Shifting the Lens: Resituating Women's Self-Esteem from the Personal to the Political

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Women's mental health is political and the erosion of women's self-esteem demands feminist analysis and contextualization. At the threshold of the new millennium when self- esteem had gained popularity as a phenomenon of interest to mental health professionals, building self-esteem became an assigned duty of many public health nurses including myself. A feminist qualitative study situated in public health nursing illustrated that the plunge in self-esteem of six North American white women was the outcome of a patriarchal social system that demands narrow gender roles for women and subsequently devalues them. Mental health professionals must shift the problematic lens of self-esteem interventions that are fixed on exposing and ameliorating individual deficits in women's self appraisals. Consciousness-raising as a strategy to bolster self-esteem is proposed: a strategy that shifts the lens on women's self-esteem from the personal to the political.

Preamble: The Paddle

The lake was moving and the air was thin. Everything sounded near, and as I completed this manuscript I realized that everything is. As each wave reached a canoe that seemed to lie in wait, my own self-esteem arrived on the shore of my consciousness, un-announced, un-relenting and un-disguised. My gaze turned to the canoe and I reached for a paddle. For the first time in my life I set out across a lake in a canoe by myself and with only myself. With each stroke, the paddle soon represented a tool in my empowerment, and the canoe seemed symbolic of my self-hood, my being. The lake was both the known and the un-known and in combination this experience culminated in a re- connection to the women and ultimately to my self. I am a strong canoe who no longer will sit in wait. I am a canoe that is perfectly suited for journeys both familiar and not. Like the lion who realized he never really needed to search for courage—he always had it—my journey down this study's yellow brick road has allowed me to realize something similar. I have a paddle. I've always had a paddle, but it took this intimate re-connection with the voices of six other women, to once again realize it.

I think I could have been one hell of a person. (Sue)

Self-esteem as a component of mental health has received enormous interest in academe, mental health practice and in North America's self-help market. One needs only to peruse a library, bookstore or an academic data base to confirm its seemingly super-status. Admittedly a Western concept, self-esteem has emerged from the work of human-potential psychologists such as Carl Rogers and Abraham Maslow (1954). At the threshold of the new millennium, self-esteem had infiltrated public health nursing in Canada and was presented to be a key determinant of health (Raphael, 1993; Duffy, 1993; Gillis & Perry, 1991; Faulkner, 1997). Its centrality to health was un-questioned within public health nursing circles and this translated into a practice model grounded in the linear argument that if communities are to be healthy, community health nurse work must bolster the self-esteem of individuals and families. As a community (public) health nurse, I recall being troubled by this sudden shift in practice that included the rapid development and provision of public-health nurse led self-esteem groups. To me, this strategy to enable improved mental health seemed far too simplistic. I was concerned that the message would explicitly locate the source of self-esteem within the participants themselves, i.e. in how they chose to view themselves and their life circumstances. As a nurse I have an ethical responsibility to be both benevolent and non-maleficent in my work with people and it is these responsibilities that fueled this study.

In this article I will illuminate the journeys of six women who joined self-esteem groups hoping to feel better. From my experience of listening to the voices of six women and in being a participant-observer in several consciousness raising (CR) groups with the participants it is clear that individualistic conceptualizations of mental health are inherently flawed and dangerous. It is my argument that the individual self-esteem movement is un-productive for women's self-esteem and in locating the cause of its erosion on the thought patterns of women it is dangerous and maleficent. Through bearing witness to what Shreve (1989) calls the click or the moment of realization that their self-esteem was not due to individual flaws or weaknesses but rather was an outcome of years of oppression and misogyny, I will argue that the only model for enabling self-esteem growth with women is one where the helping professional enables consciousness raising that roots self-esteem in the political rather than the personal.

Overview of the study

Shifting the Lens captures the rich narratives, emergent themes and practice recommendations gleaned from a four-phase year and a half feminist qualitative study that came to a close near the threshold of the

new millennium. Based on a review of North American nursing literature spanning from 1977-1997, I became convinced that a qualitative study exploring the lived experience of women's self-esteem was necessary. I found no published qualitative study that documented women's self-reported journeys regarding their self-esteem. I chose to ground the research in women's experiences rather than the perceptions of mental health professionals that were pervasive in professional nursing literature. I wanted to focus on the subjective experiences of women and in using grounded theory, the findings inductively (rather than deductively) emerged from the women's narratives. I did not start from a theory and set out to prove it. Rather, I began with broad questions and over a period of a year and a half, similarities and themes pertaining to their lived experiences emerged. This was feminist research (FR): a method that emphasizes the empowerment of women as well as naming and confronting oppressive, patriarchal and misogynist social norms and structures (Reinharz, 1992; Cook & Fonow, 1990). FR allowed me to explore how I researched in addition to what I was researching (Cook & Fonow, 1990; Munhall, 1988). My belief that the women were wise about themselves and their lives was explicit in the design of the study. From interviews to focus groups to the women's retreat, the voices and lived experience of the women were central, heard and affirmed. Feminist nurse researcher Pat Munhall (1988) sums up my overall aim in choosing a feminist grounded theory study.

> *Perhaps the most critical, ethical obligation that qualitative nurse researchers have is to describe the experiences of others in the most faithful way possible. The ethical obligation is to describe and report, in the most authentic way possible, the experience that unfolds even if it is contrary to your aims.* (Munhall, 1988, p. 153)

Feminist research seeks to give voice to women and to document these voices in their own words. For this reason, Shifting the Lens includes narratives to both connect the reader to the women but to also connect the reader to themselves.

