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A PERSON-CENTERED VIEW OF DEPRESSION: WOMEN'S EXPERIENCES

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ABSTRACT. *Openness to another's experience is fostered by broad knowledge, not by ignorance. Diagnostic information can obscure a client's experiences if it is taken as definitive, but it can enlarge a therapist's repertoire of understandings if it is used tentatively. Knowledge of experiences that occur frequently among people who share a diagnosis can sensitize a therapist to experiences that a particular client may try to convey. Four women previously treated for depression were interviewed intensively in a search for common experiences. Within their different personalities, backgrounds, and personal circumstances, these particular women seemed to share a constellation of emotional experiences that could be organized around their history of sexual and physical or emotional abuse.*

Person-centered scholars and clinicians have often resisted using diagnostic labels out of concern that classification of people can interfere with authentic human relationships (e.g., Rogers, 1951, pp. 223-225). In addition to implying distant and unequal social roles of expert "diagnoser" and dependent, helpless "diagnosed," diagnosis carries a danger of importing a system of assumptions about personality – of casting the person as "a depressive" or "a schizophrenic," as if the diagnosis encompassed the person. One might falsely assume that all Major Depressions (for example) are alike or that all diagnosers are objective and equivalent (Boy, 1992) and so fail to listen to the unique experiences of the person who was labelled as depressed. In understanding supposedly common diagnostic features, one might tend to view depression from the external perspective of a diagnostic manual or an abnormal psychology textbook. These potential attitudes are deeply antithetical to the person-centered goal of viewing each individual's unique experience from within his or her own internal frame of reference.

Although we acknowledge these dangers, we see countervailing advantages in developing a systematic person-centered diagnostic frame of reference (see also Bohart, 1990). Chief among

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these is the possibility of accumulating an understanding of clinical conditions, to help clinicians understand more quickly or more deeply what their clients are trying to tell them. Thus, we do hypothesize that common clinical manifestations (in this article, the symptoms of depression) *may* reflect common client experiences, which may or may not be shared by a clinician. In particular, we suspect that many people who are depressed experience the world in some ways that are like each other. We do not assume that all people who appear depressed share particular experiences; in a person-centered psychology, every generalization is tentative and subject to disconfirmation by each client. We suggest that adopting a scientific epistemology of tentativeness can free clinicians to use the results of research on people given particular diagnoses without turning people into diseases.

A crucial difference between a person-centered view of depression and that advanced by such systems as the DSM-III-R (American Psychiatric Association, 1987) is the viewpoint from which the depression is described. Most diagnostic systems take an external viewpoint; signs and symptoms are described from the clinician's perspective, ideally as elicited by standard questions. It is often implicitly assumed that the person making the diagnosis is healthy and the one being diagnosed is pathological and that the two do not share common experiences. Thus, the client becomes "other" to the diagnostician. A person-centered approach, by contrast, uses the clients' frames of reference. The diagnostician and the client may have some of these experiences in common. The experiences need not be viewed as pathological in order to be useful for understanding the diagnosis.

In a person-centered diagnostic system, a clinician can never be sure that his or her understanding is correct. All knowledge is tentative, particularly knowledge of another person's experience. Maintaining the attitudes and skills necessary to treat knowledge tentatively is central to the practice of client-centered therapy. It would be a misuse of knowledge of diagnostic categories – like any knowledge about groups of people – to assume or to insist that a client has had a particular experience. In the same way, reading that Chinese students describe counseling as less potent than do American students (Page & Cheng, 1992) or reading about ways that the experiences of homosexual couples may be similar or different from those of heterosexual couples (Knopf, 1992) can usefully sensitize counselors to their clients' experiences. But it would be a misuse to assume that a particular Chinese student necessarily believes that counseling is not powerful or that a particular gay couple has necessarily had the experiences Knopf (1992) describes.

Person-centered diagnostic information may be useful in framing reflections. For example, knowing that many depressed women share an experience of having been physically, sexually, or emotionally abused in primary relationships, a clinician can be alert to a particular client's possible struggles to acknowledge and articulate such an experience. Thus, it can allow a therapist to hear what a client may be saying at a particular moment in therapy.

