Work in Progress

The Meaning of Care: Reframing Treatment Models

Irene P. Stiver, Ph.D.

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The Meaning of Care: Reframing Treatment Models

Irene P. Stiver, Ph.D.

About the Author

Irene Pierce Stiver, Ph.D., is Director of the Psychology Department at McLean Hospital, Belmont, Massachusetts, and a Principle Associate in Psychiatry at the Harvard Medical School.

Abstract

The traditional model of therapy, which stresses objectivity, neutrality and distancing is explored. This model reflects a style more congenial to men than to women, since it emphasizes objective, unemotional and impersonal attitudes. While various therapeutic strategies contribute to distancing in therapy, the formal and informal language which is used in diagnosing is examined with particular emphasis on the ways in which women are more victimized than men by these processes. The distinctions between types of "caring" will be explored, since "caretaking" contributes to distancing and inequality in the therapeutic relationship, while "caring about" allows for more egalitarian and genuine interaction.

At first blush the connection between caring and psychotherapy seems obvious and yet for many of us trained in the traditional model of therapy, caring about one's patients often is seen as something which may get in the way of effective treatment. The maintenance of distance between therapist and patient as well as general prohibitions against the expression of caring can be attributed to two major assumptions underlying this traditional model. The first assumption is tied to a broader model of treatment in which the treatment of the patient requires that the treater be objective, nonemotional and relatively impersonal in order to be most helpful to the patient; it involves a kind of caretaking through, for example, the prescription of medication, the administration of appropriate treatment strategies, etc. Personal qualities of warmth and kindness are certainly seen as important assets but they should be monitored carefully lest the therapist become "too involved," i.e., perhaps care "too much" for the patient.

Let me say a few words here about the complicated meanings of "caring." I believe one needs to distinguish between "caretaking" — the giving of care which implies a more parental and, if you will, unequal relationship — and the concept of "caring about" which suggests more of an investment of feeling in the other person with no implication about status or equality. While both types of caring are considered suspect in the process of therapy, I believe that "caretaking" is relatively acceptable as an attitude of the treater — indicating the intent to do what is in the patient's best interests; while "caring about," with the possible *expression* of caring feelings, is seen as more threatening to the therapeutic process. Later I will explore some of these distinctions in more detail.

The second assumption is that growth and change can occur only if the therapist does not gratify the patient. The experience of frustration and learning how to tolerate and respond to deprivations in therapy

are seen as valuable and therapeutic. This assumption also would argue for the need for the therapist to be relatively neutral and objective. The earlier and more extreme view of the psychoanalytic model in particular emphasized the need for the analyst's neutrality and his personal reactions to his patients were often labeled as "countertransference" which needed to be analyzed away.

While this model has been modified through the years, with the role of empathy and concepts such as the "holding environment" gaining importance in the therapeutic process, there are still strong prohibitions against more open expression of therapists' feelings toward the patient. Let me make myself clear at this point. I am not advocating that therapists become emotionally involved with their patients, either in the service of gratifying their own needs or through misunderstanding their patients' needs. I am, however, raising serious questions about the all-encompassing discomfort experienced by many therapists about having and expressing caring feelings about their patients.

In this presentation I will be examining the model of therapy in which objectivity and distancing play such an important part. Specifically, I believe that this model is essentially a masculine model since it reflects a style much more congenial and familiar to men than to women, i.e., objective, nonemotional, impersonal attitudes, etc. For precisely this reason, this model does not seem to work very well with women, and perhaps not with some men either. The need to erect barriers to create distance from patients may also then reflect countertransference reactions among male therapists toward their female patients, who are different from them in important ways. Later, I will be tracing some significant differences in male and female experiences of self and in the pathways each sex has taken developmentally, which will help in the understanding of the nature of such countertransference reactions.

While there are various therapeutic strategies which contribute to distancing in therapy, I will be addressing the ways in which the formal and informal language of diagnosing and labeling contribute to the barriers between therapist and patient and both maintain and reinforce a state of inequality between them.

An Illustration

A brief vignette which describes the experience of a colleague and friend perhaps can illustrate both concretely and symbolically some of the issues I have been outlining so far. My friend, to whom we will refer as Alice Smith, is a clinical psychologist in her 50's, highly regarded and respected in her profession. At the same time that she has managed to be active and productive in her work, she has also suffered for years from profound and debilitating depressions. Several years ago after many trials on various antidepressants, she responded very postively to a new drug and reported that she had never felt better. During this time she was in psychotherapy with a woman psychiatrist, also an analyst, who felt that since she was not familiar enough with the field of psychopharmacology and since medication had proved to be so important with my friend, it would be best to refer her to another psychiatrist who specialized in pharmacology. He would monitor and prescribe medication, concurrent with the ongoing psychotherapy. This was certainly acceptable to everyone and things proceeded well.