The first phase involved my observation of three separate public health nurse-led self-esteem groups. I was introduced and was invited to share my interest in self-esteem, the study structure and my commitment as a nurse researcher to protect their confidentiality in both these groups and in the subsequent study. I took field notes pertaining to the structure, content and process of the groups, the role of the nurse, the role of the participants and some general observations regarding to what

participants were hoping to accomplish. At the close of the groups I provided letters of information and informed consents to those women who were curious about the study. Seven women telephoned me and six white, middle-class, heterosexual, able-bodied, English speaking women consented to participate in two to three confidential interviews. Each of the women met with me at least two times and they were provided with their transcripts along with an invitation to add, delete or change any portion they so desired.

The six women were then individually approached to join the third phase of the study: a potluck meeting with the other participants. All six agreed. The method known as constant comparison (Glaser and Strauss, 1967) enabled me to analyze their interview transcripts and use the themes served as the basis of discussion for our put luck. This potluck meeting was audio taped, as were the four subsequent meetings. The women asked to keep meeting and what was planned as a one-time get together emerged into several which were hosted at various participants' homes, co-led by four of the participants and emerged into consciousness raising sessions. All but one of the participants participated through all of the five CR sessions. As our final CR session edged towards closure, I received a telephone call from Melanie. She and Frida had been speaking and "missed their woman's group." After some discussion, we planned a weekend retreat at a serene and wooded setting where the women hiked, cooked, painted and talked. Somewhere between the laughter and the tears, we developed a model for future nurse-involved self-esteem groups that was clearly rooted in a model of CR akin to what feminist author and poet Marge Piercy (1970) had written to me about when I was a part-time graduate student and a full-time public health nurse. The model shifted the lens: it focused on helping women understand women's lives politically.

Through this process, what became clear was that individualistic notions of mental health, and the strategies rooted in such conceptualizations, place the onus of responsibility for quality of life solely on individual women. This victim blaming strategy is maleficent. The root of low self-esteem does not rest within individual women themselves, but within patriarchy and the systemic oppression and devaluation of women. Narrow gender role expectations for women (which are then devalued), the denial of anger, constant oppression and the overall denial of lived authenticity are the true roots of self-esteem erosion for many women. In addition, the distressingly predictable erosion of self-esteem in many women's lives was not transformed by didactic lessons teaching women to change the way they think, but rather by connections with other women through consciousness-raising sessions eventually co-led by the women themselves.

REVIEW OF THE LITERATURE

Mental health, Individualism & Self-esteem

> *My self-esteem depends on how I deal with things people say. Some days I take it completely personally. I carry around a lot of stuff I don't need*. (Pauline)

Self-esteem has its roots in Carl Roger's and Abraham Maslow's humanistic psychology popularly referred to as the human potential movement (Price, 1982). According to humanists, the key to understanding the nature of the mind is the individual's own perception and the interpretation of external events (Price, 1982). There, in my view, exists the seed that grew erroneously into widespread blaming of individuals for apparently misperceiving external events or worse yet, not adapting properly. Similar to psychotherapy's view that "it's all in your head", one of the most pervasive tenets of the human-potential movement is that we all create our own reality. Maslow's (1954) Hierarchy of Needs remains essential un-questioned reading for nearly every human service provider. His view that needs are hierarchical and that basic lower level needs including food, shelter, safety, and belonging must be met before the higher needs including self-esteem and self actualization can be met. Self-esteem and self- actualization are theorized as the need to fulfill one's individual potential, and are only attained by "growth motivated people" who are autonomous and who interpret external events appropriately, and adapt to societal expectations accordingly. Autonomy and independence are revered within Maslow's (1954) model of healthy human potential.

Another root of the self-esteem movement is the philosophy of Individualism, where autonomy and independence are revered. According to feminist philosopher Jean Grimshaw (1986) individualist-based mental health should be critiqued for "professing a doctrine of self-interest and personal autonomy at the expense of recognizing the social origins of the self, the necessary interdependence of human beings, and the profound social change that is necessary before any substantial form of human liberation can come about" (p. 149). Besides these three short comings, the suggestion that a process of personal change or individual effort will lead to individual liberation and fulfillment is simplistic at best, and socially irresponsible at worst.

Feminist psychologist Phyllis Chesler (1972) argues that mainstream mental health scholarship's hegemonic belief that appropriate adjustment equates to mental health is dangerous and

erroneous. According to this belief, if a person can adjust and function as she/he is expected by society, then s/he is deemed to be mentally healthy. The message for women is that we must transform ourselves into what culture expects of us. Within a patriarchal social system, this transformation or adjustment is an easier task with many more rewards for (some) men than it is for all women. For white, able bodied, heterosexual, middle to upper class men, living according to societal expectations and roles brings power and authority. For women, living according to patriarchal gender role expectations equates to a continued deferral of one's power, agency, and selfhood while at the same time societal devaluation (Figure 1). Women must either be a woman on patriarchy's terms or be labeled mentally ill.

This focus on personal transformation can also be found in mental health nursing literature. In an attempt to understand why public health nursing would invest in self- esteem (SE) groups, seemingly without analysis, a review of SE in the nursing literature was warranted. Primarily found in psychiatric nursing journals and textbooks, SE is largely constructed as a means to an end; an ingredient required for positive health and health behaviors. Gillis and Perry (1991) explored how SE was linked to locus of control and how in combination these give way to physical activity and health. Duffy (1993) similarly explored how SE determined healthy choices in behavior. Faulkner (1997) posits that SE and self-efficacy are linked, and again presents SE as a key determinant of health. These are a few examples of the pervasive argument in the nursing literature that SE and health are linked. The link is simplistic and in my view dangerous and damaging. Rather than focusing on the antecedents to SE as Bell-Meisenhelder (1985) did, these authors and many others focus problematically on the thought patterns of individuals rather than the social and relational forces that shape thought and self-appraisal.

