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Relationship Satisfaction: Impact and Consequences for Women's Emotional Health and Treatment

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RELATIONSHIP SATISFACTION: IMPACT AND CONSEQUENCES FOR WOMEN'S EMOTIONAL HEALTH AND TREATMENT

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ABSTRACT: This study uses feminist theory to examine the variables of relationship length and relationship satisfaction as predicators of both self-esteem and emotional functioning for women. Using a national sample of data gathered from 1,257 female survey respondents this study found significant relationships between emotional functioning, self-esteem, and self-reported relationship satisfaction which was supported by regression testing and path analysis. In addition, a significant negative relationship was noted between a woman's self-esteem and her with-holding of verbalized displeasure or disagreement with her partner. Implications for women in therapy were discussed.

KEY WORDS: relationship satisfaction; feminism; self-esteem; women in therapy.

Considerable research has been compiled to suggest that women suffer higher reported rates of non-violent mental illness than men (Bayes, 1988; Chesler, 1981; Cox, 1981; Radloff & Cox, 1981; Tavris & Wade, 1984; Williams, 1977) and that self-defeating personality disorder, anxiety, and depression in particular, are more clearly defined as female problems (Goldberg, 1994; Brownmiller, 1984; Chesler, 1981; Faludi, 1991; Heim & Snyder, 1991; Radloff & Cox, 1981; Tavris &

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Wade, 1984; Tavris, 1992). Some researchers have also reported that "this finding is not due to artifacts of reporting, to women's greater willingness to admit symptoms, nor to biases of mental health professionals" (Barnett & Baruch, 1981, p. 284).

Since no one has concluded that women are biologically or genetically at greater risk than men for either mental or emotional illness generally, or for depression particularly, and some have concluded that women are, in fact, more adaptive than men throughout their life span (Williams, 1977), explanations for differences must be found in environmental context: social roles, sex differences in socialization and practice, societal expectations, and in the way women's lives are different than men's lives (Brownmiller, 1984; Faludi, 1991; Hite, 1989; Tavris, 1992; Walters, 1990; Walters, Carter, Papp, & Silverstein, 1988).

Using feminist theory as the ideological backdrop, we attempt to look at the impact of relationship status on women's self-esteem and emotional functioning with the hypothesis that since stress may increase susceptibility to depression (Radloff & Cox, 1981) psychology should examine the social contexts within which women live (Weisstein, 1971). Relationship is one of those contexts.

Previous research has looked at the social context of women and women's emotional health and has provided us with a non-traditional view of the interaction. "Single, divorced, and widowed women have fewer mental health problems than men in the same categories" (Williams, 1977, p. 334), concluding that the marital relationship has a less advantageous effect for women than men (Benningfield, 1992; Bernard, 1982; Tavris & Wade, 1984).

WHAT THE LITERATURE SAYS

Most women hope that marriage will give them a sense of being valued and an appreciation of their personhood (Benningfield, 1992). Instead, what women often find, both in marriage and other female-male relationships, is abuse, blame, and fatigue. In 1991, Faludi found spousal rape to be legal in 30 states, battering listed as the leading cause of injury to American women in the 1980s, and almost half of all homeless women (the fastest growing segment of the homeless) to be refugees of domestic violence. Wallerstein and Blakeslee's (1989) 10-year longitudinal study of divorced families found that 50% of the divorces in their study were sought by women who were ver-

bally or physically abused, lonely, demeaned, drained, or belittled by the relationship and that younger women in particular were happier a decade after the divorce.