Viewed in this way, a person-centered diagnostic system serves clinicians much as does biography, anthropology, mythology, art, or diverse life experience: It enlarges the repertoire of understanding that clinicians can bring to bear in listening to their clients. It speeds and deepens communication; in effect, it substitutes (partially) for prior clinical experience or life experience that matches the client's. It calls attention to what might otherwise be overlooked and offers ways to express what might otherwise be obscure. It suggests hypotheses that can be tried. It offers no certainties but it does suggest possibilities. Thus, when a client is struggling to express some long-denied or distorted experience that may not have occurred in the clinician's personal life, the clinician can – always tentatively – use the knowledge of a person-centered diagnostic system to recognize and articulate the experience.

In this article we illustrate the results of an ethnographic study of women who had previously received psychotherapy for depression. During intensive interviews, the participants described their experiences of depression and the personal circumstances that led to and affected the course of these experiences. Placing several people's apparently different stories together exposes

common themes that might be less noticeable if each were considered alone (Rosenwald, 1988; Wiersma, 1988). The results offer a perspective that may help sensitize person-centered clinicians to core features of women's experiences of depression.

METHOD

The participants were four women who, according to their clinic records, had been previously diagnosed and treated for depression: Jasmin and Elizabeth, who wanted to be identified by their real names, and "Penny" and "Denise," who asked that their identity be concealed. They were interviewed three times, twice individually and once as a group.

In the first interview, each woman was asked to tell the story of her experience of depression. The interview was transcribed and analyzed in detail, to prepare a narrative account for each woman and to identify themes. A written summary, which included a chronological narrative, a set of documented themes, a theoretical analysis, and the investigator's interpretation, was returned to the woman. Each participant read and reacted to the initial analysis. The second interview sought feedback about the initial summary and invited reaction and elaboration. The woman's reaction was reviewed and the original analysis was modified accordingly. Then, themes common to all participants' experiences were compiled, and a written summary of the commonalities was given to all four women. A final group interview explored their feelings about the accuracy of the reported commonalities and about their participation in the study (Schneider, 1991).

The procedures used in this study were analogous, on a larger scale, to the technique of reflection in client-centered therapy. The written individual summaries returned to each participant before her second interview and the written summary of commonalities returned to all participants before the final group interview tried to capture the content and feeling that they had communicated. Their reactions confirmed or disconfirmed the summaries' empathic accuracy and led to revised, more refined, more accurate versions. In this way, the substance of this article is the product of a dialectical process, in which the participants and the investigator have negotiated an account of the experience of depression.

This study of women's experiences of depression was Charlene's (CKS) Ph.D. dissertation research at Miami University. Bill (WBS) served as chair of Charlene's dissertation committee and has listened, made suggestions, argued, edited, and written parts of this article. Charlene planned the study and conducted the interviews, however, and the interpretations express her viewpoint in her voice. Thus, in this article "I," "me," and "my" refer to Charlene.

Intensive studies of people's lives frequently touch on topics that are personally significant for investigators, and thus involve them in self-examination and personal learning. Conversely, the investigator's life and values shape a study's focus and expression, so readers can better understand the report if they know something about the investigator (Stiles, 1993).

I first became interested in depression in 1977. I had a B.A. in psychology and was a full-time suburban housewife and new mother. My family and I attended a small fundamentalist-Christian church and I observed one woman after another from that congregation being hospitalized and diagnosed as clinically depressed. Although it was only women who were becoming depressed, I did not become aware until I began to study depression in my master's program in clinical psychology that being a woman had anything to do with being depressed.

This experience of watching women struggle and suffer with depression led me back to graduate school and, ultimately, to this work on depression in women. The question, "Why women?" became a nagging one. The experience also led me to adopt my current feminist perspective on depression. I now believe that the higher rate of depression in women is a political as well as an individual and clinical issue. In doing an ethnographic, narrative interview study of women who have experienced depression, I have chosen to get close to the participants, to listen to their voices, and to view them as collaborators.