About a year later some physical problems emerged. After experiencing back pain, my friend was diagnosed as suffering from osteoporosis. At times she became quite debilitated, but amazingly her spirits remained reasonably good. And then another blow occurred, when breast cancer was diagnosed. She handled this extremely well, did not become significantly depressed but arranged for several consultations and second opinions and finally decided to have a lumpectomy and radiation treatments. During this period of radiation treatment, she often felt quite ill and also continued to experience back problems so that she was frequently in significant physical distress. Her therapist caringly noticed what a physical effort it was for her to get to her appointments and suggested that until she felt better they conduct their therapy on the telephone. My friend was most relieved at this suggestion and accepted it enthusiastically.

In this instance the therapist was able to be flexible and apparently did not experience her concern or caring about her patient to interfere with the effectiveness of therapy. It then occurred to my friend that perhaps she could arrange something similar with the psychopharmacologist she also was seeing. When, however, she asked him for phone consults instead of coming in to see him personally for a while, he became angry and accused her of "acting out" to get special treatment, since he felt that she could perfectly well come in for the appointments and that also it was important to maintain an objective stance and not to gratify his patient for her best interests. She, however, was hurt and felt very misunderstood but she

accepted the situation. At some later date she had to call to reschedule an appointment. When his secretary asked who she was, she said, "Dr. Smith," and was put through to him immediately. When he heard who it was, he became very angry and told her she was being manipulative in trying to get him to talk with her on the telephone instead of leaving a message. My friend was most upset at this angry outburst and asked, "Why are you so angry?" to which he replied, "You should have said you were a patient."

What I want to highlight about this story are two major observations: 1) such terms as "acting out" and "manipulative" are often used as pejorative labels to talk to and about patients in ways which maintain both distance and a certain balance of power in therapeutic relationships and which significantly interfere with the process of caring; 2) I believe that the psychopharmacologist's anger at his patient for "getting through" to him reflected the anxiety aroused in him because she had crossed the barrier he needed to erect between him and her (and perhaps his other women patients) in order to maintain the distance for *his* comfort in the relatlonship.

Thus, the typical standards of "care" in general psychiatric settings and in psychotherapy which often support both explicitly and implicitly the need for barriers between mental health professionals and patients may serve the function of containing the anxiety of the treaters more than the treated. Yet as we have seen, some of the barriers erected have been developed with a rationale about how psychotherapy works best, which justifies them as serving the best interests of the patient.

"Diagnosing" and evaluating

Let us now examine those barriers created by the formal and informal language used in "diagnosing" and evaluating patients. I hope to show how they result in uncaring rather than caring in psychotherapy. The belief that women are more readily victimized by psychiatric labeling was the major theme of Chesler's book on *Women and Madness* (1972), and also was illustrated dramatically in the classic study of Broverman, et al. (1970). Broverman's study demonstrated a double standard of mental health since clinicians set different standards for healthy men and adults from those of healthy women. Among the terms to describe healthy women were "more submissive, less independent, more suggestible, less competitive, more excitable in minor crises, more emotional and more concerned about their appearance," than either healthy men or the generic healthy adults. Chesler felt that the other side of this double standard of health was the labeling of pathology for those women who were seen as too passive, too dependent and overemotional. She felt that this simply represented an overconformity to feminine sex role stereotypes, a caricature of those "female" behaviors which were labeled healthy in the Brovermen study. Chesler noted that pathological labels were also assigned to those women who were nonconforming to such sex role stereotyping and were called aggressive and castrating. Thus, women have to walk a thin line between being too feminine — i.e., histrionic, dependent — or not being feminine enough as described, for example, in a paper entitled "The Angry Woman Syndrome" (1971). Men, on the other hand, need only to conform to the male sex role stereotype in our culture to be identified as healthy and in fact are labeled as unhealthy primarily if they display characteristics which are seen as stereotypically female, i.e., dependent, passive.

In a recent paper entitled "A Woman's View of DSM III" (1983) Marcie Kaplan illustrates the degree to which masculine biased assumptions about what behavior is considered healthy and what unhealthy are codified into diagnostic categories, which in turn influence evaluation and treatment. D*SM III* (1980) is the third edition of the diagnostic manual created by the American Psychiatric Association which is the standard used throughout the mental health professions. The author notes that such bias is reflected primarily in the codifying of personality disorders which, according to DSM III, entail "significant impairment in social or occupational functioning or subjective distress."

Kaplan's analyses of the Histrionic Personality Disorder and the Dependent Personality Disorder are of particular interest. Although Chesler and Broverman published their ideas and data over a decade ago, their observations about diagnostic labeling of women are still alive and well in both these categories. Thus, the items listed to warrant a diagnosis of Histrionic Personality Disorder include ones similar to those Broverman and others reported that clinicians used to identify the normal healthy female, such as "overreaction to minor events," "vain" and "dependent": and also include those items that would represent what Chesler called the over-conformity to the female stereotype or caricatures of female behaviors; e.g., behavior that is "overly dramatic, reactive and intensely expressed" (1980).

The Dependent Personality Disorder is defined as "Passively allows others to assume

responsibility for major areas of life because of inability to function independently and subordinates own needs to those of persons on whom he or she depends in order to avoid any possibility of having to rely on self" (p. 324). Since women are generally seen in our culture as more dependent and less mature than men, and since they are encouraged to put others' needs ahead of their own, they would readily be vulnerable to such a diagnosis. And indeed the manual reports that both the Histrionic and the Dependent Personality Disorder are found more frequently in women than in men.