Heim and Snyder (1991) found the best predictors of wives' depression in marriage were overt conflict combined with attribution of marital problems to themselves, and the failure to attribute marital problems to their husbands. While Lewis (1989) found inconclusive evidence for a relationship between "individual psychological health and marital quality for women," he did find that anxiety and depression were "significantly correlated with marital competence for women and not for men . . ." (p. 66). Since Lewis' highly competent marriages include commitment, intimacy, and a feeling of closeness along with power sharing, it may be that if women can not make those processes happen they assume they are incompetent and responsible for the failure (Heim & Snyder, 1991). Women are supposed to be relationship responsible, responsible for knowing everyone's feelings, for "heading off problems at the pass," and for knowing what or who needs emotional "fixing" and how to fix it (Pierce, 1971; Boss & Weiner, 1988; Tavris, 1992). Gilligan's (1985) study of women and morality found that women wish not to hurt others even while solving conflicts. Woman's definition of morality includes helping others through service and meeting one's obligations and responsibilities even if anticipating "a conflict between remaining true to herself and adhering to her principle of not hurting others" (p. 192). Gilligan's perceptions include woman as vulnerable and susceptible to adverse judgments of others stemming from her uncertainty about her right to make judgments and/or the price she pays for making them. Hare-Mustin (1988) simply interprets women's concerns with relationships as the "need to please others when one lacks power" (p. 38).

Looking at gender difference in the psychological well-being of spouses, Jessie Bernard (1982) noted in the early 1970s that marriage was better for men than for women. Later, Beavers' (1982) study of healthy, normal families also found that life was not equally normal for all the members. "Adequate families" that raise competent children often had a mother "that expressed considerable self-doubt, relies on tranquilizers, and is somewhat depressed" (p. 53). Women in the adequate families were often overwhelmed with their responsibilities, sexually dissatisfied, and often psychosomatic while men in the same families functioned well and were sexually satisfied. Since most American families are in the adequate range it is logical to assume that most American wives sacrifice (Leupnitz, 1988); women

tend to delay or dismiss their need for self-actualization for the good of the family members (Scanzoni, Polonko, Teachman, & Thompson, 1989). Spiegel (1982) goes as far as stating that the word "family is a code word for mother" (p. 95).

"Home is the main workplace for many women; it is a refuge of relaxation for very few" (Bateson, 1990, p. 121). In American homes women shoulder 70% of household duties (Faludi, 1991, p. xiv). Whether women are the main providers employed outside the home or full-time homemakers makes little difference in the amount of their household responsibility (Perry-Jenkins, Seery, & Crouter, 1992). Subsequently,

> more wives than husbands report marital frustration and dissatisfaction; more report negative feelings; more wives than husbands report marital problems; more wives than husbands consider their marriages unhappy; have considered separation or divorce, have regretted their marriage; and fewer report positive companionship (Rubin, 1979, p. 66).

Women often cope with marital unhappiness in one of two ways: they initiate legal divorce (Vital Statistics of the US, 1987, U.S. Department of Health, pp. 2–32), or they divorce emotionally, that is they both stay and leave the relationship simultaneously. Women "create a double life for themselves, finding another primary relationship, whether it be with school, work, a lover, children, or friends-yet 'staying' in the marriage" (Hite, 1989, p. 439).

Research on "family" uses a paradigm idealizing the marital bond, while ignoring the "remarkably high degree of struggle, dissension, and disenchantment" in long-term first marriages; it neglects to explore the "lesser power" women experience in decision-making, the pragmatics of female economic inequality, and vulnerability, and how women are punished when they deviate from what is thought to be their ideal role (Scanzoni, et al, 1989, p. 17).

PURPOSE

This study uses feminist theory as its base and examines the variables of relationship status, length, expression of negative affect, and satisfaction as the predictors of both self-esteem and emotional

health for women. Feminist theory uses description, analysis, vision, and strategy to describe what exists, analyze why that exists, determine what should exist, and hypothesize "how to change what is to what should be" for women (Bunch, 1987, p. 245). A feminist therapy perspective must include consciously the developmental experience of the woman within a patriarchal culture, a critique of former sexist theory and therapy practices, integration of feminism into the general classical body of psychological knowledge, and the use of female experience in theory development (Walters, 1990). Like its theory, feminist therapy reflects both the viewpoints of the therapist as well as the particular needs of the client (Kaschak, 1981).

