Work in Progress

From Depression to Sadness in Women's Psychotherapy

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Abstract

Twice as many women as men experience depressive episodes. In order to understand this finding better, it is important to clarify the concept of depression and to do this through a focus on sadness.

Current literature tells us that twice as many women as men experience depressive periods, and one out of ten women can expect to have a serious depression in her life[1] (Weissman & Klerman, 1977). Married women in particular are more prone to develop depressions than both married men and single women who are heads of households (Radloff, 1986). Some workers stress difficulty in the marital relationship as a precipitant of depression in women rather than the marital status per se (Weissman & Klerman, 1987).

Traditional theoretical and psychodynamic approaches to depression do not adequately take into account this greater incidence of depression in women, nor do they help us understand these striking findings. Newman (1984) has raised questions about the accuracy of the diagnostic methods which lead to the findings of higher rates of depression in women. While this point awaits further clarification, we know that depression is certainly very common in women. In papers which emphasize a relational conception of women's development, Kaplan (1984) and Jack (1987) have offered new views on depression. Kaplan notes that some of the key elements of depression, such as inhibition of activity, inhibition of anger and low self-esteem are in fact encouraged in women's development. They are very similar to the characteristics used to describe women in our culture, e.g., the need to please others, to accommodate to the expectations of others, not to listen to one's own wishes and to blame oneself for one's unhappiness. Jack describes women's relational self coming into conflict with societal and familial social norms of the "good woman" and "good wife". These views lead the women "to lose themselves in the process of trying to establish an intimacy they never attained" (p. 179) because others were not there for them, nor

allowing and encouraging them to engage authentically.

We would like to continue the exploration of why women become depressed. We will do this through a focus on sadness, and consider some therapeutic implications of this emphasis.

Sadness and depression

Depression has been classified and divided in a variety of categories including depression as a personality type, neurotic and psychotic depressions, and endogenous and reactive depressions. Although we will be discussing clinical depressions which are *reactive* to a range of life events, we will also be talking about those women who have a history of an underlying depression and are vulnerable to become more acutely depressed when existing coping methods are disrupted by stress in their current lives. We believe that many women have been depressed over long periods of time, largely as a consequence of disconnections in their day-to-day experiences with the people important to them. As Kaplan noted (1984), the losses in women's lives are not of "oral" and "narcissistic supplies" as the traditional literature indicates, but rather of the *opportunity to participate* more fully in relationships, with both authenticity and a sense of empowerment.

The kind of chronic depression which many women experience occurs along a continuum of dysphoric reactions from mild to more severe expressions of underlying hopelessness, low self-esteem, a sense of helplessness or powerlessness in effecting any change in their lives and with a more or less constricted self-concept. These characteristics become more intense and more symptomatic when an acute depressive episode develops; in addition, depressive symptoms would then include a profoundly dysphoric mood, retardation of functioning, suicidal ideation and the potential for suicidal behavior.

We would like to delineate depression as a clinical syndrome from the emotion of sadness. This distinction will help to clarify the psychological meanings of each. In addition, the distinction between sadness and depression has important implications for the psychotherapy of depressed women.

Considerable confusion exists in the literature in the variety of terms used to talk about dysphoric experi-ences, such as sadness, sorrow, melancholia and mild and severe depression. Some writers use sadness, sorrow and depression interchangeably, while others carefully distinguish sadness as "a normal emotion" from depression as a pathological state. With the exception of those more biologically oriented who view depression as a distinct illness with particular biochemical and genetic characteristics, most writers tend to see sadness on a continuum leading to depression.

Freud, in his classic paper, "Mourning and Melancholia" (1917/1961), said that mourning was characterized by "normal grief" in response to a major loss, while melancholia was a more pathological reaction. Unlike normal grief, it was accompanied by a significant lowering of self-regard and an intensification of guilt feelings. Gutheil (1959) believes that pessimism adds the element that changes sadness to depression. Arieti and Bemporad (1978), in talking about "mild depression", say that it "is difficult to differentiate it from the feeling of depression as a normal emotion, generally called sadness, which is part of the gamut of feelings of the average individual" (p. 63).

We would like to suggest that, phenomeno-logically, significant and qualitative differences exist between sadness and depression. It is a difference between a "feeling state" and a state in which feelings are hidden; what is left is a "nonfeeling state" but with clear dysphoric components. Although we do not see sadness and depression on the same continuum, we do believe that when there is not an adequate relational context in which sadness can be experienced, expressed and validated, depressive reactions develop.

The relative lack of attention to sadness and its role in depression may occur because sadness is a powerful emotion. Intense affect is often seen as more characteristic of women's experience than men's. It is both devalued in our culture and threatening to those who are more defended. Not only does no entry exist for sadness in the indexes of many major books on depression, but our own professions give little attention to helping trainees (and more experienced clinicians) recognize, identify and experience their patients' sad feelings with them. The tendency in our culture to admire and value more stoical responses and to devalue intense open expressions of sadness and grief occurs in family settings and to a large extent in the practice of traditional psychotherapy as well.

