused on communication and listening skills, constructive and negative feedback, clarifying options in difficult situations, and assertiveness in initiating reasonable requests and declining unreasonable requests.

Problem-Solving Training:
Participants in this study (Moon & Eisler, 1983) were asked, after defining an anger problem and generating numerous possible solutions, to implement and evaluate the one perceived to offer the best possibility of success. This task followed initial discussion of anger as a normal part of life and acknowledging the possibility of effective coping, resisting the urge to act impulsively or do nothing when provoked to anger, and in defining and formulating anger problems.

Cognitive-Relaxation Coping Skills:
This method involves training in progressive relaxation and relaxation coping skills such as "(a) deepbreathing cued relaxation (relaxation on each exhalation of 3-5

breaths), (b) relaxation without tension (relaxing by focusing on and releasing tension from muscles without tension-release exercises), (c) cue-controlled relaxation (relaxing on the slow repetition of the word "relax"), and (d) relaxation imagery (visualizing personal relaxation images)" (Deffenbacher & Stark, 1992, p. 160). Cognitive restructuring skills taught included the identification and changing of demanding and overgeneralized self-dialogue. Application of skills learned involved "(a) preparing for an angering event, (b) confronting a moderate-anger situation, (c) confronting an angering event that was unresolved or in which the person limited the expression of anger, (d) confronting a high level of anger, and (e) confronting the individual's worst difficulties with anger" (p. 160).

Relaxation Coping Skills:
The relaxation coping skills treatment paralleled the cognitive-relaxation treatment, emphasizing only the relaxation skills.

2. Psychotherapy Using Ego Based Developmental Theory

This treatment approach, identified by Wilt (1993), acknowledges both "physiologic maturational factors and environmental influences" (p. 236) affecting human growth, with early childhood development establishing the foundation for later growth. The client is encouraged to examine and change the blocks that inhibit the full development of potential, and with the therapist's partnership, to "build healthier emotional and cognitive structures" (p. 236). Before dealing directly with anger or rage, individuals are assisted to gain strength and understanding of their developmental process and the defense mechanisms used to defend against the anxiety that has become attached to the anger.

A core issue identified is the primary attachment women have to relationship, complicated by the cultural encouragement toward caretaking roles that reward women for nurturing others before speaking for their own needs. Addressing the negative cultural view of the direct communication of feminine anger is of primary importance.

The techniques outlined below are used after a therapeutic relationship has been developed. It is also crucial to have first managed the original crisis that brought the client to treatment. Specific treatment is outlined for women who express anger readily and for those who hold anger in. Included in the treatment guidelines is an emphasis

on the development of a sense of self separate from others, the use of such cognitive tools as genograms before the stimulation of memory to assist in identifying patterns of difficulty within the family of origin, and social analysis which places a woman within the context of her environment and addresses social and cultural constraints that have affected her. After the relationship with the therapist has been developed, anger and rage issues with the family of origin are explored. It is noted that often underlying situations of "deep anger" (p. 245) the real issues of loss and hurt is accompanied by a strong sense of grief over not receiving the nurture that was needed. Calming techniques are used to decrease some of the physiological responses to anger such as decreasing "blood pressure, brain wave activity, and muscle tension" (p. 246). Finally, assertiveness techniques are suggested for teaching adaptive responses to anger.

3. Summary of Treatment Guidelines

Treatment approaches in the therapeutic management of women's anger (same for both groups):

1. Develop a sense of self, separate from others, strengthening ego boundaries.
2. Facilitate healthy appraisal; use genogram to identify patterns of anger management and separation difficulties in family of origin.
3. Implement a social analysis.
4. Work out anger and rage issues regarding family of origin.
5. As client individuates, assist through panic, anxiety, and grief, being sensitive to the client's desire and fear of becoming engulfed with the therapist.
6. Facilitate anger where the response is avoided. Teach calming techniques when the response is overacted.
7. Assist client to focus anger and do something about the threat experienced.
8. Teach and reinforce effective techniques in dealing with anger.

Specific group treatment approaches for women who readily express anger:

1. Assist client to focus anger on real source, often family of origin, and to use calming techniques.
2. Assist client to do something effective with her anger to develop a sense of control.
3. Move client to use intellect rather than emotion.
4. Decrease ventilation of anger, teaching calming techniques.
5. Assist client to use assertive responses rather than aggressive responses.