I believe the very descriptions of these diagnostic categories reflect a misunderstanding of the behaviors involved, which I hope to demonstrate more fully later. Kaplan points out, however, that *DSM III* scrutinizes the ways in which women express dependency but not the ways men express dependency. For example, men do rely on others to maintain their homes, care for their children, respond to their emotional needs, etc. More important, however, is Kaplan's observation that neither the earlier *DSM II* nor the current *DSM III* addresses those male behaviors which are caricatures of masculinity, which could be seen as impairing social functioning and if not producing subjective distress in the men, themselves, may provoke it in those with whom they live. In following this line of thinking, Kaplan indulges in some fantasy and develops two fictitious categories to be included in *DSM III.*

One she called the Independent Personality Disorder and the other the Restricted Personality Disorder. Here are some of the criteria she lists for the Independent Personality Disorder: "1) puts work and career above relationships with loved one, e.g., travels a lot on business, works late at night and on weekends; 2) is reluctant to take into account the other's needs when making decisions, especially concerning the individual's career or use of leisure time, e.g., expects spouse and children to relocate to another city because of individual's career plans."

Her Diagnostic Criteria for Restricted Personality Disorder include:

A."Behavior that is overly restrained, unresponsive and barely expressed, as indicated by 1) limited expressions of emotions, e.g., absence of crying at sad moments; 2) repeated denial of emotional needs, e.g., of feeling hurt; 3) constant appearance of self-assurance; 4) apparent underreaction to major events, e.g., is often described as stoic.

B. "Characteristic disturbances in interpersonal relationships as indicated by 1) perceived by others as distant, e.g., in individual's presence others feel uncomfortable discussing their feelings; 2) engages in subject changing, silence, annoyance, physical behavior or leave-taking when others introduce feeling-related conversation topic; 3) indirectly expresses resistance to answering others' expressed needs, e.g., by forgetting, falling asleep, claiming need to tend to alternate responsibilities" (pp. 790, 791).

The bias reflected in these formal classifications of mental illness is even more dramatically evident in our informal language. Such terms as manipulative, seductive, controlling, needy, devouring, frigid, castrating, masochistic and hysterical have been used pervasively primarily to describe female patients, with the clear implications that such patients are hard to tolerate, almost impossible to treat and if one does not manage them carefully one will be taken over, fused with, devoured, etc. Even when the perception of the patient is more benign, the labels of "dependent," "seductive," etc. are at best patronizing. The end result of such labeling is that the patient is not understood and not cared about.

Let me share with you a brief clinical example. I was asked to consult about a young woman who had become anxious and depressed enough to require rehospitalization after a period of fairly good adjustment. She is a young, attractive nineteen-year-old honor student at an ivy league college, and is highly intelligent, very sensitive and articulate. She talked readily to me on several occasions about the anguish she often experienced in a world which felt unreal to her. When I approached one of the administrative psychiatrists to discuss the case, he told me immediately that she was "very manipulative" and was going to be "a handful." I was a bit surprised, since she was always well mannered and quite cultivated with me and I asked him what he meant. "Oh, when we do rounds, if you look around at the group talking to her, everyone looks tense and uncomfortable." As I mused about this curious definition of "manipulative," I thought about what her major concerns were — she was always afraid that her ability to put up a good facade, to be so well socialized and so successful at academic pursuits, etc. would hide what she called her "true self," the self that was so terrified, so uncertain and so confused. Her concern was that she would be misunderstood. I was often very moved in her presence by her unusual capacity to communicate the power of her frustration and pain. I could imagine her "performing" at rounds, while at the same time being vigilant about how others would respond to her, and feeling helpless

and even desperate if they did not see what was underneath the facade. I also know that once she felt the other person did not understand her, she gave up trying, with a deep sense of disappointment and underlying rage. That her anxiety and anger at being misunderstood were communicated to those conducting rounds must have contributed to feelings of discomfort among them; I also believe they needed to ward off the intensity of her underlying feelings. The labeling of her as manipulative also created a climate which kept her at a distance and cut off the possibility of understanding her or of engaging with her in a meaningful way.

Male patients certainly may be misunderstood, but I am focusing here on the specific kinds of language which affect women. I would like to suggest that when the language is pejorative and serves to maintain distance between the therapist and the patient, women are more likely to be victimized in the process than are men. We know that the greater number of patients in therapy are women and among therapists, men represent a significantly higher proportion than women. But it is not even that simple. Women who enter this profession have largely been taught by men (and treated by men) and in order to survive in their careers have often needed to adapt to the standards and values which have been associated with their professions; so that most therapists, male or female, may be very much influenced by those standards classifying mental health and illness which reflect the masculine model of therapy described above.