In particular, the resistances in families to help others, especially children, stay with their feelings of sadness and disappointment probably follow from the readiness with which parents experience their children's feelings of pain as accusations which lead mothers and fathers to feel they are bad parents. Also,

parents sometimes find it intolerable to endure what they imagine their children experience when they do feel sad. In any event, when children find that the very people to whom they look for support when they encounter disappointments in life are not truly available to them and do not legitimize or even tolerate their feelings, they often conclude that they should not have such feelings, that they are somehow to blame for whatever led to those feelings, and they soon learn to hide and defend against the feelings.

We believe that the major task in therapy is to help our women patients who are depressed move from that nonfeeling and defensive state to an affective experience in which their sadness can be recognized and validated. We often ask patients who are diagnosed as depressed whether they are feeling sad or depressed. At first, they often look confused and indicate that they don't know the difference or that they feel both. Then we elaborate, "When I ask if you feel sad, I mean something like do you feel close to tears, are the tears connected with sad images, losses of important people, do you feel a lump in your throat, does your heart feel like it's breaking sometimes, does it sometimes feel like unbearable grief? These feelings", we add, "may be different from feeling 'depressed'; that may be more like feeling in a black pit or a deep tunnel, bleak and heavy, with no sense of any hope or light at the other end, without many images other than doing away with oneself, seeing no way out of the muddle, and feeling that one is a bad person and that nothing can change that." Patients sometimes have further elaborated this description of depression with such phrases as, "feeling dead inside" and "feeling like I am always under a black cloud".

When we have asked these questions, many people can differentiate immediately between sadness and depression. Some are able to say they know both states and can remember instances in which they felt one or the other. For example, one of us interviewed recently a 30-year-old married mother of two young children who was acutely suicidal. While she believes she has been depressed for many years, the suicidal ideation has escalated over recent months. Most significant, for many years, beginning at age four, she was sexually abused by her brother-in-law. Although she told her mother and sister about the abuse, they left her feeling unprotected and did not acknowledge her deep fears. When asked whether she was feeling sad or depressed, with the elaborations outlined above, she stated very clearly, "Depressed". She went on to say she saw no purpose in continuing to live; she was "a torture to her husband", and if she died, she would save her children from her "terrible influence".

She said she felt completely trapped in her marriage since she could not bear to have her husband touch her. However, she could not see herself existing without him. Similarly, she could not bear her worries about her children's well-being and felt that she deserved to be punished by God who would take away her children. As she said all this, she maintained a completely flat and matter-of-fact mood as though she had thought it all out logically, and that's how it was. When asked if she remembered feeling sad sometimes, she responded immediately, saying, "Yes, only two weeks ago when I visited my father-in-law in the hospital after he had a heart attack". She really cared for her husband's family; and as she sat with her father-in-law, she held his hand to reassure him, wanted to cry and felt very sad. We might speculate that the threat of losing her father-in-law put her momentarily in touch with her yearnings for a father who would have been more protective of her and as caring as her father-in-law, but those yearnings were too painful for her to tolerate.

Another woman's father had been in a coma for months. She had been anticipating his death for some time but rarely felt in touch with her sadness about losing him. Typically, she did not acknowledge the importance of this imminent loss and reported, instead, that she had no energy, felt tired all the time and was oversleeping. She missed appointments and "didn't give a shit" about anything. Alternatively, she became enraged at the ways she felt her life had been wasted because her father did not recognize that she had such a need for his help when she was younger. At those times she couldn't hold any caring feelings for her father.

These reactions can be described as depressive or as some ineffectual attempts to flee from both her depression and the underlying sadness. The therapeutic work at times does lead her to an awareness of her terror of losing her father, her shock and sorrow at seeing him change from a person of enormous stature into a "wizened little man, paralyzed and unable to speak, like a nonperson". She then talks of missing him and of those times when they were connected and he talked to her and tried to help her plan her life. At these times she becomes tearful, and on rare occasions she sobs as she acknowledges how much she loves him and how unbearable it was for her when he was not responsive to her.

Although both women seemed to ward off sadness more than depression, they reported feeling

less empty, more substantial and less alone when they experienced the sadness more directly. Indeed, we believe that if therapy moves productively, a shift occurs from depres-sion to sadness which, in turn, leads to a shift away from hopelessness. A major increase in the woman's sense of worth occurs when she feels she has feelings, a change from the kind of person who has no feelings. Although all people feel great relief when they can feel again, women are often particularly self-condemning when they believe that they have no feelings. The optimal therapeutic situation would allow for a legitimiz-ing of the woman's painful feelings, being truly with her as she "stays with the feelings" and seeing these feelings in the context of her relational needs and the pain she experienced when these needs were not met.