For women who hold anger in:

1. Assist the client to increase awareness of anger and all feelings.
2. Facilitate the experience and expression of anger.

3. Assist client to experience that her anger is limited, and she does not have to become a "bitch."
4. Assist client to work through own guilt responses to anger and inhibiting responses from others.
5. Assist the client to use well-established nurturing skills on self. (Wilt, 1993, p. 241)

Specific emphasis is placed on treatment differences when working with women who hold anger in and with those who readily express anger. When women hold anger in more time may be required to nurture a positive sense of self as well as conduct a more in-depth social analysis to determine cultural conditions that have caused fear of the expression of emotion. Exploration of anger can take place only after a strong sense of safety has been established, accompanied by cognitive restructuring to assist in the development of a healthy perception of the expression of emotion. With women who readily express anger, facilitating the development of focus on the current source of anger will be an emphasis of early treatment. The approach will be more cognitive based, developing a "step-by-step plan" (p. 251) for the effective management of anger. Distracting and calming techniques may be beneficial. Stimulation of repressed anger is possible only after "the client has developed a solid beginning sense of control, focus, and boundary formation" (p. 252).

ANGER MANAGEMENT WITH FEMALE OFFENDERS

Three programmes of anger-management for women offenders were found in the literature (Wilfley, et al., 1986; Rucker, 1991; Smith, Smith & Beckner, 1994). Wilfley et al. designed a group treatment approach for a maximum security facility in Cedar City, Missouri, based on research conducted by Novaco, noted above, with the stated purpose "to provide the participants with an opportunity to gain an awareness and understanding of their anger and to develop appropriate methods for managing it" (p. 44). The group consisted of eight women who met for two hours per week for eight consecutive weeks. Group activities included "brainstorming, behavioral rehearsal, relaxation, verbal exercises, stress inoculation training, and discussion" (p. 45). Homework was assigned between sessions to encourage self monitoring of response in anger-arousing situations through the use of a daily log. Contacts were employed to foster assertive behaviour in specific situations, and strategies were discussed for continuing after completion of the group sessions. Wilfley et al. reported outcomes of

increased personal control, responsibility, and empathy, as well as "an increased ability to generate and utilize alternatives which led to much more flexible, creative, and constructive responses when faced with anger provoking situations" (p. 41). In addition, a mutual support system developed among the incarcerated women as they encouraged one another during the week between sessions.
The authors noted a "strong need and enthusiastic interest" (p. 50) among the female offenders for anger awareness and management groups, citing little effort and time required to encourage eager participation. Though four of the eight women dropped out of the programme, the effect was "an increased feeling of specialness and commitment expressed by the remaining four group members" (p. 48). During the course of the programme the women addressed personal issues from their past and the central theme of their isolation from family, society and self. Changes in self perception were noted as women gradually moved from a self imposed isolation used as a coping mechanism to display increased interest in, and respect for, one another.

Rucker (1991), in a study designed to create nonviolent niches within a medium security prison for women, defined the research task of establishing an environment where women will be encouraged to make positive life changes rather than focusing their energy on merely fighting for survival. The programme that was tested was based on the Alternatives to Violence Project (AVP), an educational programme originally introduced in the New York State prison system by a volunteer group approximately fifteen years ago. The stated core philosophy is "to affirm the existence and legitimacy of personal power and to give participants the experience of shared power exercised cooperatively, responsibly and well" (AVP Basic Manual, 1985, quoted in Rucker, 1991, p. 4). Within this programme power is defined as the ability to create "win/win" (p.4) situations rather than coercing others to get what is desired. To facilitate empowerment, the programme emphasizes the affirmation of individuals, the development of a cooperative environment based on trust and empathy, and the development of communication and conflict resolution skills. The format includes two, three day intensive, experiential workshops followed by six weekly one and one half hour follow up sessions.