Developmental differences

Recent writings on the psychology of women by Miller (1976, 1984), Gilligan (1982), Surrey (1984) and others have brought to our attention the extent to which women are seen as lacking and defective when evaluated according to masculine models of personality theory and developmental psychology. These models fail to recognize the unique qualities of female development and experience. Gilligan noted that women were seen as lacking in moral development only when compared with data gathered on all male samples collected by Kohlberg; in examining the female experience of morality she demonstrated how much it is organized around issues of responsibility for other people within the context of investment in relationships. In the same way, current developmental theory has stressed the process of separation and individuation and the achievement of independence and autonomy as the hallmarks of maturity. This model, however, seems more applicable to male than female development in our culture. When this model is applied to women, they are seen as relatively immature and dependent, since the model overlooks the power and significance of human relationships for women and ignores important differences in the developmental paths followed by men and women.

There is, in fact, a significant asymmetry when one compares the process in men and women as they move from their earliest relationships with their mothers and fathers through adolescence into adulthood. Since mothers experience their daughters as more like and continuous with themselves, there begins a particular relationship between mothers and daughters with expectations of mutual caretaking and mutual empathic interactions and interdependency. Daughters can then experience more continuity with their past relationships, such as early dependency on their mothers and others, without seeing it as a threat to their growth and maturity. The dynamic of the mother-son relationship follows another developmental path. Mothers experience their sons as different from them and are under both inner and outer pressures to affirm this difference. The cultural expectations of how boys should be are internalized by mothers; they believe that in order to help their sons develop a strong masculine identification they need to encourage aggressive behaviors and separate strivings. These pressures continue to exert a powerful influence on males to be separate selves in their journey toward adulthood.

A recognition of these different lines of development and careful attention to the experience of young female children and adult women have led to a new understanding of women, a “self-in-relation” theory of development. In particular, the writings of Miller (1976), Surrey (1984) and Jordan (1984) have attempted to trace the ways in which early mother-daughter relationships have enhanced the development of empathy, the range of affective experience and other relational skills.

Miller, in writing about the development of the self in women, describes the dynamic nature of the process of connection with the main caretaker (usually a woman). The connection is not with a static figure but with a person who is involved in ongoing relationship. Thus, the internalization of the mother reflects what is happening between people, and is represented in a relational mode. The evolving self is one which cares both about others and about the relationship, itself, between two or more people.

Surrey describes the early representation of self in girls as being a more open sense of self with more permeable boundaries in contrast with the more limited and boundaried self characterizing boys. Miller notes also how often women's involvement in relationships is misunderstood, either in pejorative fashion by labeling women as dependent or in more apparent positive fashion by referring to women as altruistic. But the latter description also misses the point when it suggests a sacrifice of a kind of self-interest, when in fact women engaging in relational interactions experience them as a source of great pleasure, gratification and as self-enhancing.

While it is not the purpose of this paper to elaborate in great detail this new conceptualization of female experience, I believe it can serve as an important context in which to talk about how women often are evaluated and compared to standards that are not relevant to their experience. I am suggesting, too, that counter transference issues evoked in many male therapists who treat female patients contribute to a misunderstanding of women which is maintained through this process of labeling and diagnosing.

Miller (1976), Stiver (1983) and Surrey (1984) have raised questions about the ways in which the emphasis on separation, individuation and "becoming one's own man" have had a negative impact on the development of self in men, often resulting in a rigidifying of boundaries between self and others and interfering with the development of their relational selves. This theme is more fully developed in Bernardez' paper on "The Female Therapist in Relation to Male Roles" (1982). "The contradictions," she writes, "between the advantages in the social realm and the impairments in the emotional and psychological realms inherent in the male role have not been examined by psychotherapists." In particular, Bernardez observes that the very factors involved in rearing men for independence may also lead to "suppression or underdevelopment of qualities of nurturance, empathy, affiliation, cooperation, affective awareness and expressiveness."

In tracing the socialization process for men, she notes as especially important the extent to which males in our culture are pressured to separate and give up very early their strong connections with their mothers. But also she believes that the nature of these early connections with the mother contributes to the development of highly ambivalent attitudes in men toward women. On the one hand, the mother is certainly experienced as a very powerful figure since she so often is the primary caretaker; while on the other hand, her position in the social world is secondary and often devalued. As a consequence, men are both threatened by women's apparent power and contemptuous of their apparent inadequacy. This early loss of connection with the mother, and the social pressures which prohibit the little boys' continued open dependency on the mother before these longings can naturally be resolved and reorganized, lead men then to deny and defend against their longings for dependent, affectional ties with others.

According to Bernardez, this premature separation from mother leaves little boys with a feeling of abandonment and vulnerability to loss which is hidden behind a more independent exterior. The underlying rage that many men experience toward women is understood by her to be in large part related to this sense of abandonment and to feeling cut off from a more continuous close connection with their mothers as valued figures in our culture. Thus, men do not typically have sufficient opportunities to develop their self-in-relation because of the enormous pressures placed on them to perform and achieve in independent fashion, and they are denied a fuller participation in a growing relationship with their mothers, with all the emotional richness that this implies.