Perhaps the major difference between sadness and depression is that the depressive experience is very isolating and nonrelational. It is exquisitely self-centered in that the person has withdrawn from others and has focused on her personal defects, often around concerns about appearance and performance; essentially, this focus represents displacements from the more important concerns associated with feelings about those significant relationships which have been deeply disappointing or have been lost. Thus, the person may often feel stupid, ugly, evil, not likeable, etc. A deep sense of hopelessness, helplessness and self-blame accompanies these self-perceptions since she believes that nothing can change them.

On the other hand, genuine feelings of sadness enhance the experience of connection with others and increase self-esteem. Sadness, unlike depression, allows for more direct awareness of the meaning and importance of lost relationships or disappointments in existing relationships. This, we believe, follows from the woman's increased sense of connection with her self through the direct experience of feeling something "real". This feeling leads to an increased sense of authenticity as well as increased empowerment which, in turn, begins the process of moving away from the depressive and isolated position.

Without a safe relational context which is responsive to the depth of a depressed person's underlying sadness, the depressive position is in some sense preferred, since one often has the illusion of being less vulnerable in isolation than one feels when in danger of abandon-ment. This state of alienation, however, maintains the person in the depressive position; it becomes more and more threatening to expose one's vulnerability to a world which is perceived as either unresponsive or hostile and critical. Simultaneously, the person feels more and more undeserving of help from others.

An illustration

Our basic notion is that many women who suffer depression have not been able to experience their sadness and, most important, have not been able to experience it within a context of empathic and validating relationships. There is one major reason why this occurs: The people in the surrounding context of relationships (and often society in general) do not recognize that a disappointment or loss has occurred. Alternatively, they may recognize that some kind of loss has occurred, but they do not recognize its significance or magnitude for the woman. Not only do they not help the woman acknowledge the loss, they often actively prevent her from doing so and, therefore, contribute to severe confusion and self-doubt. Sometimes the woman initially may have some sense of her feelings, but people around her are conveying the strong message that she shouldn't have them. There's no reason to have them; so if anything is wrong, it must be that something is wrong with her.

One of us worked on a project on stillbirths some years ago which illustrates this point. This study was begun by Bourne (1968) and Lewis (1976) in London in the Sixties. They had observed that women who suffered stillbirths often became depressed and/or experienced a great deal of trouble with the next baby. They also noticed that almost everyone connected with the stillbirth acted as if it hadn't happened and fled from the whole experience as quickly as they could. It was what they called a "nonevent". Almost no one in the woman's life would allow her her sadness nor be with her in it. This included the husband or male partner, the woman's mother, father, sisters and other family members as well as friends, the nurses and certainly the doctors. Almost everyone said platitudinous kinds of things like, "Cheer up. You're young. You'll get pregnant again and have a baby soon". However, the woman couldn't forget about it and couldn't cheer up.

Hospital procedures reinforced the definition of the situation as a "nonevent". The dead child usually was not given a name; there was no funeral or any ritual; the child was not brought to the parents and thus was never seen by them.

Bourne and Lewis believed that the mothers' depression and the troubles with the next child could be prevented if the mothers could experience their sadness. Lewis tried to work with hospital staff members to convince them to bring the baby to the mother and father, to encourage the parents to give the child a name and to have a proper funeral and burial. He was not making much headway with hospital staffs. In many instances, staff members became very angry and often characterized the

proposals as cruel. (We believe that staff members reacted this way because they had not been trained in dealing with the sadness and were afraid to have to deal with it openly in their work.)

Almost by chance a woman newspaper columnist heard of this work. She herself had had a stillbirth and had gone through the same depression and terrible feelings of isolation. She wrote one column on the topic, and hundreds of letters from women poured in to the newspaper, all confirming her experience.

After this public expression, real change occurred. The recommended alterations in hospital routines came about, and now there are self-help groups for women who've experienced stillbirths, as well as other reproductive losses. In general, because some societal institutions now recognize this event, the people around the women (their partners, families and friends) are beginning to acknowledge that something has happened and to be with the women in their experiences of loss. That is, society now has defined what is happening in a fashion which includes more of the truth of the women's experience. This new societal definition of events renders other people more able to recognize their sadness too. The whole picture has improved.

Before these changes occurred we saw some of the women in treatment, sometimes along with the whole family. The woman's depression was very striking. Usually her sense of isolation and of being alone with these feelings was very powerful. Sometimes the husband's sadness appeared very obvious, but he rarely could stay with it and not veer off. Thus, the woman was usually "carrying" the sadness that the husband (and sometimes other family members too) did not let themselves experience together with the woman.