COMMON THEMES IN THE WOMEN'S EXPERIENCES OF DEPRESSION

I read each interview many times, cut the transcripts into strips, and categorized and sorted the strips to identify themes in each woman's reported experience. These themes were prominent, explicit, repeated elements in the transcripts; they were not unconscious or hidden, nor were they objective or neutral. I meant them to convey the experience of depression from the woman's internal frame of reference, in a way she would readily recognize, rather than from the external frame of reference of a detached diagnostician. I gave each theme a name – in most cases, a phrase the woman used that seemed to capture a repeated idea or feeling. Later, after each woman had read and discussed her individual themes, I compared the separate sets of themes, to identify those that were common to these women. The following sections describe these common themes.

In this review of common themes, Denise's story is used to illustrate how the themes appeared within one individual's unique experience of depression. Denise was 48 years old at the time of the first interview. She was a nurse by training but was not employed outside the home and instead volunteered her time as director of an organization that granted dreams to seriously ill children. For example, a child with a brain tumor might be referred, and the organization would grant the child's special wish to go to Disney World or to meet their favorite celebrity. Denise had been married for 28 years and had one son, then 25 years old. She was the oldest of four children in a family she described as dysfunctional. Denise identified herself as a Christian. She was not in good health at the time of the interview, suffering heart problems, irritable bowel syndrome, and diabetes.

The Experience of Abuse: An Organizing Theme

Denise experienced emotional abuse growing up in a family where she feared that her alcoholic father might beat her mother to death. She experienced covert sexual abuse[1] from her father, or what she described as "emotional incest." She said, "He did emotional abuse or it was incest to me and it was very, very hard to take that . . . I was taking my mother's role and I was taking this abuse from my father because she wouldn't stand up for herself." She spoke of her father commenting that she was "so dirty" and that men were always looking at her. Her father was strict and Denise recalled stringent rules. Because of her father's demeaning comments about Denise's sexuality in adolescence, any memory she had of sexual feelings or activities in her youth was overshadowed with feelings of shame.

The other three women had also experienced significant sexual abuse and physical or emotional abuse. Taken together, the common themes resembled reports by other survivors of sexual abuse (Bass & Davis, 1988; Courtois, 1988). A history of abuse was not a criterion for inclusion in the study, and I had not expected this consistency. (I conducted the first interviews with these women in November and December of 1988, prior to the more recent popular attention to sexual abuse.) Elizabeth was a victim of father-daughter incest from the age of seven to seventeen. Jasmin was physically and emotionally abused her entire life by her mother who was diagnosed as manic-depressive, was emotionally abused by her alcoholic father, and was raped at the age of eleven by some of her cousin's friends. Penny had been sexually abused in at least three incidents. At the age of nine she was dragged into a shed by a group of neighbor boys and at the same age remembered being in bed with the teenage brother of one of her friends, but did not recall the specific details of these incidents. She was also coerced into the basement by her step-grandfather, and inappropriately fondled and kissed by him while he forced her against a wall. He exposed his genitals to her and while his hands were occupied with this task she ran upstairs because she was sure he meant to rape her.

In spite of my feminist orientation and my clinical experience working with abused and battered women, I was surprised when the common theme of abuse became apparent in the course of analyzing the women's stories. I had set out to study depressed women, not abused ones. Nevertheless, in my understanding of these women's experiences of depression, their common experience of abuse became a central organizing factor.

The abuse these women experienced early in life seemed to reverberate throughout their lives. Understanding their experience as victims of abuse brought coherence to the other common themes in their stories. The coherence contributes to a person-centered view of depression insofar as it suggests a (tentative) way for clinicians to understand more quickly and deeply what some depressed women may be trying to say.

Of course, these four women's experiences do not, by themselves, prove that being abused causes women to become depressed. On the other hand, an American Psychological Association Task Force on Women and Depression (McGrath, Keita, Strickland, & Russo, 1990) did suggest that there is a statistical link:

> Victimization in interpersonal relationships is a significant risk factor in the development of depressive symptomatology in women. What is presented clinically as depressed mood may be long-standing posttraumatic response to experiences of intimate violence and victimization (p. 28).

The women who participated in the study made a causal claim for their own lives. Penny said in the group interview, "After the physical abuse is over, then you have to handle the emotional and the mental abuse that the physical abuse put there." Denise responded, "Caused!" "Exactly!," replied Penny.