While not addressing the subject of anger specifically, the programme emphasized a nonviolent approach to conflict resolution. Participants were admitted into the programme on the basis of the following criteria:

> We must be willing to set aside old, habitual assumptions that violent or destructive solutions are the only ones possible and be willing to try something different, something creative; we must believe that a win/win solution is possible and that there is something in the person who is challenging us, no matter how hidden it may be, that is willing to join us in seeking such a solution; and, finally, we must expect the best, not only from ourselves, but from others in our interactions with them.
>
> (AVP Education Committee, 1985, quoted in Rucker, p. 104)

Thirty two subjects participated in two comparison groups which differed only in the content of the follow up sessions. In follow up to the AVP workshops, one group received additional emphasis on the development of conflict resolution skills, role plays of conflict scenarios, guided meditations, and affirmative exercises, while the other focused on sexuality issues such as prostitution, lesbian relationships, problems associated with the difficulty of sexual expression in prison, AIDS, and other sexually transmitted diseases. Results of the comparison of the two groups showed that the AVP/skills group was more able to formulate "I" statements in response to a situation of conflict, were more able to communicate their conceptualization of nonviolence and said they were more controlled in the group with regard to what they thought and said. Participation however dwindled in this group weekly, due possibly to the repetitive nature of practising skills. The AVP/sexuality group became more cohesive during the follow up, due to the stimulating nature of the discussions. It was concluded that AVP/sexuality is most productive over the long term.

While results indicated no statistically significant change in levels of trust, empathy, or locus of control in either of the groups, a contradictory trend emerged. Participants indicated they expected, as a result of the programme, to have more personal power in the ability to control their lives but also reported an expectation that powerful others and chance would control their lives. The researcher concluded "while participants' sense of personal power seemed to increase during the course of the project, they maintained an awareness of the coercive and unpredictable nature of the penal environment in which they lived" (p. 82).

A further conclusion was drawn that the one and one half hour follow up sessions once weekly were not enough to sustain the "deep level of trust evidenced" (p. 125) during

the workshops. This trust was demonstrated in one specific trust exercise. Members of the group would lift one woman from a position of lying flat on the floor to a level where they would cradle her in their arms, slowly turn a complete circle and gently lower her again to the floor. This trust lift exercise was experienced by the women as a particularly powerful method of emphasizing the issue of trust discussed in the workshops. At the conclusion of the study, the researcher questioned whether that level of trust can be sustained in a prison setting. An environment of "inflexible rule enforcement, faulty communication, and suspicion evidenced by the security staff in their interactions with both the participants and researcher" (p. 102) was considered to be counterproductive to the establishment of the nonviolent niches that the study sought.

Suggestions for improvement include placing more emphasis on making the connection between such techniques as "trying to find common ground, basing a position on truths, risking creativity rather than violence, and using surprise and humour" (p. 116). Further research is warranted regarding the question of how the positive AVP environment may be advantageous in establishing a sense of freedom and safety that allows for self expression. Suggesting what makes the programme so effective is its potential to "enable and encourage individuals to either create their own strategies for growth or make better use of already-existent programs within the prison setting" (p. 128), Rucker maintains such empowerment must be taken seriously.

The third anger management workshop for women inmates (Smith et al., 1994) was provided to a group of eleven medium-security women inmates at the Utah State Prison. The workshop had four objectives: to understand common symptoms of anger, why people get angry, how anger can be managed more effectively, and to help women inmates incorporate anger-management suggestions into their lives. The workshop consisted of three consecutive weekly two hour sessions. Discussion centred around the emotional, physical, cognitive, and behavioural symptoms shown when people are angry, common strategies for managing anger, and the development of personal anger-management strategies. Between session homework focused on keeping a daily record in which women were asked to rate their anger on a four point scale, to identify events that triggered their anger, and to distinguish signs that indicated to them that their anger had reached a dangerous level. After being asked to implement the anger-management strategies women had developed, the strategies were evaluated, with an emphasis placed on those that were most effective.

Results indicated that "a three session workshop on anger management can have a significant impact on women inmates" (p. 175). A focus was placed on helping women to think before they act on their anger, emphasizing such strategies as walking away from a conflict, breathing exercises, and cognitive interventions such as concentrating on pleasant thoughts and positive images.

In addition to the three programmes surveyed, in a selected review of the literature over the past fifty years, Schramski and Harvey (1983) examined the effectiveness of psychodrama and role playing in male and female correctional environments. Their study suggested "cautious optimism" (p. 249), indicating though the method has "been well-used in correctional environments, [it has been] somewhat less well reported" (p. 252). This study does not report anger results specifically, citing more general improvements in group members who were, for example, more "helpful, trusting and interpersonally adequate" (Maas, cited in Schramski & Harvey, 1983, p. 245).

OTHER PROGRAMS

The following programmes or treatment interventions, while not specifically anger focused, are included because of the correlation between levels of self-esteem and anger noted above, and an emphasis on building positive relationships which, of necessity involves a creative, nonviolent approach to conflict resolution.