How can we understand the relationship between these processes in masculine development and our conceptualization of female experience and development as occurring in a relational context, in which emotional expressiveness, interdependency and mutual empathy are encouraged? If men have to deny these qualities in themselves to defend against the strong connection with their mothers, which is prohibited and devalued, they might indeed find threatening the expression of these qualities in women. Indeed as Miller (1976) has pointed out, men's need to control women is in part a reflection of their need to control the *feelings* which women "carry" for men.

Diagnostic differences

If one reviews the descriptions of pathology in *DSM III* (1980), there are some interesting differences between those categories reputedly found more often with women than those more often found with men. The Histrionic Personality, The Dependent Personality and also the Borderline Personality all have characteristics which involve interactions with others and intense expressions of affects. In contrast, those types of pathology more typical of men, such as

Paranoid Personality and Antisocial Personality, involve symptomatology which distances rather than engages with others, e.g., the paranoid's suspiciousness and the sociopath's exploitation of others. Thus, women are apt to express their conflicts and concerns more in emotional, relational terms and men need to defend against the intensity of their own feelings and yearnings for connection. The result is that traditionally trained mental health professionals use techniques which create distance between them and their female patients. Their male patients already have distanced themselves by the very nature of their symptomatology.

A relevant observation is the way medication can be used as a distancing strategy. Women are reported to receive a disproportionate number of drug prescriptions for both mental and physical conditions (Fidell, 1973). Women are also more likely than men to have their depression and anxiety treated with drugs (William, 1974). I was supervising a male resident who, in the service of caretaking, quickly offered to prescribe antidepressant medication to a female patient he was treating when she began to cry about an abortion she had had only three days previously. As he and I talked about it, it was clear to me that he could not tolerate the intensity of her pain and sadness which he warded off, distanced, through offering medication.

Men's need for distancing, however, is often coupled with intense anger at women, both from a sense of abandonment early in development as well as from envy of women's freedom to express feelings. The quality of the descriptions used to identify female psychopathology suggests that intense anger must fuel these descriptions. In reviewing the literature there are no titles about male pathology that compare with such titles as the "Intractable Female Patient" (Houck, 1972) or "The Angry Woman Syndrome" (Rickles, 1971) — with the exception of more pejorative labeling sometimes used to describe those males guilty of violent and destructive behaviors and who end up more often in prisons than in mental health facilities.

Take as an example the description of the diagnostic classification of the "Hysteroid Dysphorics" by Klein (1972): "They are fickle, emotionally labile, irresponsible, shallow, love-intoxicated, giddy and shortsighted. They tend to be egocentric, narcissistic, exhibitionistic, vain and clothes-crazy. They are seductive, manipulative, exploitative, sexually provocative and think emotionally and illogically. They are easy prey to flattery and compliments. Their general manner is histrionic, attention-seeking and may be flamboyant. In their sex relations they are possessive, grasping, demanding, romantic and foreplay-centered. When frustrated and disappointed, they become reproachful, yearnful, abusive and vindictive and often resort to alcohol" (p. 152).

While Klein recognizes that this rather histrionic description may be considered misogynistic, he states that it is consistent with a caricature of femininity in our culture. If I may quote again, he notes "women with a normal range of emotional responses utilize a wide variety of exhibitionistic and seductive social tactics with discretion and accuracy. The hysteroid dysphoric patient is a caricature of femininity because her pathological sensitivity to rejection drives her to attempt to repair her dysphoria by an exaggeration of the social, seductive and exhibitionistic tactics allowable to women in our society" (p. 152).

In a paper by Houck on "The Intractable Female Patient" (1972), a type of "borderline patient" is described as particularly troublesome. The author quotes from the dictionary definition of "intractable" as best illustrating the kind of female patient he means, "not easily governed, managed or directed, obstinate, not readily manipulated or wrought, not easily relieved or cured — unruly." He also finds these patients in therapy to be "assertive and manipulative." His formulation is essentially that these women simply want to take flight from responsibilities at home and they use the hospital as an escape. Thus, he recommends that the hospitalization be short, therapy supportive only, and that "the woman's attention needs to be firmly fixed on home, family and adult obligation." Most important, however, the author says, is the "aggressive work" that needs to be done with the spouse who is seen as so passive and without ability to "dominate" his wife.

The anger evident in these descriptions of female pathology underline my contention that the countertransference attitudes many male therapists have toward many female patients contribute to the need to distance in therapy and to erect barriers between therapists and patient, which in turn maintains the therapist in a position of power and control.