Chaotic Families/No Parental Protection

All four women described chaotic families in which they experienced abuse and felt unprotected. Both in her family of origin and in her family life as an adult, Denise spoke of how "things are just not right at home." She commented, "I guess if I had a solid base to shoot from I'd be okay in some of these other things." Her father was alcoholic and physically abusive to her mother, and she felt caught between them.

> I was giving every ounce of my energy to try to keep my dad from killing my mom and trying to keep things stable at home and take care of the house and take care of the other kids. Yet, she had no right to take advantage of me. . . . She didn't protect me from it.

In her home life as an adult, she said, "[My husband] very seldom ever wanted to have sex with me. I think that that was a big, big, big part of my depression. . . . It means I'm not wanted and that's not right." And she felt helpless and out of control trying to raise her hyperactive son. She said, "He was born screaming and he screamed all of his life."

Inability to Act

All of the participants described an inability to act on their own behalf. In childhood physical, emotional, or sexual abuse, the child is repeatedly subjected to trauma over which she or he has no control. Assertive action typically fails to stop the abuse and may intensify it. These women's inability to assert themselves as adults seemed understandable as a continuing response to being victimized.

Denise's theme that I labeled "Fighting Inside Myself" described her difficulty making decisions and acting on her own behalf in many areas. For example, she said:

> Always just back and forth. I'm always in pros and cons in every situation I have. Try to get off the fence to either side. It's not so much making decisions, but it's what would be the *best* way to do this. . . . It drives you crazy.

Low Self-Esteem

A link between the women's experiences of abuse and their inability act seemed to be low self-esteem – not seeing themselves as worthy of their own expenditure of energy. Each woman felt worthless and, to some degree, disconnected from herself. As one participant put it, "I was not my own person." It was difficult for them to think highly of themselves when people close

to them so obviously had not. As another participant so graphically described, "My mom was treating me like I was a log or something outside."

Denise said that she became aware of how low her self-esteem was when she realized she told herself, "You're worthless," for such minor infractions as staying in bed late.

Hyper-Responsibility/Maintaining Control

Maintaining a sense of control and an exaggerated sense of responsibility for others was another common theme. The women found that when they began to feel out of control they also became depressed. Penny asked the others in the group interview, "Do you always feel like you have to solve other people's problems?"

As children, these women undertook adult responsibilities because they experienced their surroundings and the adults in their lives as unpredictable, out of control, and dangerous. I could understand their themes of maintaining control as a carrying forward of this sense of responsibility for others into their adult lives.

Denise began her story by saying, "I'm a person that takes very much control of everything. Sometimes I think I lose control and it just isn't working anymore so I have to break down and get some help." She went on to say, "Feeling helpless is the worst part. Just not knowing what to do with the various things in my life."

Fearing that her father might kill her mother, Denise took the responsibility for keeping her mother alive upon herself at a very early age. Also, in the midst of her chaotic family life, she took on the responsibility for trying to see to it that the family was run as smoothly as possible. She said, "I was the oldest of four children and I was having to be in control and be a responsible child."

Denise carried her sense of responsibility into her adult life. She tried to maintain control by being perfect. She said, "I had to be perfect all the time. . . . I was going to be the perfect mother."

> In about tenth grade I decided to become a nurse. I took care of everybody for twenty years. . . . So this organization that I am in now, I'm still taking care of people. . . . I've been taking care of all these families and all these kids.

Loss of Childhood/Old Beyond Their Years

All of the participants experienced feeling old beyond their years. Their felt loss of their childhoods reflected their having switched roles with the adults in their lives, establishing a pattern of trying to gain control by being hyper-responsible, to bring some safety and order to the danger and chaos that surrounded them. Denise said:

> I always joked that I was an old lady when I was born. I was always keeping my parents from killing each other and I was an old lady. . . . Even as a child, I never played. I didn't know how to play.

Inability to Express Anger

Each of the participants described being unable to express anger. Insofar as these women had been victimized, they had reasons to feel intensely angry. Originally, however, expressing anger toward their abusers could have brought severe retaliation.

Denise said, "You feel so angry about so many different things and don't know what to do with that anger and I turned it in on myself. Then I end up being very depressed."