We thought that this story would help to illustrate our central point because this issue now appears so clear, although it was not at all clear initially. Further, it offers an example of how preventive work, and even some change in societal definitions of reality, can come about. However, it is not a good example in other ways. For one, it may be clearer because it concerns a discrete and dramatic event. It is not like the many disappointments and disconnections which occur over long lengths of time throughout many women's lives. These are causes for sadness which are much harder for others to understand, and even the woman herself to recognize. Second, the frequent causes for sadness in a woman's life usually are not physical like a stillbirth; rather, they are the actions of the people closest to the woman, often members of her immediate family or her partner. We will describe a woman whose experience illustrates these much less obvious points.

Clinical examples

Mrs. A. is a 48-year-old woman, married to a very successful lawyer. She has two daughters, ages 19 and 24. She entered therapy with symptoms of a clinical depression, including tearfulness, insomnia, loss of appetite and irritability. She was described by her husband as "difficult" at home. She talked about what a bad mother and bad wife she felt she was, although she had many complaints about her husband. The husband had contacted a psychiatrist he knew personally who made the referral, describing these depressive symptoms and suggesting that issues about aging were probably the underlying precipitant.

At the first session Mrs. A. said she was "an alcoholic", that she had been trying to tell her husband this for some time, but he did not take her seriously. She had told one other person, her physician, who told her he took it very seriously and would call her husband and discuss it with him. He never called, and she never returned to see him.

Although she attributed much of her bad feeling about herself to her alcoholism, she stated clearly that she was not prepared to stop drinking. She believed she would never have the courage to do so. She often became quite tearful but without any sad content to her thoughts; instead, the tears usually accompanied her feeling powerless to change her life and her deep feelings of frustration about her husband and her problems at work. She was always having angry outbursts and creating scenes at home which she saw as "childish" attempts to get her husband's attention or to get him to take her seriously. After each of these scenes, her depression intensified.

Early in our work together I had remarked several times that she looked very sad to me. She told me much later that she hadn't any idea what I was talking about, and she did not then know what being sad meant. She did know, however, that she felt awful and desperate. She stated that she wanted to stop drinking, which she did secretly and alone, but she could not imagine existing without the numbing effects of alcohol. Although she did not understand what I meant by "sadness", she felt that I did take her seriously and in particular knew that I appreciated how much she both wanted to continue to drink and to stop drinking.

I continued in a very low-key fashion to suggest that she attend some Alcoholics Anonymous meetings and gave her a meeting book. I told her she did not

have to stop drinking until she was ready, but she could go to AA meetings and would get help there learning how to stop, how to move from the stuck position she was in currently. Six months after she entered therapy, she began to attend some selected AA meetings, and three months after that she did, in fact, stop drinking. She became quite actively involved in AA and also joined a women's substance abuse group.

One day she was telling me that the previous evening she had felt an urgent need to phone each of her two daughters who were living in different cities at some distance from her. The daughters had spent the previous weekend visiting each other. The main reason for this urgent need to call them was that she felt very sad about the effects her alcoholism may have had on them, and she wanted to persuade them to attend Adult Children of Alcoholics meetings.

In the phone conversation her older daughter told her that she wished she had taken time off from school some years ago as had her younger sister. My patient remembered then that there had been some discussion about this several years ago, and both she and her husband had been dead set against it. Remembering it all, she felt even sadder and began to weep. She said to her daughter, "I wish I had been able to be there for you then, to listen to your wish to do that then, but I could not hear you — all I cared about was how I was going to get my next drink. I feel so sad that I failed you then".

This encounter seemed to both my patient and me a clear indication that she had just taken an enormous step. Precisely *through* her ability to be sad, she was more empowered than ever before to establish a more mutual relationship with her children, who certainly felt closer to her as a consequence of these changes in her.

As Mrs. A. moved out of the depressive position and as she no longer numbed her feelings with alcohol, she was able with genuine sad affect to speak about those disappointments in her life that really mattered. For example, she felt her husband was very much the center of her life, yet saw in a variety of ways how little she was the center of his life. She viewed him as a good and decent man, but felt he could not listen to her. Instead, he expected that she be available to meet his needs. His needs included her hostessing social events important to his career, even when she felt it put her in jeopardy to participate in situations which involved serving alcohol.

As we talked about this issue, she brought in a letter from her mother which she felt was typical although she had never truly noticed it before. Her mother had suffered from recurrent depressions for many years and had always deferred to her father. The striking thing about the letter was that it was replete with phrases such as, "your father thought", "your father said", "your father would like". She began to see some similar patterns in her own marriage. Another moment of genuine sadness occurred when she was talking about a special occasion in the past when she had wished her father had given her a fur coat. At first she berated herself for being so petty and then began to weep, which astonished her. She was surprised that she felt so deeply about what seemed to her to be such a trivial matter. She was able to stay with the sadness when I suggested that what she wanted from her father, who was a very reserved and withdrawn man, was an expression of his caring for her, a sign that he valued her and wanted to respond to her needs.