This study is unique in that it considers how relationship satisfaction influences the self-esteem and emotional functioning of a large sample of women. In traditional studies relationship satisfaction is often considered the dependent variable and emotional health variables are typically considered as the independent variables. In other words, researchers working through a non-feminist lens will often consider how the emotional functioning of the women impacts relationship satisfaction rather than the converse. This distinction is important because within the feminist perspective it is likely that over time the relationship quality or satisfaction may erode the emotional health and self-esteem of women who are given more responsibility for the maintenance of the relationship.

METHODOLOGY

This study design was based on the 1994 survey data compiled by the Preparation for Marriage, (PREP-M) questionnaire (Holman, Busby, & Larson, 1989). Composed of 204 Likert Scale and categorical questions, the PREP-M was primarily designed for individuals and couples currently "engaged or seriously considering marriage" to evaluate readiness for marriage through inter-couple comparison and group comparisons of "values, attitudes, and beliefs and perceptions of marital readiness."

Sample

The sample included 1,257 female respondents ranging in age from 17 to 63 with more than half the sample (66.1%) age 21 or

under. Almost one-third of the population (30.7%) was reared in small families consisting of two children in a large city of more than 100,000 (33.1%). Only 22.1% of the population was reared in single-parent, step-parent, foster parent, or adoptive homes or by other extended family. These women had mothers who were in their first marriages (74.9%) and were reported by their daughters to be very satisfied in their relationships (34%). The majority (88.1%) of the population was Caucasian, 6.5% was Hispanic, 2.5% was African-American, and 2.3% was Asian. Initially the Latter Day Saint religion was over-represented in this sample as many of the respondents came from the western area of the United States. Therefore, the data were weighted to equalize the stated religious affiliation component to 10% Latter Day Saints. The majority of the respondents were then represented by the Protestant religions (43.6%) which is similar to the overall population of the United States.

Relationship in this study was defined as a female-male heterosexual relationship. Almost half, 49.3%, were single and dating, 21.5% were single and not dating, 13% were engaged, 7.3% were married, 6.3% were cohabiting, 1.9% were divorced or widowed and dating, and .7% were divorced or widowed and not dating. More than one-third (35.4%) who were in a current relationship were experiencing a relationship of more than two years in length, 22.2% had been in relationship between one and two years, 16.1% had been in relationship 6–12 months, and the remaining 20.7% had been in a relationship less than six months.

Overwhelmingly this population believed in equal sharing between husbands and wives in financial decision-making (95.1%), in the sharing of child discipline (90.6%), in initiating sex (90.4%), in responsibility for teaching children (89.6%), and in child care responsibilities (70.5%). They saw less equity in activities such as earning a living (62.1%) and housekeeping (47.1%) where the female respondents felt it was a wife's responsibility more than a husband's (51.2%) to do housework and a husband's responsibility more than a wife's (34.2%) to earn a living.

Out of a list of eight value items, this population of women listed self-fulfillment (22.5%) as what they desired most out of life with warm relationships with others a very close second (20.5%). Thirteen percent wanted security, 12.7% desired a sense of accomplishment, and 12.6% listed self respect as their most important need. The values of fun (8.6%), belonging (6.8%), and being well respected (3.7%) were not seen as important.

Scales and Variables

Scales developed for this study include: EMOFUN, an emotional functioning variable measuring self-perceived sadness and/or depressive symptoms; SESTEEM, a self-esteem variable measuring positive and negative attitudes about one's self; RELSAT, a self-reported relationship satisfaction variable measuring stability and perceived satisfaction of couple relationships; and, lastly, FEELINGS, a variable measuring behavior in verbalizing or not verbalizing displeasure or disagreement with a relationship partner. Reliability for all scales was measured by Chronbach's Alpha; EMOFUN, (.785), SESTEEM, (.829), and RELSAT, (.857), FEELINGS, (.610).

Data Analysis

Two hypotheses were developed before the analyses, using the literature review: First, that unsatisfactory relationships would have a negative impact on women's emotional health and self-esteem; Two, that women's socialization to both connect and be responsible for relationships would affect both their life values and their expectations of marriage.

Multiple Regression Analyses (in the form of a path model) were conducted on the preceding variables to examine the relationship between women's self-esteem, relationship satisfaction, and emotional functioning. In addition, the impact of women's verbalizing feelings in relationships was considered.