Protecting the Abuser/Self-Abuse

Instead of being clearly angry about the abuse, they sometimes blamed themselves or tried to see the abuser's point of view. Protecting those who have treated one abusively has been labeled "bonding with the abuser" and is part of the Stockholm Syndrome (e.g., Graham & Rawlings, 1991), a cluster of symptoms first described in victims taken hostage at a bank in Stockholm.

The hostages identified with their captors, presumably because their survival depended on it, blaming themselves for their mistreatment and defending the captors, even after the ordeal was over. Like the Stockholm hostages, Denise and the other women seemed to adopt an abuser's viewpoint, expecting themselves to sacrifice their personal comfort and personal worth to the whims or frustrations of others and blaming themselves when they failed to do this successfully.

In the group interview, the other participants commented on Denise's tendency to protect her abusive father and her mother who did not protect her. She responded:

> Sometimes I think I want to put it all on my shoulders . . . saying they really didn't mean it so I shouldn't have taken it the way I did. . . . All it boils down to is it comes right back to me and puts this big pile on top of me.

The women indicated that at times they did not treat themselves with care and respect. For example, they ate too much candy or other foods or smoked too much in an attempt to make themselves feel better, knowing while they were doing it that it would only make them feel worse. Denise commented,

> One thing that I found that has truly affected my depression one way or another is my blood sugar and eating properly. . . . I'm wondering how much depression is caused by the fact that we're not eating right or taking care of our bodies.

They became self-abusive to varying degrees, from making depreciating comments about themselves to engaging in self-mutilating behaviors. Self-abuse can be understood as an internalizing of the view of the self held by a previous abuser. Penny said she clawed her face and then only remembered it as if in a dream-like state. Coupled with her lack of memory for the past, this raised the question in my mind as to whether she had dissociative experiences. Denise revealed,

> I've always had this thing. . . . I pick my cuticles until they're clear down here [to her knuckles] and bleeding and raw. . . . I blame it on nerves, yet I'm wondering if it's a self-mutilating type thing.

I wondered if these women might have experienced more serious incidents of sexual abuse than those they reported, since self-mutilation and dissociation are usually seen only in those who have been victimized from a very early age and in a very severe way (Bass & Davis, 1988).

Lack of Safety/ Fear of Intimacy

Each participant felt unsafe and was afraid of intimacy. Their feeling unsafe in intimate relationships seemed easily understandable in terms of victimization. These women grew up in environments where they were not safe and where the respect for boundaries necessary to experience intimacy had been violated.

Denise grew up afraid for her mother's safety and unable to protect her own emotional boundaries. About the way her father ran the family, Denise said, "You did not make any decision on your own and whatever you did was not right." When Denise reached puberty, she felt her sexuality was always on trial. She described her father's reaction when she returned home from dates:

> I had not done something right. . . . it was always this lecture and he gave me this constant feeling of being on guard and being afraid. Any time I was seeing a male, I was committing something that was wrong so I felt dirty.

Denise lost hope of intimacy in her marriage when her husband lost interest in her sexually and became involved in cross-dressing and in performing sexual acts with the family dog. About this Denise felt, "Just total lack of trust. Committing adultery with me in his own way. . . . So it was just this awful feeling of me not trusting even your own husband."

Eventually, Denise dealt with feeling rejected by her husband and with her sexual needs by having affairs. Because of the inevitable secrecy and deception, she found intimacy was not possible here either.

It was the worst time . . . because I was trying to live two lives . . . its a lie from the beginning and there's nothing to place any trust in. . . . You can't trust the other person. You can't trust you.

When her husband found out about her affairs, she and her husband felt intimate for a time, but Denise found this intimacy frightening.

We were so together at that point. That was a really scary place to be because I've never been really, really together with him. . . . I had to pull away from my husband because I had no freedom of my own. Yet, freedom of my own gets me into problems. It keeps me isolated.

COMMON THEMES IN HEALING

The women also described common experiences they had as they healed from their depression.

Needing to Have Fun

All of the women saw the need to have fun as an essential part of their recovery from depression. Penny felt that she would feel younger if she and her husband would go out and have fun once in awhile. Jasmin and Elizabeth had themes labeled "Make Myself Happy," and "Time with Children/Fun."