A year later when her father died and she went to see her mother, her mother's first words to her were, "I am free!" Although my patient was amazed to hear this from her mother, she had done enough work around her own depression and sadness and the struggles in her marriage, to hear what her mother said in the context of her mother's depression and the nature of her life with her father. It proved very liberating and it allowed her to feel more empowered in her relationships with her mother, husband and children.

Two other brief illustrations highlight the ways in which current life events precipitate more acute depressive reactions in women. The meanings of these life events in the context of the woman's experience are often misunderstood. For example, a woman in her 50's, married to a very powerful businessman for 30 years, became acutely depressed after a family argument. The marriage had been difficult from the start, but she had learned to accommodate to her husband's many demands, including performing as hostess of large parties and accompanying him on many business trips. She felt considerable underlying resentment toward him and often felt used and exploited by him. But she played her part, and she in turn was given many material things in the form of jewelry, fur coats and the like. She had a very close relationship with a younger sister who lived nearby and who was frequently at her house.

As a result of a major family argument between her husband and her sister's husband, her husband banished the sister from the house and insisted that her name never be mentioned again. The patient's more chronic depressive state developed into an acute

clinical depression at that point. We would speculate that the major impetus to the depression was less the friction with her husband, her anger at him and her "identification" with her sister (which were certainly all there), but more the loss of her relationship with her sister. This relationship had allowed her to tolerate her sadness and profound disappointment in the marriage, and she could, therefore, stay on the nonsymptomatic side of her depression. The loss of her sister confronted her more dramatically with the disappointments she had with her husband, and she felt completely alone to cope with her vulnerability about all the feelings stirred up in this situation.

Another woman who was also in a disappointing marriage became depressed after her mother died. A more traditional understanding of this case would suggest that her depression represented a pathological grief reaction to the loss of her mother with whom she had an ambivalent relationship. Closer scrutiny suggests another story. This woman came from a very protected, conservative background. At age 18 she fell in love with her husband who was very handsome and charming; she looked forward to a romantic and sexual relationship with him and to having many children. She learned very early, however, that her husband was not very interested in sex or children. After 10 years they finally did have one child.

She felt sustained by her relationship with this daughter, with whom she was very close, but also by frequent telephone contact with her mother, whom she saw as her closest friend. They spoke to each other often, and she felt her mother was the one person who helped her, as she said, "keep my head on straight". When her mother died, she lost the one person who helped her tolerate her deep disappointment in her husband and offered her an empathic relationship to counter the isolation she felt in her marriage. Again, this case could easily be misunderstood, and she would be identified as too dependent on her mother.

Theoretical issues

We will examine briefly the current theoretical understandings of the dynamics of depression. They are based largely on early psychoanalytic formulations with modifications introduced by ego psychologists and object relations theorists. None of these dynamic formulations addresses why depression is so prevalent in women nor explores the role of sadness in the therapeutic work with seriously depressed women.

Although our interest here is in the psychological rather than biochemical and genetic aspects of depression, it is important to note that hormonal, biological and genetic hypotheses offered to account for these gender differences have not to date yielded consistent findings (Weissman & Klerman, 1977; Weissman & Klerman, 1987).

While there are a number of important differences among the various theorists, there are some common themes which reflect the prevailing assumptions about the etiology of depression. The early psychoanalytic writers recognized the significance of loss as a major precipitant of depression. However, they believed that those most vulnerable to depression were fixated at the oral stage where they had experienced the first major loss through deprivation and rejection. Abraham (1927), Freud (1917/1961) and others thought that the depressed person's earliest relationship with the mother was characterized by a profound ambivalence in which loving feelings were blocked by hateful feelings. The hateful or angry feelings were, however, repressed because of fear of further loss and were expressed through self-recriminations, guilty feelings and the like.

The recurrent themes are that those people vulnerable to depression were fixated at the oral stage and were, therefore, unusually dependent and needy; these individuals regressed to this dependent, needy state when confronted with losses later in life. Since their relationships with their mothers were characterized as "ambivalent and narcissistic", they were unable to sustain loving feelings; and their intense, hostile and angry feelings were too dangerous to express; anger was then repressed and turned inward, and thus contributed to the depressive symptomatology of low self-esteem and guilt.

Bibring (1953) offered a somewhat different model of depression. He saw it as a state of helplessness of the ego which arose when there was too great a discrepancy between the appraisal of one's own abilities on the one hand and one's level of aspiration on the other. Although he postulated a range of life circumstances which could create such a state of helplessness — from aspirations to hold on to the lost person even in the face of death, to entertaining grandiose expectations for recognition and success — he believed there needed to be an earlier vulnerability based on fixations at any one of the psychosexual levels of development. Even later writers of the interpersonal school, such as Arieti and Bemporad (1978), also came down to a model which

goes back to the early years when the vulnerability for depression was firmly established.