The trouble I found with the un-questioned and un-supported link in nursing that better self-esteem is in the hands of the holder, was that it limited the scope of nursing practice and in my view gave way to maleficent practice. As well, simplistically linear relationships such as if a woman has more self-esteem she'd exercise more (Gillis & Perry, 1991), fail to recognize the myriad of forces at play regarding SE, physical activity, and body image in the lives of women. Klose and Tinius (1992) designed SE groups for (versus with) patients and instructed participants to focus on the present because "the past is best kept there" (p. 8). Barstow (1995) suggests nurses should ask patients who "self-mutilate" to list the positive qualities others see in them, rather than identify ways in which their rights had been infringed upon and enabling the participants to understand the relationship between denied rights and cutting (van

Daalen, 2004). Nowhere in these models was an opportunity for participants to come to voice or come to consciousness regarding their journey. The focus was on changing their thought patterns, period!
What was also clear in the literature was the belief that SE is a characteristic of human beings best addressed on an individual basis. Unfortunately this is not an un-common focus in nursing as most nursing practice is relegated to the treatment of individual "pathology" rather than social pathology. What is troubling is that a twenty year span of nursing literature pertaining to SE not only focused solely on fixing individuals, it neglected to explore the socio political aspects of mental health and failed to incorporate the lived experience of individuals, i.e., their lives-as-lived. In failing to ask people about their SE, its antecedents and how to support its nurturance, the practice and scholarship of mental health nurses complicitly miss the mark.

As a construct, self-esteem is pervasive in mental health nursing, and according to Kling, Shibley-Hyde, Showers and Buswell (1999) it has also received relative "super- status" as a construct within psychology (p. 472). In their meta-analysis of gender differences in SE, these authors reviewed nearly 400 studies devoted explicitly to SE or that identified SE as a core concept of analysis. These studies plus the many in nursing combine to reinforce SE's super status. Recently, Baumeister et al., (2003) published a critique of this un-earned status and published this in North American psychology's pinnacle journal of the American Psychological Association. Here, as with Raphael (1993), the authors call into question the assumptive equation that high SE equals health, happiness and interpersonal success. While the authors found that high SE is important to people and has a strong relationship to happiness, the authors conversely found that SE is not linked to doing better at school, better interpersonal relationships or abstaining from smoking, alcohol or early sexual activity. In fact, the authors argue that it is actually good relationships, affirming school experiences and an ability to make mistakes without ridicule that bolsters SE. In other words, Baumeister and colleagues exposed not only a flaw in the heterogeneity in conceptions that high SE is always better than low SE (see also Baumeister, Smart & Boden, 1996), but exposed that it is not high SE that causes healthy behaviors but rather having one's needs met and one's goals supported.

In the early 1990's public health nursing in Ontario began to explore the United State's Task force on Self-Esteem and Canada's Canadian Council for Self-Esteem situated in Vernon, British Columbia. California's task force indicated that social problems such as drug and alcohol 'ab'use, chronic welfare, and poor educational performance could

be traced to people's lack of self-love or esteem (Vasconcellos, 1994). Nursing's diagnostic system called nursing diagnosis reflected this in its category named Self-esteem disturbance. Within this category, nurses are instructed to teach people to change the way they think (NANDA, 1996). It's not difficult to see strong remnants of individualism as well as an implied self-ownership in this conceptualization of self-esteem.

As a public health nurse, I recall becoming troubled by public health's newfound answer to enabling health. The belief that in simply teaching individuals to like themselves more, not care what others think, and turn off their inner-critic would in itself enable health was in my view unethical and wholly inadequate. In telling people to change how they think sends a very clear message: if you have low SE it is your fault. This is victim blaming. Raphael (1993) agrees and states that "evaluative judgments that one makes about oneself do not appear to have clear explanatory value in predicting behavior and this may be due in part to the tendency to place responsibility for behavior within the self rather than upon the specific environments " (p. 21). During his tenure as a researcher with the Center for Health Promotion at the University of Toronto, Raphael urged public health departments to question whether self-esteem was a determinant of health. Instead of self-esteem being the focus, he invited public health practitioners to focus on the conditions related to low SE. I met with him when planning this study.

Raphael and I were unique in our thinking. Self-esteem groups were being planned across Canada, including within my own public health department, and the community response was overwhelming. What I knew was that I could not participate in a well-intentioned strategy that placed the onus of responsibility on the shoulders of women, and it was this concern that gave rise to this study. I do recognize that one could argue that this study is complicit in maintaining SE's un-questioned super that I called into question earlier. In Shifting the Lens, I did not set out to call into question SE as a construct. Instead, I chose to start with a critical analysis of the placement of SE's lens, i.e., on individuals themselves. It is my hope that the reader will not only question notions of SE that negate socio-political influences, but also call into question the Western superiority of the self-as-separate: separate from others, separate from nature and separate from an authentic self. This false separation not only erodes women's mental health and rewards autonomy over connectedness, but also adversely affects the health of nations, both animate and inanimate, which are vulnerably connected through time, soil and air.

Frida, Sue, Jessica, Melanie, Sarah & Pauline: Understanding their journeys to self- defined low self-esteem

On an inner scale, the one I don't let the world see, I'd say I'm a five out of ten in my self-esteem. It's difficult to keep up the performance because of having to live up to the standards like the typical good home life, having the kids, doing the groceries, laundry, etc. Through it all, though, you never realize you're a good person. (Sue)

In order to understand how best to support women's SE, nurses and other mental health professionals must understand the lived context within which SE develops. Through the careful analysis of several interviews with this study's participants, several common experiences emerged as pertinent in their journeys to self-defined low SE. These experiences included abuse, required emotional repression, devaluation, un-met needs (particularly within relationships), body image pressures, denied respect, barriers to female friendship, the expectation to adapt to restrictive gender roles, the denial of voice, a denial of authentic living and authentic self-knowing and a resultant guilt-ridden focus on personal transformation. These themes, or common threads as depicted in Figure 1 were woven together not in a beautiful tapestry. These threads, all interconnected, came together like a knot:

Now that I realize all of these things, I have to figure out how to undo them. My life, at 40, feels like a knot and I'm not the one who tied it. (Melanie)

Abuse

Several of the participants described experiences of several forms of abuse:

I remember being beaten as a kid. I remember being six and being beaten on the head because my hair was straight that day and I was apparently an embarrassment. (Sue)

He was sexually abusive to me. Forced sex was not a problem for him at all. He didn't believe in any tenderness. (Sue)

Growing up as long as I can remember I was chunky. My mom would feed me all this stuff and then tell me I was fat. It hurt the most when I would hear it from my dad. (Sarah)

A lot of times my mother would say "I wish you weren't born." I think that it was because of what she was experiencing in her marriage. (Frida)

The women knew these experiences were forms of abuse and yet in describing them to me, they doubted their significance to the study. Many told me that this was the first time they had been able to speak of these experiences without being silenced or having their perceptions dismissed or minimized.

Never Being Good Enough

The women described many instances of devaluation and of being told that either their efforts or they, themselves were not good enough. Frequently these messages were from parents, children and male partners. The participants who had children were made to feel that their efforts as mothers were equally inefficient especially in the eyes of their husbands. In dialogue, they were able to see that other people in their lives had brought on this feeling, but struggled with discounting the messages because of their frequency and intensity.

Emotional Repression

Throughout her entire life, every participant had a continuous message that what she was feeling was wrong, stupid or a sign of mental instability. In addition to this, the women shared many other feelings during their lives: all of which they had barely spoken of until coming into dialogue with one another and me. Table I outlines these common life journey emotions.

Table I: Common Life Journey Emotions

I FELT...				
-afraid	-angry	-powerless	-confused	-loving
-sad	-hopeless	-guilty	-bored	-disconnected
-bad	-frustrated	-depressed	-abnormal	-lonely
-numb	-incomplete	-constrained	-blamed	-crazy
-odd	-stupid	-unhappy	-suicidal	-alone

I did a lot of swallowing of emotions. I guess because you want to do the right thing because you're a wife and you're a mother and you're a caregiver. So I swallowed and said "Fine. I'll put up with it for now, but later no." (Melanie)

I had a sexual attack at the age of five, which was company my parents had invited over. When I tried to talk about it later, she slapped me across the face and called me a dirty girl. I wasn't allowed to talk about it. I wasn't allowed to hurt, and until recently, I never knew just how hurt I was. (Sue)

I had hip surgery when I was young so I couldn't do much. I was told I was faking it, that I was a monkey [referring to the way she had to walk on her hands]. They weren't joking either. They meant it. My dad told me I was faking it, and that I was looking for attention. He'd later remind me about how much of an athlete my brother was and that I couldn't do anything. There were so many times when I had to come down the stairs on my bum and I was afraid to let anyone see. (Sarah)

Anger? Not! Don't feel it. You're wrong. It gets squished. That's the complaining I told you I get accused of. He'll say don't complain. For me, when I realized that things in my life weren't lining up, I got angry. What I try to say gets covered up. No one wants to listen. (Melanie)

The women spoke of the necessity and expectation to repress their emotions. No one wanted to hear them, and if they allowed themselves to feel them, their role as caretaker would be adversely affected. The women were in fact denied their emotions. They were told that they were complaining, bitching, that they were making a big deal out of nothing and that they were crazy. Many of them sought out the self-esteem groups in order to learn how to handle their emotions better, so they would be "able to cope" better.

Un-Met Needs Within Relationships

The participants in the study described their many relationships including those with their mothers, their male partners, their female friends, co-workers, bosses and children. Within each of these relationships, the women described countless instances where their needs were seen as secondary at best, and that they longed for reciprocity, respect and affirmation. Their ideal life situation would include being in a mutually fulfilling relationship with friends and a partner who respected, heard, trusted, liked, believed in, communicated and supported them. Instead they found themselves responsible for everyone else's self-esteem including parents, partners and children.

I should've had a partner that would've backed me up and valued my nurturing. I'll be damned if I'll spend my next forty years with that man. I'd rather be alone and satisfied, than together and abused. (Sue)

We haven't been getting along for years. I'd say I was verbally abused at home (thinking while speaking). He's verbally abusive, very controlling. He's not a talker, and I'm the kind of person who likes to talk about things. We have never communicated and this is really big for me. Maybe we're not right for each other. (Jessica)

I'm lucky I have a good relationship with my boyfriend. It's one where he accepts me. (Pauline)

I felt I needed to save my mother. I needed to protect her from my father and from herself. She always threatened she would kill herself and leave us alone (crying). She was always alone at night and my father wouldn't come home…. that's when she'd want me to be with her…. And I'd sit on top of her lap. She wasn't able to be there for me. (Frida)

If there was a miracle? I'd have friends. (Sarah)

Self-Blame and Women's Focus on Individual Transformation

It was very distressing to hear the women blame themselves for their eroded self- esteem. Much of this ownership translated into their focus on individual transformation.

I seem to attract people like this. My boyfriends were like this. They'd say I was fat when I tried to break up and tell me that I'd never get anyone else. I don't know whether I'm looking to see that in people. I guess I bring it on myself. (Sarah)

I tend to be one of those people who have trouble dealing with criticism. (Pauline)

For many of the participants, their ultimate decision to change themselves culminated in their signing up for the public health department's self-esteem groups. They wanted to change how they viewed their life circumstances, so they could feel better emotionally. They believed that it was their fault and the self-esteem groups reinforced that belief in attempting to teach "better" ways to think about themselves and to cope differently.