Denise's theme, "Play/Pleasure," concerned her feeling so deprived of a childhood that she didn't know how to have fun. As Denise reflected on her experience, she realized the huge loss she felt in not having had a childhood and began to grieve this loss.

When Denise had her affairs, she described this time of her life as a time when she had fun. She said, "This was so totally unlike me. . . . But I played during that time. It was the best time." The guilt Denise experienced during her affairs took some of the pleasure out of her fun. At the time of the last interview she had made a pledge to herself that she would find less destructive ways to have fun.

Seeing the World Differently

As their depression lifted, the participants had the common experience of seeing the world differently. For Elizabeth this included regaining a will to live and enjoying her husband's company. Jasmin used a coping strategy she described as getting a "Different Perspective" – taking some time away from her problems in order to see them differently. Penny described getting a "Better Perspective" as a way she had learned to take better care of herself to keep from becoming depressed.

Denise gave examples in the group interview of trying to change her negative "self-talk" as a way she was seeing the world differently since she was less depressed. For example, she would catch herself saying, "You're worthless," and say something positive to herself instead.

Being Responsible for Self

As the participants healed, they became more responsible for themselves. Jasmin's theme, "Responsibility - For Me" concerned learning how to take responsibility for her own needs rather than focusing on taking care of others. Penny found she had to learn "who was responsible for what." As she took more responsibility for her own problems and less for others' problems, she experienced less depression.

Denise too saw taking more responsibility for herself and less responsibility for others as part of her healing. She said, "Finally I realized I can only be responsible for myself and I'm not doing too well at doing my own problems let alone taking care of all of theirs." During the time of the

study, she was pleased with herself for getting air in her own tires instead of waiting for her husband to do it for her, refusing to continue her volunteer position unless she get paid for her work, and taking a leave-of-absence from her job in order to ready herself to find new employment.

Breaking the Isolation

When the participants realized that others had experienced problems similar to theirs and that they did not have to face these problems alone, they felt less depressed. Elizabeth wanted to share this message with those who would read this study. She said, "Tell everybody to never try to carry all the burdens alone because you can't. You have to share your feelings with somebody." Learning in group therapy that others had experienced sexual abuse was a turning point for Elizabeth when she had been suicidally depressed. Similarly, when Penny learned that other women had experienced depression and had learned to overcome it, she gained the hope that she could also learn to cope better. She participated in this study because she hoped that telling her story might help someone else.

Breaking the isolation of depression and realizing that she was not alone was an important theme in Denise's healing.

> When I was in the hospital, since I used to work at the hospital, [one] of the nurses came down that I used to work with. . . . We've grown away from each other because I've isolated myself. She could only stay a few minutes because she was on duty and I just wanted to say, "Don't leave! Don't leave! I have too much to ask you." . . . I just realized how much I loved all of it and loved being connected with people and I said, "I have to stop keeping myself isolated. I have to get out and be with people."

Breaking the isolation was also one of the positive results the women enjoyed from their participation in this study. Penny said about reading the report on the commonalities in participants' experiences:

> It was nice to know that there are other people out there that have been in the same position that I have been in. . . . A lot of times when you're really depressed, you do feel like you're all by yourself . . . it's nice to know that there are other people who have gone through the same things you have. You're not the only one that ever felt that bad. When I read these things about these other women, I felt like even though I hadn't met them . . . it was like, "Yeah! I understand what that was like for you!"

As a step toward breaking their isolation, the women exchanged phone numbers before they left the group interview.

Words for "Something Wrong"

In the theme "Something Wrong," Jasmin and Elizabeth described how they had had no words to label their experiences. Both of them felt relieved to be given the label "depression" – in therapy and again in this study – to name their experiences. Similarly, Denise said she found it helpful in reading her story to see things summarized and labeled.

Naming and labeling and describing seemed to validate these women's experiences. In theoretical terms, the labels and descriptions used in therapy and in these interviews symbolized the women's experiences, allowing them to think more clearly about the experiences and take them into account in making decisions (Rogers, 1951). Having a name and a consensual description for their experiences showed that other people had experienced similar things. This seemed to make participants less likely to question their own reality and to give them a sense of personal power over their own experience.