Most important, through focusing so consistently on early loss and fixation, these theories do not acknowledge the power of those life experiences which precipitate or trigger appropriate sad reactions. In this paper we are suggesting that the very lack of recogni-tion of the legitimacy of the sad responses to life events results in the sadness going underground and the ultimate development of depressive symptomatology. This sequence was illustrated in the examples of women whose sorrow and sadness about their stillbirths went unacknowledged, and who became depressed; and in the vignettes of women who were profoundly disappointed in their relationships with their husbands but did not feel entitled to their sadness and thus became depressed.

Epidemiological studies of depression suggest that life events and social connections correlate significantly with depression (Belle, 1982; Paykel, 1982; Turner et al., 1974). The classic Brown and Harris study (1978) found four vulnerability (background) factors for depression in their samples of depressed women: having three or more children under 14 living at home, lacking employment away from home, loss of a mother before the age of 11 and lack of an intimate, confiding relationship with a husband or boyfriend. While there are no comparable findings with samples of depressed men, these vulnerability factors do speak to some of the significant life circumstances confronting many women; it is also likely that there is little recognition in the day-to-day lives of these women of the power of these events to evoke sorrowful and sad reactions. The stage is then set for the women to develop more severe depressive reactions when faced with a loss or traumatic event in their lives.

Other empirical studies have raised questions about the roles that dependency and anger play in depression. As noted earlier, most psychodynamic explanations of depression have stressed early deprivation of "oral supplies", rejection, abandonment, etc., which resulted in a lack of resolution of dependency needs. Such individuals, usually women since women are most vulnerable to be labeled dependent in this pejorative way, are considered at risk to become depressed in response to later life events which recapitulate these earlier deprivations. However, Weissman and Paykel (1974) report that although dependency was a characteristic of the depressed state, it was not an enduring feature of the depressed women. When the depressed women recovered they were not found to be more dependent than the nondepressed women. It is also likely that a misunderstanding of behaviors labeled as "dependent" in depressed women contributes to maintaining the woman in the depressed state.

We would like to suggest that when a woman is depressed this "nonfeeling state" keeps her out of touch with her true emotions. As a consequence, she becomes more and more fearful of making a move to effect any kind of change and might certainly appear "passive", "dependent" and "stuck". In reviewing the literature on depression, it is impressive to see how highly pejorative and judgmental is the language used to describe the so-called "dependency" of the depressed person, e.g., clinging, demanding, greedy, voracious, devouring and the like.

Empirical observations also do not support the assumption that depression is a consequence of repressed anger. Weissman and Paykel report that the depressed women they studied were in fact more hostile and angrier than the women in the control group. Interestingly, they found that indications of the hostility of depressed women were rarely apparent to the psychiatrists interviewing them or seeing them in treatment but were reported to be observed readily by family members. In particular, children were often the targets of the depressed women's anger.

We believe that the anger does erupt more forcefully for some women as they become less defended and more depressed in response to significant life events, but that the anger feels dystonic, threatening and guilt-provoking. When women experience disappointments in the important relationships in their lives, feelings of deep frustration and anger develop but are shut out of awareness for several reasons. We know that women have a history of difficulty feeling entitled to their anger and coping with it (Bernardez-Bonesatti, 1978; Miller, 1983), and that they are very afraid that expressions of anger will jeopardize what relational possibilities they believe they do have. Also, women are threatened by the possibility of hurting those they care about.

What is perhaps even more central is that the depressed woman has not dared to be fully aware of the nature of her disappointments. A lifetime of not listening to her own thoughts and feelings and a lack of belief that she is entitled to feel bad keep her disappointments out of awareness. We believe that many women find after marriage that they do not have the kind of relationship they have expected all their lives, in which their husbands want to know their experiences and value the whole relational process. Because the depressed woman then is not

clear why she is angry, she often finds reasons in the form of complaints, tantrums and irritable outbursts over apparently trivial matters (Bernardez, 1988). All of these behaviors confirm her sense of herself as unreasonable, bad and unworthy and contribute to self-sabotaging behaviors in her relationships.

As a result, expressions of anger are not liberating, but rather maintain the depressive spiral of isolation, guilt and self-hate. The therapeutic techniques many of us learned to use with depressed people, to help them get their anger "out" instead of turned inward, often has disastrous consequences. We have seen instances of depressed women becoming more suicidal after they have been encouraged to be more expressive of their anger in therapy sessions.

Instead, therapeutic work should help women patients to appreciate why they are angry and to understand why it is so hard to be angry. Through this approach women often can see more clearly how angry they have been for a very long time, why they did not understand it and consequently felt helpless and powerless to move with it.