Implications for psychotherapy

This brings me to the sexual issues that further reflect this theme in psychotherapy. In a paper on dependency (Stiver, 1983), I have noted that for reasons related to how men are socialized, they often search for intimacy primarily through sexual

experience. For many men, one of the few settings in which they can give expression to their needs to be given to and cared for, and can experience deep feelings and still feel manly, is in the bedroom. I believe that often male therapists' experience of caring for their female patients takes the form of strong sexual feelings which often are projected onto the patients; then the female patients' needs to engage with their therapists, to be accepted and valued, are consequently misunderstood and misidentified as "seductive." I am not unmindful of women's propensity to sexualize relationships, but I believe for many women to be "sexual" is also a way of "being" and relating with a man. It is the therapist's responsibility to understand women's particular way of incorporating sexuality as part of their total way of being, and also the distorted aspects which occur because women are still seen, and react to being seen, more totally as sexual objects. Bernardez (1982) believes that men's tendency to sexualize relationships serves to ward off loving and tender feelings and is often a disguised expression of anger. For some male therapists it is a significant struggle to ward off sexual feelings toward their female patients, and this may contribute to even greater distancing. Other male therapists we know act out their impulses directly in sexual contact with their female patients. While there are more data about the greater incidence of such acting out than was available before (American Psychological Association, 1975), we continue to hear about female seductiveness and very little about men's needs to sexualize relationships.

A brief clinical example is illustrative. I was seeing a woman in therapy who was in her 40s, quite conservative and diffident but also friendly, with good social abilities. While in general conventional, the one area in which she expressed some zest and creativity was in her dress. She wore clothes that were unusual but always modest and tasteful; she wore bright colors, unusual fabrics, etc. Before she started to see me, she had been in treatment with a male psychoanalyst for three years. She liked him and was aware of warm and affectionate feelings toward him since he seemed caring and interested in her. After about a year of treatment, he told her she was dressing up for him, accused her of being seductive and urged her to talk about her sexual feelings for him. She was hurt and felt that there was after all something bad about how she dressed — one of the few areas in which she felt good about herself before — but she also felt she failed as a patient since she was not aware of having the feelings she presumably was supposed to have. As the therapy moved toward termination, her therapist told her that his marriage was foundering and he wanted to establish a different relationship with her after the therapy ended. This was very traumatic for her. It felt as if all the work she had accomplished was undone and that her sense of his caring was all in the service of his sexual interest in her — the precise feeling she had had with her husband. This was the impetus for her coming to see me. I might add, she continued to dress with a flair with me — which I valued and appreciated and saw no reason to challenge or interpret.

More meaningful terms

I would like here to attempt in the most general way, because of limits of time, to take some of the female behaviors so pejoratively labeled by our diagnostic categories and translate them into terms more meaningful from the point of view of the self-in-relation theory of female experience and development.

Let us consider first the behavior of the "Hysteric." Most noteworthy is the intense expression of emotions associated with this classification. The criteria which indicate that such expression occurs "in reaction to minor crises" suggest that it is relatively unprovoked or unexplained by the social context. I would suggest, instead, that women's efforts to be heard and truly listened to are often experienced as intensely frustrating when the other person seems emotionally impervious. The result for the woman is often an escalation of intense feelings with increased loss of focus and defusion of intense affective expression. There is a tendency for women, particularly when in trouble, to present a kind of self which often feels unreal in the service of desperately trying to enlist the other person to relate and engage with them in an emotionally meaningful way. This presentation may take the form of an exaggerated expression of affect in order to be heard, attended to, and is also a reflection of the woman's compliance with the expectation of how she needs to be, to engage the other to respond to her in some fashion — even if it be in an angry and uncaring way.

Next we will look at the Dependent Personality Disorder, presumably so characteristic of women. In a paper on "The Meanings of Dependency in Female-Male Relationships" (Stiver, 1983), I took the position that the term dependency has acquired a pejorative connotation precisely because it is seen as a feminine characteristic. But most important, I believe that women are not basically more dependent than men. They have, however, an investment in presenting

themselves as dependent as a means of becoming engaged with others and it has been the established mode of relating to men in the expectable direction. Men, we know, have their investment, too, in seeing women as being more dependent than they are. I have suggested also in the earlier paper that pathological dependency is not being "too dependent," as the literature suggests, but rather is a function of the underlying rage about unmet needs. Those who are called "too dependent" are often those who ask for help in such a way that makes it very difficult to respond because of the communication of underlying rage at both self and others. Thus, it is not the asking for help, the dependency on the other person, which is problematic, but the ease and comfort with which one is able to identify what one wants and then to ask for help. I do not think women have any more trouble than men do about that.

Another diagnostic category found more often in women than in men that needs re-examination is "depression." Why it is found more in women than in men has been explored by others with developmental, social and biological explanations offered (Arieti & Bemporad, 1978; Bart, 1971; Weissman & Klerman, 1977). What is of particular interest are the marital differences in incidence of depression. Among the single and widowed, men are more likely than women to become depressed, while women are more likely than men to become depressed during their marriage (Radloff, 1975). That marriage is more stressful to many women than men has been noted in the literature (Bernard, 1971). I would like to suggest that the depression found in women who are married may reflect the frustration they experience in making the kinds of connection they want and often cannot get. As Alexandra Kaplan (1984) points out in a paper on "The Self-in-Relation: Implications for Depression in Women," depression in women cannot be seen solely as deprivation or loss of psychological supplies, but as a result of the lack of an adequate relational context. Thus, some women experience a continuous sense of loss when they are in relationships in which there are limited opportunities for mutual empathy and mutual empowerment. I believe also that since women need to deny their own needs in the service of being unselfish and attentive to the needs of others, they develop underlying resentments — which they turn inward, considering the degree to which our culture prohibits more open expressions of anger in women (Miller, 1983).