I feel that I have a lot of things to work on, like I have to believe in myself more. I need to work on being less timid. (Frida)

> *I have to learn to be more assertive. I tend to be shit on a lot of times. I'm too soft an individual. People tend to walk all over me and I don't Know how to say no and then deal with it. I have a lot of growing to do.* (Jessica)

> *I get into these total downslides.* (Melanie)

> *I need to be more confident and know that I'm not dumb.* (Jessica)

> *I'd like to be more resilient.* (Pauline)

They believed that they brought negative events on themselves, and that they were at fault if their lives didn't change for the better. They believed their thinking was flawed, and they constantly apologized for their emotions during the interviews. At first, they didn't look at causes. They looked at themselves.

The Knot: Patriarchy's Common Threads

> *Everything changed when I got my period. All of a sudden my life became very controlled. I was told when I could speak, when I could cry, and if I could be angry.* (Frida)

Fueled by my ethical responsibility of benevolence, I sought to understand the root of SE erosion for six women who joined SE groups. What soon became clear was that a pervasive experience of patriarchal oppression was the common denominator framing the women's SE journeys. It was this oppression that denied the women of authentic self-definition and positive mental health. The women, such as Frida, spoke at length about oppressive gender role expectations including an expectation to defer to men, be selfless, quiet, thin, happy, there for others and above all else, nurture and maintain relationships.

> *I was the oldest of five children. My mother really depended on me for emotional support, and for physical support in the sense that I needed to do things around the house to help with the raising of my siblings. A lot of responsibility was placed on me. A lot of adult responsibilities were placed on me as a child. I was a child living as an adult. Now I'm responsible for him and to him and it's still not good enough. What about me? Where are my needs in all of this?* (Frida)

The women described countless instances of clear oppression including denied rights, denied voice and denied intrinsic value.

> *I wasn't allowed to deal with my abuse. I remember at the age of ten trying to talk to her about it, and she struck me in the face and called me a dirty girl. How dare I ask about that person, or talk about myself.* (Sue)

> *... my mom doesn't even listen to me. We were just there last weekend and she asked me a question, and I went to answer and she had turned to talk to someone else. And I was like, hello? It was always like that, feeling invisible. I still do.* (Sarah)

> *Growing up, I didn't see any difference between my male cousins and me. I laughed when I wanted. I could get angry. Everything changed when I got my period. All of a sudden my life became very controlled. Domestic responsibilities were all of a sudden mine. I was told when I could speak, when I could cry, and if I could be angry. This was when my self-esteem first began to drop. I experienced my first bout of depression then. I was no longer in control of my life anymore. Everything changed after I became a woman.* (Frida)

The interconnected threads of patriarchy's knot are depicted in Figure 1. For these six women, the link between patriarchal gender roles for women and the subsequent devaluation of them contributed to the lived experience of unsupported SE. They spoke of being disrespected, most often by those whose opinions mattered most: partners, parents and peers. They were concurrently denied emotion and longed for respect.

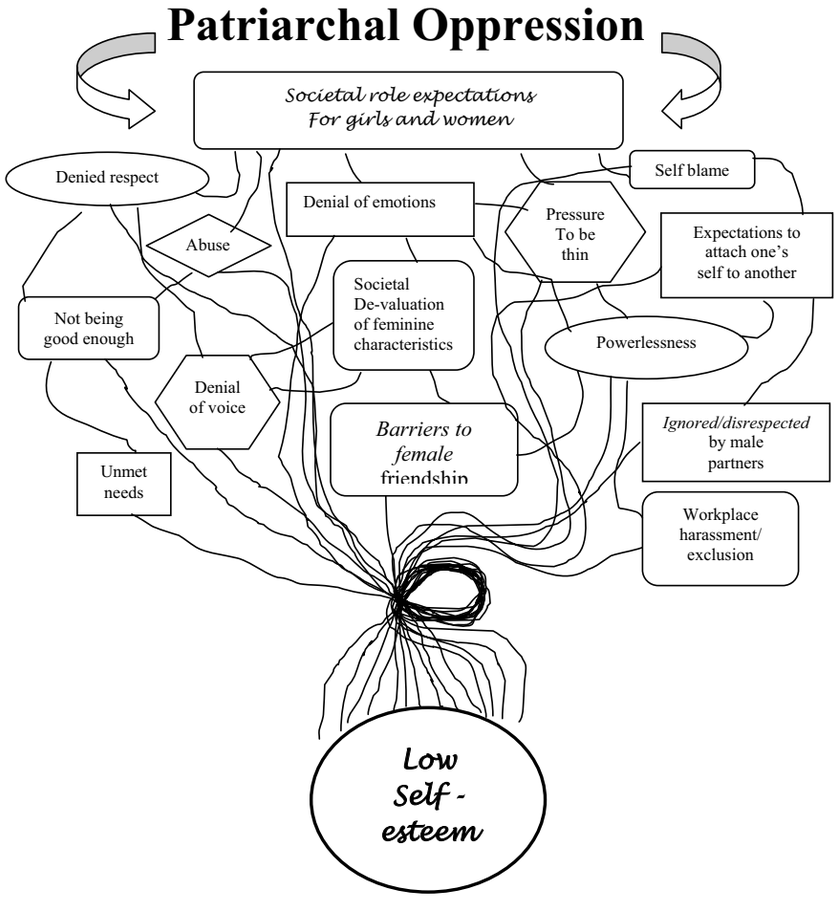

Figure 1. Patriarchal Oppression

When I would speak of my needs with my mom, they would be discredited. When I would speak of my needs with my husband, the same thing occurred, sometimes violently… sexually. I offered him divorce or prison. He said he'd be good. I think at that time I'd had my first baby. (Sue)

I wish I could find somebody who talks to me, and treats me like a queen. (Jessica)