RESULTS

Path analysis was done to track the effects of the independent variables on emotional functioning (see Figure 1 for the Initial Path Model). To explore the relationships between the variables as illustrated in Figure 1, several multiple regression analyses were conducted. In the interest of space only the final path model and decomposition table will be presented. The full correlation matrix and expanded regression results can be obtained by writing the first author.

The first regression was conducted to examine the direct effects of the length of the relationship, the expression of feelings, self esteem, and relationship satisfaction on the emotional functioning of women. Together, the independent variables accounted for 45% of

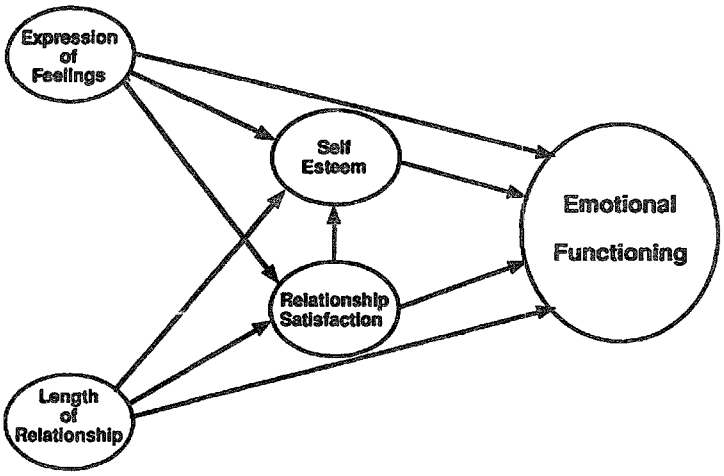

FIGURE 1

The Initial Path Model

the variance in emotional functioning for women in this study. The Length of the Relationship and the Expression of Feelings did not have a significant direct effect on emotional functioning.

The second multiple regression looked at the influence of RELSAT, FEELINGS, and LENGTH, on the dependent variable, SESTEEM. The independent variables explained 7.5% of the variance in SESTEEM. All variables were significant except LENGTH.

The third multiple regression looked at the influence of FEELINGS and LENGTH on the dependent variable, RELSAT. Together the variables explained 8% of the variance in RELSAT.

The final path model with the significant variables is presented in Figure 2.

A Decomposition table with the indirect, direct, and total effects of each variable is presented in Table 1. Table 1 demonstrates that the dependent variables studied had an effect on the emotional functioning of women with some variables having a greater influence than others. Self-esteem had the largest direct influence on the emotional functioning of women followed by relationship satisfaction. A woman's inability to express her negative feelings within her relationship had the greatest indirect impact on her emotional health. It is interesting

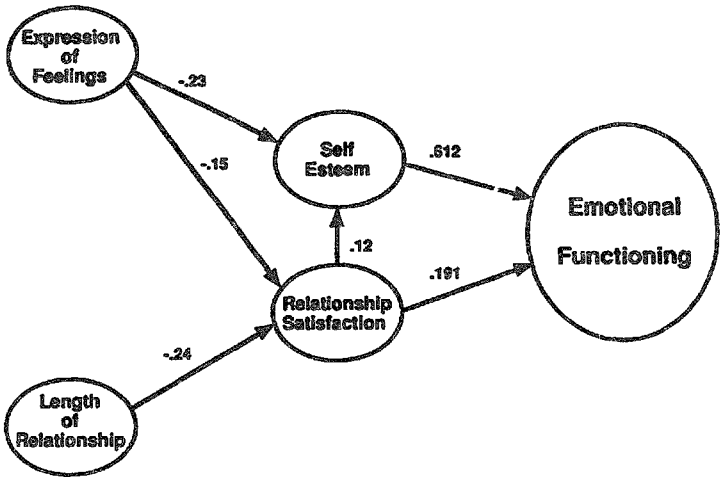

FIGURE 2

The Final Path Model

that the withholding or withdrawing of a woman's negative feelings had such a powerful negative effect on her self-esteem directly but only influences emotional functioning indirectly. It may be that a woman's self-esteem is a shield, or at least a gatekeeper, for emotional health. That is, only when a woman's self-esteem is eroded, perhaps through the consistent denial of self-expression of her feelings, does her emotional functioning begin to show signs of deterioration. In addition, it appears that the length of a woman's heterosexual