1. OUTDOOR PROGRAMMES

Three outdoor programmes for women offenders appeared in the literature (Wilderness Experiences for Women Offenders Program, 1990; Jose-Kampfner, 1991; Stumbo & Little, 1991) as well as a fourth outdoor therapeutic programme for women (Crump, 1993, 1994).

Initially funded by the Minnesota Department of Corrections, the *Wilderness Experiences for Women Offenders Program* consists of a three day and a nine day wilderness trip designed for groups of eight to twelve women who have been convicted of felonies. The three day trip, at a cabin setting involves a nature hike, learning necessary camp skills of fire-building, cooking, and knot tying, serves as preparation for the nine day trip which includes a rock climbing segment and a canoe expedition. In addition to learning the skills of wilderness travel and map and compass use, participants take

leadership roles and, as a group make route and timing decisions. Positive stress management is encouraged by the trip leaders. Throughout the programme participants have an opportunity to:

- increase their awareness of their strengths, experiences, and abilities as building platforms for learning new skills;
- learn to cooperate by participating in situations where they help each other and have to rely on each other for help;
- increase their self esteem;
- increase their risk taking capacity;
- develop a positive body image;
- make decisions as individuals;
- integrate personal wants and needs into group decision making;
- increase their positive image of women by having positive role models and successful group experiences;
- be in an environment where racism, sexism, and other difficult interpersonal topics are discussed in a constructive way;
- learn new outdoor living skills.

Although the programme has not been formally evaluated, it is recognized as providing incarcerated women with a powerful resource for managing stress, increasing self esteem, and learning skills for working cooperatively with other women (Mitten, 1995).

Jose-Kampfner (1991) and Stumbo & Little (1991) report the success of children's visitation programmes at the Huron Valley Correctional Facility in Ypsilanti, Michigan and at the Dwight Correctional Center in Illinois respectively. The *Children's Visitation Program (CVP)* began at the Huron Valley Correctional Facility in 1988 and has served more than one hundred children and fifty mothers. Allowing for a more natural interaction between mothers and children than the prison visiting rooms usually allow, the programme permits mothers to spend time alone with their children unaccompanied by other adults. Non uniformed Department of Corrections staff are present during the visit in addition to a clinical psychologist who also provides family therapy. The children are permitted to run freely and play with other children. Visits lasting approximately three hours take place in the regular visiting room which is temporarily converted into a playroom, and outside when weather permits. Group activities such as singing and story telling are organized at the beginning and end of the visits with the remainder of the time available for mothers and children to organize as they choose. Community volunteers provide transportation for those children who

live far from the facility, an involvement which provides the community with an awareness of the particular problems faced by incarcerated women. A committee of ten inmates who are elected from among the prison population form the governing body of the programme. In addition to making decisions about the decor of the visiting room and the disciplining of inmates who violate programme rules, committee members learn further skills of organization, record-keeping and conflict resolution.

Since it began, the programme "has served not only to restore the bonds between mothers and children, but also to greatly improve discipline at the institution" (Jose-Kampfner, 1991, p. 132). Ninety percent of the mothers, in a questionnaire said they would avoid any activity that might mean the loss of the Saturday visit. Seventy five percent said "the visits had effectively prevented them from engaging in misconduct" (p. 132). No contraband has been introduced in the twenty seven months since the programme was initiated.

"*Camp Celebration*" (Stumbo & Little, 1991) was initiated at the Dwight Correctional Center in the summer of 1988, funded by a three year federal grant. Located on the grounds of the facility, the programme operates for thirteen weeks each summer, with up to twelve mothers per weekend bringing their children for a forty-eight hour visit from late Friday afternoon until Sunday noon. Consisting of usual camp activities of campfire, skits, and songs, a nearby community resident provides farm animals, a pony, lamb, and goats, which are enjoyed by the children and cared for by the inmates. Similar to the Huron Valley programme, security checks are conducted in an unobtrusive manner, and security has not been a problem as women have not wanted to violate rules that would mean their participation might be jeopardized. With "few other programs rival[ing] the benefits delivered to the women with such little staff cost", Camp Celebration is considered to be "an integral part of the overall parenting program" (p. 144). A camp manual and a research report documenting the effects of the programme is available from the Dwight Correctional Center.