I've tried to understand these different roles [wife, mother, daughter, student, sister] and identify them, understand them, and then to see the conflicts that arise between these different roles. Like between being a mother and being a student and how the guilt works in there. You know, do I fulfill my needs for personal development and my pursuit of knowledge or do I devote all my energies and time to the raising of a child? What percentage of my life do I put on hold to give to a child? This guilt needs to be addressed. (Frida)

A feeling of a fragmented self created feelings of being incomplete for some of the women. They looked back on their lives and lamented over what could have been. Being responsible for every one else's self-esteem, being caregivers, and having their voices ignored, left some of the women wondering not only who they were, but also who they might have been. The common threads of patriarchal oppression denied these women of their right to be themselves and culminated in a ragged knot. Patriarchy prescribes restrictive gender roles and these roles often devalue women. If this lose-lose situation remains hidden from women's conscious awareness, it can (and did) culminate in a spiral of vehement self-blame and corroded SE. The ragged threads, hidden from their view, grew together like scar tissue: discolored, lifeless and seemingly un- acquiescent. It is the knot that demands transformation, not the women.

I do not wish them [women] to have power over men but over themselves. (Mary Wollstonecraft, 1792)

The experience of being oppressed, repressed, and ultimately depressed was most apparent when we spoke of a miracle. I asked them, "How would your life be or feel if I could snap my fingers and a miracle happened… and all of the issues we've spoken of during our time together had been addressed? How would your life be different?"

If a miracle happened and all the issues in my life were addressed and I didn't have low self-esteem? (long pause ……thinking) I would feel complete. I'd feel free. (Sarah)

I would have more control in my life… more freedom. (Melanie)

My dreams would be part of my reality. (Frida)

I think I could have been one hell of a person. I think they robbed me of my potential to have been that one hell of a person, instead of being used. (Sue)

DISCUSSION: OPPRESSION, DENIED ANGER AND DENIED AUTHENTICITY

The threads included in Figure 1 framed our five CR sessions. There, in a climate of affirmation and connectedness, the role of oppression, denied anger and denied authenticity became almost like a seventh participant. We came to realize that their life journeys were fraught with three hauntingly similar messages: You can't do, you can't feel, and you can't (really) be. They cried as they spoke of their unheard anger and of their spiral into self-loathing and debilitating self-blame. They never felt good enough or that they truly belonged. Gerrard and Javed (1995) believe that through oppression, women are socially othered, trivialized, and dismissed. They argue that it is this process of societal marginalization, or being othered that contributes to their loss of self-esteem and loss of an authentic self. Wyckoff (1977) believes that oppression and alienation are interrelated. "A person feels alienated because she is oppressed and then lied to about being oppressed" (Wyckoff, 1977, p. 15). The women in this study shared feelings of alienation as well as many repeated experiences of dismissal, being controlled, abused, harassed, discounted and/or discredited by significant others and then having no one who wanted to hear about these experiences. Alone, alienated and confused, many of the participants sought help from their physicians and their local public health departments.

Oppression

The most pervasive contributing factor to the erosion of the self-esteem of this study's participants was that of oppression. At several stages in their lives, key individuals such as male partners, siblings, parents, female friends, employers or children exerted power and control over them. This overpowering, the participants told me, broke their spirit and eroded their self-esteem. Oppression occurs when one individual or group asserts power over another individual or group thus marginalizing the person(s) to a social state of otherness. The oppression experienced by the women in this study included being ignored, dismissed, silenced, rejected, controlled, constantly compared to others, devalued, disbelieved, victimized and scrutinized. Societal sizeism damaged their love of their natural body size, and for some, how they looked became a large part of their self-esteem. Compulsory heterosexual coupleism

contributed to some of the participants marrying earlier than they wanted, while for others it created a barrier to leaving an unhappy relationship particularly if they had children. Lastly, sexist role expectations together with an expectation to define themselves in relation to others, brought discontent, lowered self-esteem, and denied self-actualization. When the women attempted to voice any dissatisfaction with their abuse, harassment, neglect, devaluation or unhappiness, their feelings were minimized, trivialized, pathologized and dismissed.

Denied Anger

Women's assigned roles, including compulsory selfless care taking and the development of others, are required yet socially devalued in North American culture. This double bind has been argued to be a major contributor to women's mental health problems and their subordinate position in patriarchal societies (Miller, 1983; Levine, 1989, van Daalen, 1998). "Women's assigned subordinate position generates anger and it is usually made to appear [in a patriarchal society] that subordinates [women] have no cause for anger. Further, if they feel anything like it, [they are convinced] there is something wrong with them" (Miller, 1983, pp. 1-2). Jean Baker Miller (1983) documented a cyclical relationship between subordination, a required repression of anger and eventual erosion in SE for some North American women. This cycle was apparent in the life journeys of the participants. Miller goes on to explain that the norms of femininity do not include the expression of anger and that if women do verbalize frustration, it threatens their relationship with parents, partners and peers. No one wanted to hear Melanie's anger. Frida was told she was overreacting and Sue was slapped. The message is powerfully debilitating: You do not have the right to verbalize being mistreated, hurt or ignored. You are not important.

Eventually the participants verbalized their anger to myself and to one another. Collectively we viewed this as emancipatory because what it demonstrated was that they were shifting the blame from themselves to the misogynist view of women. It was freeing to finally verbalize their feelings. In Figure 2, Miller (1983) illustrates the cycle of repeated subordination, anger and diminished self-esteem. Miller argues that repeated instances of subordination and an expectation to repress the resultant anger leads to feelings of frustration, and an inability to act on one's own behalf. This inaction creates feelings of weakness in the subordinate, and erodes the self-esteem. The cycle continues and over time and subordination and denied anger lead to the internalization of an outsider's view of the self: one that suggests the subordinate has very little social worth.