The therapeutic encounter can then offer a safe place to risk the expression of authentic feelings, such as sadness and anger. When this relational context is characterized by empathic understanding, women can begin to clarify what they are feeling and appreciate the meaning and legitimacy of what they are sad about. Through this process they can begin to feel empowered to move out of the position of isolation and self-hate.

As stated earlier, we believe that many women become depressed when there is no place for them to experience the anguish associated with significant disappointments and losses in the important relationships in their lives. We suggested too that the culture at large, and family settings as well, do not readily tolerate and legitimize women's painful feelings in response to life events.

Married women in particular often feel that they have no right to "complain" if their husbands are decent men, offer financial security and if their children are healthy and "ok"; yet we know many such women do get depressed — and they typically blame themselves and are blamed by others as wanting too much, being too dependent or having too many "complaints". Rubin (1976) reports that working-class women, asked what they value most in their husbands will say, "He's a steady worker, he doesn't drink, he doesn't hit me" (p.93). However, we also know that among the significant variables countering depression in these women is having a husband or boyfriend who can be a confidant.

In fact, many women feel deep disappointment in the important relationships in their lives, but they often feel unable to act to change the situation because the important people and the whole surrounding culture do not provide the framework of thoughts and words with which they can even begin to formulate — let alone express — what they are feeling and seeking. They cannot become empowered. It is the very experience of being disempowered that contributes to lack of self-worth, a deep sense of failure and self-blame and an inability to identify and feel entitled to those things which really matter — i.e., connections in the way women are seeking them. This is, of course, the set of conditions which will inevitably lead to further immobilization and depression.

The most growth-enhancing therapeutic encounters are those that provide for the mutual experience of connection through the therapist's readiness to be with the patient in her pain. All of us have our sorrows, and all of us need the relational opportunities to feel them. It is the process of being truly moved by whatever our patients are experiencing that contributes to the mutuality of the relationship and the empathic experience. And it is this process which empowers both therapist and patient to move out of the depressive position.

All of us who have worked with depressed patients know how readily the therapist begins to feel hopeless, disempowered and depressed in the face of the patient's isolation and disconnection. The patient is unable to identify what she is truly feeling and does not feel entitled to her sadness; instead, she feels unworthy as well as deeply resentful and consistently defies any offer of help. This maintains the depressive spiral.

This constellation can be interrupted through the therapist's efforts to help identify the underlying sadness and by "bearing" together with the patient what appear as unbearably intense emotions. For it is the very expression of authentic feelings which strengthens the connection between patient and therapist and allows them both to move in a mutually empowering way. The patient then is no longer feeling alone and bereft. As she feels more understood and as her own feelings develop more clarity and expression, she can experience more positive self-worth and can begin to hope for and move toward more gratifying connections in the future.

[1]The exception is manic-depression which occurs at an equal rate in women and in men. This finding is consistent with other data which suggest a greater biological component to this condition (Weissman & Klerman, 1987).

Discussion summary

After each colloquium presentation a discussion is held. Selected portions of the discussion are summarized here. At this session Drs. Judith Jordan, Alexandra Kaplan and Janet Surrey joined Dr. Stiver in leading the discussion.

Question: I wonder if you could say something about sadness and anger in the therapy with women who are recovering from sexual abuse and also from battering relationships.

Stiver: That is a very relevant question since women who have been sexually abused or battered often have had to split off many feelings, particularly their sadness and anger.

The sadness will be difficult to touch for some time. Instead, there are the more depressive symptoms — despair, self-hate and isolation.

Still, I believe the sadness needs to be addressed before the anger. The anger probably would be the more dangerous feeling to experience, at least early in the treatment since it would be experienced as threatening the relationship with the abuser or the batterer, despite how horrendous that relationship may be. Often that person is the only person the woman feels any connection with — and she cannot tolerate the possibility of jeopardizing it.

Jordan: One of the reasons that groups for incest victims and battered women are so powerful is that as women begin to listen to stories told by other women who have experienced similar horrible situations, they begin to get in touch with their own feelings — they begin to develop some empathy for their own experiences as well. This becomes a very meaningful way to bring the feelings back into connection.

Kaplan: For abused or battered women the sadness is particularly profound because it is related to a loss of self, of feeling so bad and so tainted and without any self-worth. I think the anger comes only later, after there is some distance from the relationship with the abuser and more of a sense of self.

Question: In the stillborn situation you said that the father was also sad but not expressing the sadness. Why didn't he get depressed? Also, why does the mother take on the father's sadness along with her own?

Stiver: That's a very big and complicated question; it relates to the still unsettled question of why depression, in general, is more common in women than in men. I think there are major differences in the developmental paths for men and women which lead women to be more in touch with feelings in many ways and to have a greater awareness of how important relationships are to them, while men are raised to be less in touch with their feelings and less aware of how important relationships are to them.