Wilderness Challenge (Crump, 1993, 1994) is a therapeutic outdoor programme begun in Nova Scotia in 1992 to serve women who are survivors of violence. The programme consists of three day outdoor weekend intensive group experiences centred around group communication and trust building exercises, sea kayaking, canoeing, and ropes course challenges. Individual characteristic responses to stress and conflict are examined following each of the activities which are sequenced to involve progressively

deeper levels of trust and physical contact. Emphasis is placed upon developing an atmosphere conducive to trust and support within the group. Confrontation naturally arising as the individual needs of women conflict are processed in an environment that encourages mutual respect. Individuals are encouraged to push beyond their own perceived limits to new learning, with strong emphasis placed on providing choice regarding level of participation in each activity. Group and individual tasks are broken down into small, manageable steps to ensure success. Groups consist of up to ten women, are led by trained therapists and outdoor staff, and are conducted year round in various wilderness areas in the province of Nova Scotia. Evaluated in its demonstration phase (Mahon, 1994), the programme was determined to be "an effective adjunctive treatment modality for survivors of violence" (Mahon, 1994, p. 1). Selected participant comments from the evaluation report include:

> *Without the safety, I would never have challenged myself to the extent that I did. I did a lot of checking out before I took the risks. I believe I am very intuitive when it comes to my safety. The reassurance played in my head a great deal. Each step I took was with much precaution. I explored all my choices and never closed any option. Feeling physically safe came with the space that was set up. Emotional safety came from my needs being met when I felt unsafe...respect for my fear.*
> (p. 11)

> *I learned to trust myself again. I saw and appreciated the positive qualities and difficulties and pain of each individual in the group and feel less fear, not threatened by others....I began to feel less isolated.*
> (p. 15)

> *I realize now there are people and places that will not hurt me. Trusting myself to know I have the strength to deal with whatever comes for me.*
> (p. 12)

The programme is adaptable to a variety of population groups and is available to private and public treatment organizations.

2. MODIFIED THEME-CENTRED-INTERACTIONAL METHOD

A modified theme-centred-interactional method focused on women and anger (Gettle, 1985) was developed on thirty female volunteers to assess its effect on anger awareness and self esteem. The programme consists of eight two hour group sessions with the overall theme of "Discovering and Understanding My Anger" (pp. 39-40). Basic principles of the model emphasize "the individual sharing herself, the mutual sharing of others, and the experience of...sharing around a theme" (p. 41). Results indicated no significant increase in anger awareness or self-esteem although participant journal entries suggested "change had occurred in the area of recognizing and expressing anger" (p. 70).

3. THE FRIENDSHIP GROUP

Utilizing "a combination of lecturettes, exercises, homework, assignments and individual follow-up by group leaders" (Lovell, 1991, p. 9), the Friendship Group manual was tested in agencies providing therapeutic daycare and parenting education to those identified by child protection agencies as having serious parenting problems. In some cases, participants had lost custody of their children. With prior abuse, abusive family-of-origin networks, and social isolation identified as some of the factors contributing to parenting difficulties, the programme focuses on "experiential skill training" (p. 5) in an effort to address isolation and enhance support by encouraging parents in the ability to be a rewarding friend. Sessions address such topic as values clarification, unsafe situations and personal boundaries, assertiveness, handling negative concerns and criticism, and refusing and making requests. Follow-up data suggests those who have completed the sixteen week programme, rather than using the skills they have developed to initiate new friendships, tend to "value the friendships they already possess differently" (p.5). Their social contacts become more rewarding to them and they thus can rely less on family networks that are fraught with long standing difficulties.

4. NOBODY THERE: MAKING PEACE WITH MOTHERHOOD

The Elizabeth Fry Society of Edmonton (1994), in response to a 1993 study entitled *Common Threads,* identified a lack of knowledge and service gap in assisting women who have either voluntarily given up, or lost custody of, their children. Researchers considered the previously held assumption that women lose custody of their children due to incarceration, noting that custody is often lost prior to involvement with the law. Eight women in this study participated in two interviews. Their stories were compiled

and published in an effort to gain an understanding of women in similar situations to "better enable the Society and similar agencies to more sensitively meet the needs of the women they served" (p. 1).