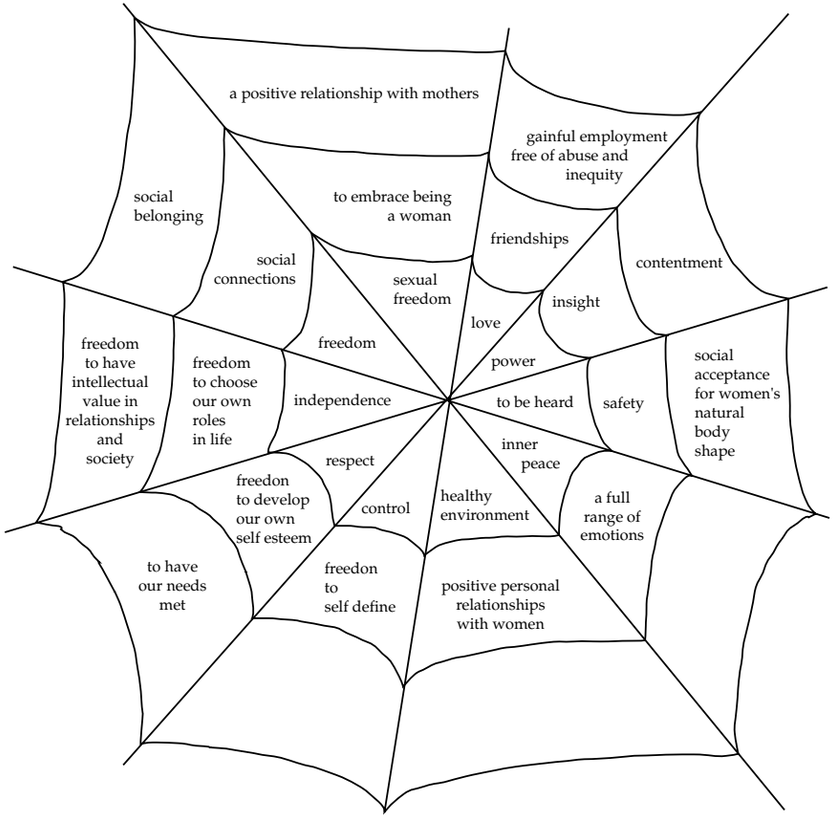

Figure 2. A Woman's Web of Needs

Looking for Melanie: Denied Authenticity

Societal roles for girls and women are oppressive and prescriptive. As well as sending a powerful message of devaluation and contempt for women, patriarchy also limits many women from authentic self-definition. Melanie recounted turning 40 and wondering who she was.

> *I turned 40 in October and that to me was a milestone. I kind of looked at my life and it was like an eye chart. I realized that it wasn't lining up with what I expected when I turned 30. I'm a housewife and I never wanted to be a housewife. I'm trying to find myself and know myself under the layers. I finally got it straight the other night. There's three parts of me or more, and this is Melanie. It's when you're in the middle of a storm; you don't see all of this until afterwards. So for the ten years I was a mother, it was total confusion trying to sort myself out.* (Melanie)

All of the participants spoke of feeling confined and judged: judged about their size, their marital status, their skills as a mother, on their ability to meet everyone else's needs around them. Sexism, sizeism, misogynist messages, un-met needs and a requirement to be everyone else's SE, the women spoke of confusion about who they were versus rather who they were expected to be. Feminist social worker Helen Levine (1989) agrees and asserts that in learning to be female, women are forced to give up their true selves. The women described the shared experience of being defined by others as well as in-relation-to others. Melanie described this phenomenon of a fragmented self whereby the layers she listed were expected yet judged as never good enough. Bepko and Krestan (1990) document how many women spend much of their lives trying to be good and end up feeling hopelessly inadequate. They speak of a societal *Code of Goodness* for women that focuses on what women are supposed to do for others rather than focusing on who they are. They document how many of the women in their marriage and family therapy practices ultimately ask themselves "If I'm so good, why do I feel so bad?", and Bepko and Krestan documents that the side effect is debilitating shame (p. 43). The path to denied authenticity is fraught with confusion and the only way the path is maintained is by preventing women to be in dialogue with one another and collectively come to understand their lives politically. In coming together, these six women came to recognize their interconnectedness; something they had never truly understood. Isolation and alienation maintains self-blame (Wykoff, 1977).

Understanding the Webbed Nature of Women's Needs

Maslow (1954) posited that needs are separate, hierarchical and if met, culminate in autonomous self-actualization. The narratives and dialogues between the six women in this study suggest a different model of needs. These women had many needs that had been denied and ignored, and the needs were connected, equal in importance and interdependent. To self-actualize and feel good about their authentic self-hood, these women wanted to be in-relationship with others in a

mutually nurturing way. They longed for reciprocity and wondered what was wrong with them when they were repeatedly denied of this. Figure 2 depicts a web: a web of interconnected needs that allow voice and choice without losing precious relationships. According to the participants, meeting women's needs for affirmation, respect, voice and authenticity will foster SE and promote positive mental health.

So, What's the Problem? Promoting Personal Ownership for Socially Rooted Problems

The notion that self-esteem has implications for one's personal health is valid. However, the focus on individual strategies for self-esteem growth sends a message to women that they are deficient and in need of repair. This allows society as a whole, and the helping professions more specifically, to focus on the women themselves rather than women's environments or a culture rooted in patriarchy and misogyny. The implicit goal of the self-esteem groups I observed was that the participant's self-esteem would be improved. The process involved diligent efforts by nurses to teach participants ways in which to think of themselves more positively, and to learn strategies to cope with life's disappointments. What was missing, however, was a critique of the challenges themselves. An examination of the barriers to self-esteem would have assisted participants to begin to disown their guilt and understand the myriad of negative messages facing women daily. There wasn't something "naturally" wrong with the women to cause their depression, powerlessness and low self-esteem. Their experiences of depression, powerlessness, denied voice, neglect, harassment, abuse, and oppression originated from a society that values men over women, and from a society that values individual power and social status above all else.