Let us now look at the characteristics of the Borderline Personality Syndrome which evokes the most pejorative labeling of all diagnostic categories and is also more frequently diagnosed in women. If one reviews the major characteristics used to identify this diagnosis in *DSM III* (1980, p. 322), again they include affective, relational features; "inappropriate intense anger or lack of control of anger, affective instability with marked shifts in mood and patterns of unstable and intense interpersonal relationships. Impulsivity, identity disturbance and physically damaging acts are also mentioned. Again, I believe the relational needs of such patients are not recognized adequately by these designations. In my own experience with such patients, I have found them highly attentive and vigilant to the other person's reactions to them, but because of disturbances in early relationships with caretakers, so much anger is aroused that it interferes with more accurate perceptions of others — and in fact significantly distorts them. Instead, one sees a repetition compulsion of maladaptive attempts both to reaffirm and repair the early pathological relational experiences which then get played out, lived out in therapy. Thus, the patient feels caught in unhealthy relationships that keep re-emerging and lead to an escalation of emotions similar to the process described in hysterics, as well as pathological dependency since there is an inability to believe that anyone can be helpful.

A few words about the "Masochistic Personality Disorder," no longer a legitimate category in *DSM III*: In a recent paper entitled "The Myth of Women's Masochism," Paula Caplan (1984) takes serious issue about the ease with which masochism is applied to female behaviors which are presumably self-sacrificing and altruistic — when both attitudes are encouraged and valued in our culture. Caplan analyzes the concept of unconscious masochism and demonstrates how one can offer less pejorative alternatives for women, and a more accurate understanding of behaviors otherwise labeled as masochistic. She notes that what is regarded as secondary to the motivation of males is focused on as primary and pathological in the motivation of females. To illustrate this point she uses as an example "the painful and dangerous occupation of professional football players," e.g., "he spends many hours being brutally assaulted in the cold, the mud and the rain. He can count on frequent and serious injuries to his body in exchange for admiration and applause for his physical strength and willingness to experience pain and injury so that others may enjoy themselves."

The concept of care

The translation of behaviors to their underlying meanings brings us back to an understanding of the concept of caring and its role in the process of psychotherapy. Earlier I spoke about a distinction between "caretaking" and "caring about." "Caretaking" I referred to as a kind of caring which allowed one to maintain a more objective, impersonal stance in the delivery of care and which contributed to an imbalance of power in the therapeutic relationship. "Caring about" I suggested was not tied to this kind of power imbalance and could be more egalitarian and also implies an emotional investment in the other person's well-being. I believe that what our women patients, and perhaps some men as well, want is to be cared about — but to be cared about in a particular way. That is, to be listened to and understood in a way which precludes the kind of distancing which exists in the more traditional models of therapy. The most powerful therapy sessions in my experience have been those in which I have been very deeply there in the relationships with my patient, and have a genuine sense of where my patient is at that time. In Jordan's paper on empathy (1984) she demonstrates beautifully how cognitive and affective components harmonize in the empathic encounter — and clarifies the importance of flexible boundaries between therapist and patient. It is this notion of empathy which plays such a central role in the "caring about" one's patients.

I think most of us, both men and women, are capable of relating to our patients in a "caring about," genuine way which involves our being present in the relationship as a real person and, I might add, which does not mean burdening the patient with personal data about the therapist, etc. But this requires a relatively nondefensive attitude and awareness of the differences in the socialization processes between men and women.

It is most important to note that styles of caring in therapy do not seem linked in a simple one-to-one fashion with sex of the therapist. That is, some women therapists have in a sense overconformed with the distancing, "masculine model" of therapy as a result of trying to survive, to be successful and adept in this field. On the other hand, I have known "caring" male therapists who are able to be flexible and responsive to both their male and female patients in a genuine, empathic and nonauthoritarian fashion. We are all aware that selective factors operate which make it more likely that such men rather than, if you will, hypermasculine, unemotional men will enter this field. However, what I have also noticed is that often these men are apt to apologize for or hide this style lest they be criticized and devalued by their male colleagues.

Let me close with an example which nicely illustrates this curious dilemma. A woman psychiatrist told me about her termination with a female patient in her last year of training. She was leaving the clinic setting and moving to another city. She felt connected to this patient and sad about terminating so that when the patient asked where she was going and if she could contact her, she told her, and added that she would be glad to hear from her. When she reported this to her supervisor, a male psychoanalyst, he told her she had been very seductive and inappropriate and was too involved with her patient. She felt bad and accepted his criticism. She also was terminating her own therapy with a senior male analyst. When asked if she could see him again when she visited Boston he said, "Certainly, I would love to hear from you." She felt vindicated and said, "What goes on behind closed doors! There are all these analysts secretly acting like human beings but nobody is supposed to know it!" I do believe that good caring treatment does go on behind closed doors, but it's time to take it out of the closet. Let us give legitimacy and value to a model of therapy that takes into account the unique aspects of female experience and development and that also allows the more egalitarian "caring about" our patients to become a matter of prime importance.