Early life trauma, most notably sexual abuse, was common to three quarters of the women interviewed. In addition, physical and emotional abuse, "parental neglect, divorce, disappearances, and incarcerations; family violence; apprehensions by social services; and repeated moves from one home to another" (p. 145) characterized their early lives. Encountering repeated trauma, the women's stories revealed a wide range of difficulties common among trauma survivors: inability to trust, "low self-esteem, high anxiety, lack of empathy, suicidal tendencies, aggressive behaviour, alcohol abuse, and school and social adjustment problems" (Galambos, quoted in Elizabeth Fry Society, 1994, p. 145). Citing Terr's (1991) suggestion that rage and extreme passivity "gradually replace the ability to trust" (p. 145), these women also lose a belief that they have the ability to make choices and control their own lives. Being emotionally vulnerable, six of the eight women became pregnant between the ages of fourteen and seventeen. Their own experiences of being mothered then became relived in their subsequent difficulties with mothering. As in the *Common Threads* study, women in this study had to hit `rock bottom' (p. 180) before becoming committed to working toward making peace with their lives. The turning point for the women came in the form of "giving up or losing their children or a significant relationship; becoming embarrassed by and afraid of their addiction or having to serve time; and beginning to fear their own death" (p. 180).

The study offers recommendations for action, too numerous to include in this assessment. Consistent is the advisement to understand the effects of early life trauma on motherhood, intimate relationships, and personal problems and the provision of services that reflect that understanding. A few of the recommendations are included below:

- Arrange for rooming-in programs for the young children of women who are serving time in prison or who are receiving treatment for addiction. If the children are too old to room in or the facility cannot be modified to handle this program, organize a regular visiting program to insure that the mother-child connection is not broken during incarceration or treatment.

- Organize and offer support groups for mothers who are fighting for custody of their children after losing them because of incarceration, hospitalization, or involvement in treatment for addiction. In addition to emotional support, these

groups should offer the women access to verbal and written information about the legal system, how to use a lawyer or legal aide, and about exercising their rights.

- Support the decisions of mothers who decide to give up their children. Treat the decision as one made out of love and made with the best interests of the children in mind. Insure that the children realize that their mothers loved them and gave them up so they would have a better chance at life. To help the mothers adjust to the loss of their children, provide occasional reports and pictures and, when possible, connect them with other women who have given up their children and handled it well.

- Insure that all who work with women who have been in conflict with the law have a firm and up-to-date understanding of the child welfare system so they can offer informed assistance and support to women who are dealing with child welfare-related issues.

- Insure that all who work with women who have been in conflict with the law understand and appreciate the tremendous pain and shame that mothers who have given up or lost custody of their children carry. Because this issue is so taboo in our society, those who work with women often do not even address this issue. However, they should be encouraging and supporting women as they tell their stories. In addition, they should be connecting women who are in similar situations and offering them support and, when necessary, counselling for unresolved grief.[3]

This is an excellent study to aid in the understanding of the connections between early abuse and later life trauma. It's recommendations are encompassing and strongly endorsed by the author.

5. HOME IMPROVEMENT - TOOLS FOR BUILDING BETTER RELATIONSHIPS

Initiated at the Burnaby Correctional Centre for Women, an initial eight session group was expanded to sixteen to allow sufficient time to "develop ground rules and adequate rapport" (Katz & Hall, 1994) necessary to deal with the sensitive issues regarding abuse in adult and parent-child relationships. The programme is considered to be used most effectively "as a stepping stone between cognitive skills and a parenting program" (Katz, p. 6). The sessions focus on identifying abuse, power and control, relaxation and communication skills, anger, healthy sexual relationships, and the effects of abuse or witnessing abuse on children. Techniques include role plays, videos, finger painting, and discussion. A significant portion of the programme addresses anger related issues. Following an exploration of a cognitive-behavioural

[3] Elizabeth Fry Society, 1994, pp.178-179.

anger model that encourages women to practice reducing anger by changing their thoughts about specific provocations, sessions explore empathy and respect statements, aggressive versus assertive behaviour, fair fighting, and jealousy and rebuilding trust. A follow up interview including both "recognition of positive growth and identifying concerns" (p. 109), concludes the programme.

The content is extensive, current, and relevant within each subject area, though the inclusion of a section on fair fighting may not be appropriate in the context of having lived with an abusive partner. Each of the sessions includes significant detail to assist facilitation.