Low self-esteem is not an individual defect or problem alone. Low self-esteem is the result of the internalization of negative peer, familial, and/or social messages resulting in disempowerment, self blame, self-hatred, and alienation. According to Spender (1985) "women interpret their failure to meet male standards as their own personal inadequacy, rather than questioning the inadequacy of the standards themselves" (p 92). In the self-esteem groups that I observed, no critique of the standard Spender speaks of existed.

Shifting the Lens: Rooting Self-Esteem in the Political

> *The helping professions have historically located the key source of most personal pain and trouble within the individual… and accordingly, the emphasis in practice, regardless of intention is focused upon individual pathology… deficits of personality… and ultimately upon adjustment at the personal level.* (Levine, 1980, p. 247-8)

Women suffer from feelings of inferiority because they are systematically subordinated. Despite the lessons in positive self-talk and assertiveness provided in self- esteem classes, women will not become liberated by acting liberated. The deficiency model of SE that guides some SE self help groups or books, maleficently focuses on individual transformation over structural awareness and change. The approach is one of treating symptoms rather than searching for and naming causes. It is reactive instead of proactive and sends a powerful message of inadequacy to women. Over time and through affirmational dialogue, the participants realized that the first step in understanding SE was to understand how patriarchy works to devalue women. For the six women and myself, this occurred in what came to be called our "woman's group".

Click

During our fifth and final CR session, I asked the women to talk about their experiences in "their women's group", and comment on what changed for them. Prior to that, there were powerful indicators that the evolution of that first potluck dinner into CR sessions was beneficial. Five of the women experienced what Shreve (1989) describes as " the click" during their experience with consciousness raising. "This click is the light bulb or the eye popping realization of what sexism exactly meant, how it had colored one's life and the way all women were in this together" (Shreve, 1989, p. 53). For the five women who verbalized the click, it simply required a safe place; a place of women where each of us could find our voice. The women now had "collective SE" as evidenced by Pauline stating, "I got connected here", as she packed her car at the end of our retreat (Corning, 2000). It was in coming together and not striving for independent autonomy that facilitated collective SE and connected notions of self. The value in sharing dialogue in a co-constructed climate of affirmation enabled the women to come to finally know other women, and eventually share pride in being female. While Sue was unable to continue after the second CR group, Pauline, Jessica, Melanie, Sarah and Frida were able to sum up their experience and their realizations as follows:

> *I've learned that it's not bad to choose yourself first. I'm giving myself permission now. It's new for me because I'm supposed*

to be everyone else's shoulder and arm. And, you know, the self-esteem group gives you pat answers but this gives you perspective. In a way it gives you connections, and a way of coping. For me it also gave me an impetus for going home and saying "This is what I need from you. That you value what I think and what I need." I got connected here, and it's helped me to be assertive in my key relationships. (Pauline)

I've related to each and every one of you at certain times over the course of our group. Also, out of this group I got feeling comfortable and talking openly about our feelings. We're feeling better because we are voicing our opinion! We are being heard. We're sharing, letting out our feelings because we can't talk at home, at least not to this extent. That's the special bond we have with women, because we understand each other. I've learned to accept myself and like myself here. I've begun to see that it's not me. (Jessica)

I realized that I can come here and be heard. And I realized that if others don't want to hear me that's their problem. A lot of things looking back, now I can go back and forgive myself for things. We got to our feelings here, and then I thought no, it's more than that. It's the whole thing: it's the journey. The going inside and bringing out. And that's what we've done. (Melanie)

This has given me a lot of insight. I feel like I have back up with you guys. I think to myself "what would you guys do, you've been through this". It sure helped me. Out of the self-esteem class I got a book. When I was asked to join this study, I thought how can I ever be heard in a group of women? But, this has been nice. This has been great because I feel like I have been heard, and I realize that it's not me. (Sarah)

For me I realized I'm not a bad person. I'm more in touch now. I'm more aware of my woman-ness. I never really thought about it before, how it is different to be a woman and how we struggle. So, for me it's understanding that I'm not alone. I've become more comfortable being a woman. For the first time (laughing) I can say this. "I'm happy to be a woman!" (Frida)

CONCLUSION: THE PERSONAL IS POLITICAL

There are limitations in this study including its failure to bear witness to the barriers facing mental health professionals practicing holistically and politically. In addition, it is essential that a study of women's SE questions how race, class, ability, sexual orientation, or age for example, intersect and impact diverse women's lived experiences of authentic self-definition and SE. Lastly, an exploration of women's mental health in countries, regions, cultures and religions where a separate self is not supported and where the notion of SE is not revered would question the super-status of SE in academe and mental health practice. Understanding how proverbs such as Africa's " I am because we are" give way to community, collective purpose, interconnected health and emotional well-being is essential in interrogating individual notions of a separate self and self-esteem itself as a construct.

Public health departments, mental health professionals and individuals seeking personal growth must shift the lens currently fixed on SE from focusing on the personal to focusing on the political. We must call low SE what it is: an inevitable outcome of an oppressive social structure that prevents women (and other marginalized groups) from reaching their full human potential. We must root low self-esteem in the political context from which it comes and adjust our individual interventions accordingly. Low SE is not an individual problem due to deficiencies of character and it cannot be fixed in eight sessions led by a well-intentioned helping professional. Low SE is about oppression and because of oppression and any interventions must shift the lens to focus on this oppression. We must resituate SE from the personal to the political. Only then, can women and other oppressed groups shed the shroud of guilt and perceived weakness that impedes on their mental health and positive quality of life.

Until we are all free… no one is free. (Lorde, 1984)

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