Anger in the Trajectory of Healing From Childhood Maltreatment

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When a girl is abused during childhood, she may not experience anger, only helplessness or numbness. Only later may the emotion of anger surface. Little is known about anger cognitions or behaviors as they occur across the years of the healing trajectory from childhood maltreatment. Data for the present secondary analysis were derived from a large narrative study of women thriving in adulthood despite childhood abuse. The purpose of this analysis was to examine the phenomenon of anger and its role in the recovery process of 6 midlife women. The 6 cases were purposefully selected because their interviews contained rich descriptions of anger experiences. Because each woman was interviewed 3 times over a 6- to 12-month period, 18 transcripts were available for in-depth examination. A typology was constructed, depicting 5 types of anger. Anger ranged from nonproductive, self-castigating behavior to empowering, righteous anger that enabled women to protect themselves from further abuse and to advocate for abused children. Study findings are relevant to extant theories of women's anger and feminist therapies.

ANGER IS A universally experienced and complex emotion. The study of this emotion has generated considerable interest from researchers within various fields of physical, mental, and behavioral health, as it has been shown to have a significant impact on these aspects of people's lives. Researchers have categorized different types of anger, as well as numerous forms of anger expression and suppression (e.g., Deffenbacher, 1995; Spielberger, 1999). The consequences of anger and its various dysfunctional manifestations can have a profound impact on the individual who experiences the emotion, as well as those in contact with that person. Historically, there have been conflicting views on what is adaptive versus maladaptive anger, as well as how clinicians can best address it in a therapeutic and health-promoting way. Views of "effective" anger management vary greatly according to gender, status, social roles, and cultural context (Thomas, 2006).

Despite the publication of several otherwise excellent books (e.g., Kassinove, 1995), little attention has been devoted to managing anger after childhood abuse. This study was prompted by a gap in the literature about anger of women who have experienced childhood maltreatment. In the larger study from which this analysis was drawn, narratives of women's recovery from childhood abuse provided a temporal view of the processes and interpersonal relationships

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involved in "becoming resolute" and, ultimately, "thriving" (Hall et al., 2009; Roman, Hall, & Bolton, 2008; Thomas & Hall, 2008). This unique sample of 44 women had achieved remarkable success in life despite egregious childhood abuse. The first author, an anger researcher, had observed some vivid anger stories in the narratives and decided to return to the data to explore these more fully. Before turning to the results of the data analysis, a brief review of anger literature is necessary to provide a background.

REVIEW OF THE LITERATURE

Maladaptive and Adaptive Anger

De Rivera (2006) theorized that anger involves a perception of a challenge to what ought to exist and an impulse to remove that challenge. Although anger is a normal human reaction to challenges, such as unfair treatment or insults to one's integrity, few people learn how to manage it effectively while growing up (Thomas, 2006). Both men and women have deplored inadequate instruction by role models in expressing anger adaptively (Thomas, Smucker, & Droppleman, 1998; Thomas, 2003). Adaptive anger entails a clear statement of the perceived offense, stated in "I" language, delivered without blaming or attacking the other person, followed by a reasonable request for amends. To state the obvious, adaptive anger does not involve property destruction, verbal or physical aggression, or use of weapons. Maladaptive anger, characterized by irrational cognitions and out-of-control behaviors, is widespread in America, as evidenced by loud cursing in workplaces, road rage on highways, and brawls at sporting events (Thomas, 2006).

Deleterious health consequences of mismanaged anger have been identified by researchers. To cite just one example from a vast literature, *hostility* (which entails pervasive negativity and frequent anger) is a predictor for cardiovascular disease, as well as poorer general health and earlier mortality (Jackson, Kubzansky, Cohen, Jacobs, & Wright, 2007). In addition to focusing attention on the general tendency to be readily "aroused" to anger, researchers have clearly described maladaptive forms of anger "expression," focusing mainly on "anger-out" (venting at others) and "anger-in" (holding anger inside; e.g., Siegel, 1985). Both of these have adverse health consequences. For example, a recent study by Lazlo, Jansky, and Ahnve (2009) found that both suppression and the outward expression of angry feelings increase the risk of poor prognosis in women with coronary heart disease (CHD).

Although explosive outbursts have received greater attention than anger suppression, especially in the research on CHD, a study by John and Gross (2004) implied that anger suppression can be maladaptive to an individual's functioning on an emotional and social level. Suppression of any emotion, anger included, has been shown to lead to decreased positive emotional experiences, compromised social functioning, and memory impairment for social information (John & Gross, 2004). Gross and Levenson (1997) found that habitual suppression of anger is as problematic as the tendency to have explosive outbursts.

Not surprisingly, there is a known link between poorly regulated anger and many of the personality disorders, as well as to depressive illness, although it is not clear whether poorly regulated anger is a precursor or byproduct of depressive illness (Plutchik, Van Praag, Conte, & Picard, 1989; Koh, Kim, & Park, 2002). Anger is also considered to be a core issue in posttraumatic stress disorder (PTSD; Franklin, Posternak, and Zimmerman, 2002) and is linked to alcohol misuse and misuse of over-the-counter drugs (i.e., chemicals used to dampen unpleasant emotional arousal; Grover & Thomas, 1993). High anger, in conjunction with impulsivity, contributes to suicide risk (Horesh et al., 1997).

Anger in Women

The body of knowledge about women's anger is relatively small, especially if compared with the voluminous literature on women's anxiety and depression. Available evidence indicates that suppression and diversion of anger are more common in women than in men, in part because of gender role socialization for femininity, which inculcates the notion that anger is unfeminine and unattractive (see Thomas, 2006, for a summary of this literature). Angry women receive pejorative labels such as *bitch* (Lerner, 1985), whereas women who conform to the feminine ideal are unfailingly pleasant and *nice*. Thus, women experience a fundamental tension between adaptive function and societal inhibition (Cox, Stabb, & Bruckner, 1999). Although some may argue that there has