In the group interview, Denise summarized some of these thoughts:

> *Denise*: The labeling helped me tremendously. To get things labeled and to know and say, "Yeah, I wasn't just thinking this and I'm not just nuts. This really is something that happened."

Once I get something labeled, I can understand it and I can work on it and I can get help for it. I just feel in the past year, it's just been a tremendous difference in my life. I'm sure this study has been a big help.

Charlene: So for you particularly, calling abuse abuse was a big change for you?

Denise: And shame shame and anger anger . . . It tied up a lot of loose ends for me. Kind of pulled things together. Just helped . . .

Charlene: How was that for you to have to label it and say, "Wow! I was abused!"

Denise: It was freeing, in a way. It was very hard to go through it again and it brought a lot of anger up. Yet, it helped. . . . I think it cleared something up and ended something. . . . I put it out of my mind and I don't even think about it anymore.

HOW IS DIAGNOSIS HELPFUL TO PERSON-CENTERED THERAPISTS?

The aim of a person-centered diagnostic system is to convey what it may be like to be inside the person who exhibits particular symptoms. We cannot be certain that the next depressed woman you see will share the constellation of common experiences that these women reported. But we hope that if she does, your having read this article will help you to recognize and understand what she may be feeling.

More specifically, women diagnosed as depressed may have experienced sexual, physical, and emotional abuse, chaotic families, a lack of parental protection, an inability to act, low self-esteem, a feeling of hyper-responsibility and desire to maintain control, a sense of having lost their childhood and being old beyond their years, an inability to express anger, a tendency to protect their abuser and even abuse themselves, a feeling of lacking safety, and a fear of intimacy. As they heal from their depression, they may find themselves newly needing to have fun, seeing the world differently, being responsible for themselves, breaking the isolation, and finding names for their experiences. Of course, knowing that a depressed woman may have been abused and may have organized her life around being abused is not a substitute for openness and empathy. On the other hand, this knowledge may aid empathy by suggesting how the experience of abuse can pervade the life of survivors.

Is diagnosis distinct from the more general notion of clinical information about clients? Diagnosis is merely an attempt to summarize a great deal of clinical information into a compact label. Diagnoses are pervasive in clinical settings. We suggest that, rather than attempting to ignore or deny diagnoses, person-centered therapists can use them to suggest ways to understand clients.

How do you know whether the diagnostic labels are right? This tentative diagnostic information has helped us understand what these women said, and more importantly, it made sense to the women, who, in their group meeting gave the confirming response of a client who has received an accurate reflection. The participants found that labels such as "depression" and "abuse" were helpful, we think, because they accurately symbolized powerful and pervasive experiences. (We do not conclude, however, that clients always find diagnosis helpful.)

How does one know that the confirming response of a client or a research participant is to an accurate understanding or an inaccurate one, given the nature of investigator influence? Kotre (1984) listed three reactions that he counted as verifying his narrative interpretations in his study of people's adult generativity: "(1) whether the subject makes allusions, direct or indirect, to being seen and understood; (2) whether the subject's reactions, favorable or not, are consistent with story motifs; and (3) whether the subject is impelled to reveal fresh and deeper material" (p. 32). The women's reactions to the summaries of their experience and of the commonalites seemed to meet these criteria (Schneider, 1991). Their reactions showed that the summaries felt right and catalyzed self-recognition and change.

Doesn't diagnostic information give the therapist preconceptions? We recognize that diagnostic labels can be harmful if they are used as a substitute for empathic understanding. Of course our summary of commonalities does not represent accurately the full experience of any depressed woman, and it may fail completely in some cases.

So don't the labels get in the way of the therapist's open-mindedness? In effect, we favor trusting therapists to use diagnostic information tentatively and empathically (i.e., to look and listen with greater sophistication) without being blinded or deafened by it.

FOOTNOTE

[1] Courtois (1988) characterized childhood sexual abuse as follows:

> When a child of any age is exploited by an older person for his own satisfaction while disregarding the child's own developmental immaturity and inability to understand the sexual behavior (p. 12).

In a checklist of behaviors, Courtois added, "Of note is that some of these behaviors do not involve touching the child. Incestuous abuse can include gestures, comments, and observations as well as actual body contact."

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