Some people think that men defend against depression in other ways, for example, in alcohol abuse or acting out in more antisocial behavior because they take flight from feelings into action. However, I think that's a bit oversimplified. I think that men have found other avenues in which they can direct their energies such as the work arena. They become involved in performance and in doing things which can serve as ways of avoiding feelings and not dealing with what's going on in relationships. At the same time, men are usually better taken care of. Although they don't have to acknowledge relationships as important to them, they often are surrounded by those who provide relationships for them.

Comment: In my experience working with many babies who were born deformed, I think there was a lot of denial by the fathers — more by the fathers than the mothers. I think the men tended to wall off the grief. To experience the grief would be to admit that "something in my seed could have caused the deformity". There was a need to deny that responsibility. The women were much more open to experiencing it. In addition, the mother carried the child for nine months and had a relationship with it.

Stiver: I'm reminded of Zetzel's notion. She didn't distinguish between sadness and depression, but she talked about gender differences in depression. She described women as much more able to tolerate and stay with the experience of painful feelings but then not able to move out of them; while men avoidthe subjective experience of painful feelings but move into instrumental action prematurely. With the stillbirths, the men's tenden-cy more often may have been to rush to some action, some "solution", instead of knowing how they felt. Women are often caught in a more disempowered posi-tion of feeling bad and not knowing how to move out of it.

Surrey: I also think the painful feelings would be much more dystonic for men because of the way men are raised. Often there wouldn't be that much relief for a man to cry with somebody because it would cause so much conflict for him.

Kaplan: I think you're suggesting, too, that the actual experience may be a different one for the woman and the man. The woman had a relationship with the baby she carried for nine months. For the man it was more of a question of whether he "failed" if he thought that something was wrong with his sperm.

Comment: We have to look at the ways in which society at large makes it difficult for men to express their feelings and to be in a relational mode, to show their vulnerability.

Stiver: I think that's absolutely true; and, further, there's a cycle that follows from that. When men have been raised for so many years in that way, they need to ward off those expressions of feelings in others too. A kind of spiraling effect follows. The men have much more trouble tolerating these feelings in women; then the women feel more and more frustrated and unheard and in turn find it very hard both to honor their own feelings and to understand the hidden feelings in men. This spiral leads to depression.

Question: It sounds like you are implying that traditional marriage is a very sad business. If that is so, what would you suggest we do about it?

Stiver: The literature is not totally clear, but some studies suggest that marriage is more of a protective experience for men and more risky for women. Other studies suggest that marital difficulties correlate very highly with depression in women. Women go into marriage hoping to have "a mutually empathic relationship" with all that implies. Often the women meet with frustration and disappointment.

In order to appreciate this familiar experience, it's important to see how men and women usually enter marriage from very different pathways with different experiences and expectations. Although we can assume that men also hope to find in marriage a partner responsive to their relational needs, I don't think this is consciously experienced in quite the same way. And paradoxically men more often do have their relational needs responded to without having to acknowledge them. Also, men have found other avenues of trying to find gratification in their lives, which is what they have been taught — that is through work, performance, etc. It is difficult then for them to be responsive to their wives' relational needs.

As to what to do about it, that's the big question. I can respond to the individual situation rather than to the larger societal question. Certainly we all know that in our work with some couples the men do begin to feel more comfortable with their feelings and as a conse-quence more able to honor their own and their wives' relational needs. In other couples there sometimes is little change, and the men are not motivated to continue the work. Perhaps more innovative changes need to be developed.

Surrey: There are some recent data which show that the state of women's friendships, whatever their marital situation, is predictive of overall mental health — and also depression.

Kaplan: We know that women often say that if they really want to talk, they'll talk to their women friends. Women often seek out a relational context and friends outside of their marriage, and there are certainly women who choose women as partners and don't try to work out a relationship with men. The finding that Gilligan and her colleagues report is relevant. Women tend to be more anxious in the face of isolation and more comfortable with intimacy, but with men it's the reverse.

Jordan: I think a lot of the work has to be done with the men, helping to increase their tolerance for affect, particularly for the kinds of affect we're talking about today — sadness and other vulnerable feelings. The men in our culture are so socialized against feeling these feelings. If we could help men to open up to these feelings in themselves, they could then be open to them with their partners. The other need is to help open up an increased relational awareness in all people. We're not talking about you vs. me — self-sacrifice vs. self-glorification — but about developing a consciousness of the relationship of "we".

Surrey: I would say that women also have difficulty managing close relationships, all kinds of relationships, sexual and nonsexual. As a culture we have a lot of work to do in all relationships, not just male-female relationships. Mother-daughter relationships are especially significant. So I don't think we should totally focus on the male-female relationship.

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