Although problems were encountered in group management due to "inmates' poor social skills, low motivation for change, poor cognitive skills, inadequate emotional development and confrontational/abrasive attitudes" (Katz & Hall, 1994, p. 2), and trust was found to be non-existent (p. 2), the authors noted the programme had a significant impact on some of the women. Notable insights were gained and changes initiated in the area of recognizing abuse in current partners that had not been seen before, parental limit setting, personal life choices, connecting with support services upon release, and in reestablishing connection with adult children. It is apparent many of these changes would not have been possible without having participated in the programme.

Among the recommendations included in the final report of the project was the suggestion of daily sessions over a one or, preferably two week period that would better facilitate the development of an adequate trust level.

6. PROGRAM FOR INNOVATIVE SELF-MANAGEMENT

Designed for adolescents, the strategies used in this programme are adaptable to an adult population. The Program for Innovative Self-Management (PRISM) (Wexler, 1991) is shaped by the theories of self psychology that hold that "a primary motivating force for many human behaviors is to maintain a cohesive sense of self" (p. 6), cognitive behaviour therapy (noted above), and an adaptation of hypnotherapy that emphasizes client's own "naturally occurring responses rather than pushing them in a specific direction" (p. 7). The programme, structured around a combination of group and individual sessions and utilizing additional techniques borrowed from Gestalt therapy and psychodrama, recognizes that self destructive behaviour patterns "reflect attempts

to rebalance or protect the fragile self" (book jacket). The rage exhibited by the traumatized child is seen in this light. Wexler states:

> When adolescents' behaviors' seem wildly out of control, aggressive, or self-destructive, this is more than just delinquency or acting out. This is a fragmented self desperately trying to reintegrate. (p. 24)

The sixteen session hospital programme, designed to run over four weeks, introduces four central skills of self talk, assertiveness, body control, relaxation, and visualization. The model further employs a variety of innovative methods. For example, the "freeze-frame technique" (p. 68) allows the client to "slow down time" (p. 69), and explore available options before acting impulsively. By reexperiencing a situation of conflict from the past in a "focused meditative state" (p. 74) of deep relaxation, it becomes possible to slow the action down and learn that "the `uncontrollable' behavior is not so automatic" (p. 74). After examining available options, it is emphasized that "the behavior they chose originally was their attempt to take care of themselves as best they knew how at that moment" (pp. 75-76). New options are chosen to create a different ending with more positive consequences. The same result can be achieved without visualisation, where time does not allow or the procedure is too threatening, by the use of role-playing and analysis.

The model has been found to be successful in treating adolescents who display eating behaviour issues, suicidal behaviour, low self-esteem, emotional outbursts, and self mutilation.

7. Storytelling From a Jungian Perspective

Perhaps a discussion of anger treatment modalities is best concluded with a discussion of the work of Jungian analyst and *cantadora* storyteller Clarissa Pinkola Estés (1992), who believes "women's flagging vitality can be restored by extensive `psychic-archaeological' digs into the ruins of the female underworld" (p. 3). Placing emphasis on clinical and developmental psychology, she uses "the simplest and most accessible ingredient for healing - stories" (p. 14), which she perceives as "medicine" (p. 15).

Drawing upon the elements of a change oriented mythological story, Estés maintains women possess within themselves the ability to heal their rage and anger "by seeking a

wise and calm healing force..., taking the challenge of going into psychic territory one has never approached before..., putting one's old and obsessive thoughts and feelings to rest' (p. 351), and understanding the power of the self to seek solutions to what caused the rage and what can be done with it. Estés suggests that "[e]ven though the world may be falling to pieces outwardly, the inner healer is unswayed by it all and maintains the calm to figure out the best way to proceed" (p. 354). Anger thus, is used "as a creative force....to change, develop, and protect" (p. 354).

Emphasizing the function of rage as teacher, Estés states "the learning [women] are after is to know when to allow right anger and when not" (p. 363), and offers a prescription for women who are "stuck in old rage" (p. 368) that Estés has used in her work for many years. She presents four levels of forgiveness:

1. to forego - to leave it alone
2. to forebear - to abstain from punishing
3. to forget - to aver from memory, to refuse to dwell
4. to forgive - to abandon the debt (p. 370)

suggesting this work is usually accomplished in small increments over many years rather than the all or nothing manner our culture promotes. The stages are depicted by Estés as: (1) "tak[ing] a break from thinking about the person or event for a while" (p. 370), (2) "refrain[ing] from unnecessary punishing [which] strengthens integrity of action and soul" (p. 370), (3) "conscious forgetting by refusing to summon up the fiery material" (p. 371), and (4) making a "conscious decision to refuse to harbor resentment" (p. 372). The stages, in narrative form, resemble the calming techniques, self talk, and decision not to dwell on angry thoughts, noted in programmes above.[4]