Discussion Summary

After each colloquium lecture, a discussion is held. Selected portions are summarized here. In this session, Dr. Judith Jordan and Dr. Janet Surrey joined in leading the discussion.

Question: Don't you think that people who are trained in medical school, like pyschiatrists, have a difficult time dealing with "caring about" their patients?

Stiver: Yes, I think so. I thought of the model that I have been describing as both a masculine model and a medical model. Certainly I think the prescription of medical care is very much in that model, where the "expert," sometimes in a very kindly way, takes care of the patient.

Question: Are medical schools changing about this?

Jordan: One of the things that people have looked at in medical school training is the whole area of empathy. People have talked about medical schools as training empathy out of medical students. Then,

when psychiatrists start their residency they have to relearn it. Interestingly, in the last three years the Harvard Medical School, which is probably the epitomy of this tradition, began to talk about introducing courses in "compassion."

Question: While I am sympathetic to what you are saying, I have a problem training women counselors who need to learn not to overlove. I think in some respects it is more difficult not to overlove, especially for women. In some ways it is important early in the training to emphasize that we should not overlove and maybe that should be the first thing to train in counselors...maybe one needs to start training counselors to get a little distance because they are often people who have to be very loving and helpful...then later they can learn it is OK to care about their patients.

Stiver: I really appreciate what you have said. However, it is very complicated as to what comes first. For example, in the McLean setting I am one of many supervisors. By the time the trainees get to me, even early in their training, they already have been affected by a whole range of influences, so they do such things as keep their faces flat and distance patients. They really have trouble responding to their patients' emotions. In a way, I feel like a crusader and say it is OK to be yourself and to use your own person and so on. At the same time, I think I am nervous that the message of this paper not be misunderstood. I do not want to suggest that there are no limits. One really has to be attentive to each situation. You can't bleed for the patient, but you can certainly be empathic. What you really need is a perspective, because that is the only way that you can be helpful. Where you start with the person you are training in that process depends on a variety of considerations.

Surrey: It also brings up that we have to be careful when we talk about caring or loving as if they were always equal to supplying nurturance rather than confronting or standing back. Caring involves knowing how to relate at specific times in specific ways. There is a common connotation that caring means only giving, nurturing and supplying, which is not the case at all.

Stiver: Exactly, and it can be, for example, reassuring to some people at certain times to create more distance. Again, the emphasis needs to be on listening and being *there* emotionally, and being able to assess what does this person need or how can one be helpful to this person specifically. The Stone Center Working Papers on empathy (Jordan, Surrey, & Kaplan, 1982: Jordan, 1984) and on relationships (Surrey, 1985), particularly therapeutic relationships (Kaplan, 1983) make these distinctions very nicely. They include the training and clinical points you raised, and their relationship to what women and men therapists bring to their initial approach to therapy.

Question: Your discussion of personality disorders was very illuminating but it wasn't clear to me whether you were saying that some of the disorders like histrionic and dependent personality aren't disorders; or whether you were saying they are, but we can understand why women are showing more of that symptomotology because of their relational qualities.

Stiver: My feeling is that disorders are overdiagnosed for women. But we also know there are women who have major disruptions in their ability to cope. Frankly, I was trying not to take a stand on that question but to say that there is a continuum and that these may be more or less adaptive or maladaptive strategies. Obviously, the borderline personality would fall more on the disorder end than those other "personality disorders." But I think the misunderstanding of what is going on leads to a kind of treatment approach that I think is more destructive than constructive. An example is telling a borderline patient that she is being manipulative as though that is somehow a treatment intervention if, in fact, it is your misunderstanding. That is not trying to understand where the behavior comes from, what the person is communicating, what went wrong in her interpersonal relationships that cause the difficulty that she is now experiencing. It results in not listening to important pieces of information. Again, when we talk about the histrionic personality, we are dealing with more of a continuum, that is, behaviors that are mislabeled as disorders which are a very common occurrence for women in general. When women feel that they are not getting through and not being heard, they can present themselves, if you will, with an exaggeration of emotional expression. People then say, "Oh, she is being so hysterical," which is again a misunderstanding of what precipitated that behavior.

Question: In the example you gave of your friend's doctor's needing to distance from her...could that have occurred, do you think, with a male patient, too, particularly with a lower status man?

Stiver: Perhaps, to some extent. For example, this model of the therapist, along with the unequal nature of the relationship, could contribute to an attitude of arrogance toward patients who are seen as lower in the social-power hierarchy and also to a stance that keeps the patient "in his place," so to

speak. But what I am suggesting is something more than arrogance and elitism, since I believe that such male therapists experience significantly more anxiety with women patients than with male patients. They are often fearful of being overwhelmed by the woman's emotionality and her desire to relate to people. I am also pointing to a larger overall dynamic in which men are encouraged specifically to be different from what is labeled (falsely) as feminine, and I am suggesting that this creates anxiety for men. I am seeking to relate this dynamic to the prevalent treatment models and language.

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