RECOMMENDATIONS FOR FUTURE PROGRAMME DEVELOPMENT

Based on material found in the literature, the following recommendations are made for future programme development:

1. There should be an understanding among all involved with the programme, of women's anger/aggression in and of itself apart from the experience of what is

[4] Personal conversation with Catherine Lambert, a Halifax therapist who conducts residential workshops for survivors of abuse, reveals the power of the narrative approach to therapy, of women telling their stories through an integrated process with other women, which allows them to address their anger in constructive, change oriented ways.

understood of male anger/aggression, as well as an understanding of the cultural, social, and psychological circumstances surrounding it.

2. Consideration of race and ethnic background that recognizes the uniqueness of varying cultural influences, must be made.

3. A programme should encourage representations of women's anger that separate it from aggression.

4. To facilitate a healthy perception of the expression of emotion, the social context of women's anger should be emphasized, addressing the negative cultural view of the direct communication of feminine anger. Women's anger must be recognized as visible and legitimate.

5. Programmes may be most productive when using a multifaceted group approach employing cognitive-relaxation with social skills and problem-solving training. The programme must have enough flexibility to allow for discussion of personal issues as they arise among groups members.

6. The power of story (Estés, 1992) to promote change is highly recommended, and can be incorporated into any programme design.

7. An intensive format is recommended, consisting of three hour group sessions conducted daily over a one or, ideally two week period, permitting sufficient time to establish the basis of trust necessary for disclosure of personal emotion.

8. Where a daily group is not possible, an alternative format is suggested. To facilitate situations where win/win solutions may be encouraged, and incremental mastery of trust is possible, experiential trust building exercises that focus on experiencing as well as discussing emotions are recommended. It is suggested a three day intensive group combined with a ten week, two hour follow up group would provide optimum possibility for this.

9. Wilderness trips are suggested as a distinct possibility, involving an emphasis on building positive relationships, increasing levels of self-esteem and trust, positive stress management, and a creative non violent approach to conflict resolution.

10. Groups should be co-facilitated by female leaders from outside the prison environment who are skilled in an understanding of emotions, how they develop, are suppressed, and expressed among women.

11. Recognizing that often underlying deep anger is the pain, loss, and grief associated with previous violations, facilitators must be highly skilled in dealing with early life physical, emotional, and sexual trauma among women.

12. Facilitators must be knowledgable of, and sensitive to, the issues for women who have lost or given up custody of their children.

13. Attention should be made to differences in treatment for women who readily express anger and women who hold anger in.

14. The ventilation of anger should be viewed with extreme caution.

15. Intensive orientation to the programme should be conducted with prison staff to facilitate a coordinated approach, an understanding of the critical life issues women are addressing, and an awareness of the principles underlying the programme.

16. A priority should be placed on women in the context of relationships with partners, children, and friends, recognizing both heterosexual and same-sex relationships as valid and acceptable.

17. A children's visitation programme is recommended to ensure bonds between mothers and children are not broken while women are incarcerated. This would ideally be accomplished in an outdoor setting.

CONCLUSION

At the conclusion of the first comprehensive study of women's anger in natural settings (Thomas, 1993d), the author notes that among questions that remain unanswered is the consideration of "[w]hat therapeutic interventions are most effective with women whose high anger proneness or maladaptive anger management has already resulted in pathology" (p. 260). Among incarcerated women this is a question to be considered. Rucker however, speculates that "when given an accommodating correctional milieu, many offenders will make a bona fide effort to use the prison experience to improve themselves and hence to improve their chances for a decent life upon release" (Johnson, quoted in Rucker, 1991). For all women whose deep anger is waiting to be acknowledged and made visible, the words of Clarissa Pinkola Estés offer a concluding word of hope:

> Our rage can, for a time, become our teacher...
> a thing not to be rid of so fast, but rather something
> to climb the mountain for, something to personify,
> learn from, deal with internally, then shape into
> something useful in the world as a result, or
> something we let go back down to dust....rage is
> not a stand alone item. It is a substance waiting

> for our transformative efforts. The cycle of rage is like any other cycle; it rises, falls, dies, and is released as new energy. (p. 352)

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