TABLE 1
Decomposition of Effects on Emotional Functioning Scores

Source	Direct Effect	Indirect Effect	Total Effect
Self-Esteem	.612	.000	.612
Relationship Satisfaction	.191	.073	.264
Expression of Feelings	.000	−.181	−.181
Length of Relationship	.000	−.064	−.064

relationship affects her relationship satisfaction level negatively, that is, the longer she is in relationship with her partner, the less satisfaction she feels.

DISCUSSION

Strong correlations between the variables of emotional functioning, self-esteem, relationship satisfaction and feelings reveal the dance they perform together: each affecting the other most profoundly and significantly. Consistently through all statistical methods the pattern reveals itself: Emotional functioning is most affected by self-esteem while self-esteem is powerfully affected by a woman's verbalization of her feelings. This flow results in the understanding that the stifling of a woman's negative affect expression toward her relationship, her partner, or his behavior has an effect on both her self-esteem and emotional functioning.

The proverbial question "What do women want?" may be answered by "What do women say?" When researchers as well as clinicians can encourage and support women's experiences, including disappointment, disagreement, anger, frustration, displeasure, and fear, they may discover new information helpful to the dyad's healing. Therapists who create an environment safe for the woman's affect expression may find couples that can hear each other. The clinician who can facilitate successfully the stifled affect expression of the woman in the couple also might find skewed and abusive power dynamics previously undiscovered. When her partner is unable or unwilling to hear her, the woman, listening to her own voice, may grow and heal herself. Clinicians can be instrumental in helping her find that power.

Divorce is a process not a static event for women that starts long before the initiation of legal proceedings (Gerstel, 1988). Therefore, it is important for researchers and clinicians alike to examine relationship satisfaction levels of women more closely. Clinicians who have examined individual personality characteristics as having a bearing on relationships also need to look at the inverse possibilities. The data in this study show a substantial connection between the suppression of feelings by women and a decrease in relationship satisfaction that then erodes their self-esteem and affects their emotional functioning. Following the sounds of both women's voices and silences can lead us to further understanding of women's needs and fears. Clinicians and researchers must not be afraid to listen. Further research

should include qualitative work of women's own self-reported experiences of their relationships.

It may be that women, while taking responsibility for their relationships, place an extraordinary amount of energy in the early years of those relationships. In an attempt to stabilize or improve the relationship, appease their partner, or dismiss their own discontent, they may suppress their own verbalizations of dissatisfaction. Alternatively their voices may be stifled by persistent messages from their partners to be quiet. It also may be that later in their relationships results feel non-productive and relationship satisfaction, self-esteem and, eventually, emotional functioning decrease.

The women in this study stated high expectations for a marriage of equality. A decrease in relationship satisfaction could be simply interpreted as an adjustment to a reality that does not allow for equal responsibility, decision-making, role sharing, or power. This pragmatic realization may demand a clarification of or even reevaluation of the values of these young, educated women. If self-fulfillment is listed as their number one goal, what then does self-fulfillment now mean? What price needs to be paid to have warm, close relationships, security, or a sense of accomplishment? Self-respect, once clearly defined, may now be ambiguous. The message is and has been that it is women's responsibility to create and maintain the relationships they desire. To be unable to do so may be perceived as personal and/or social failure.

Further study should clearly explore women's relationships longitudinally. What happens, specifically, to relationship satisfaction and emotional functioning for women at particular points in time, after 5 years, 10 years, etc.? How do women assimilate society's messages about women and accommodate their own needs simultaneously in the parameters of a male-female relationship? When does the state of disequilibrium become so intense for women that incongruity results in stress, tension, and both the external and internal breaking down of women's relationship with both her partner and herself? Further survey populations studied should include greater age, ethnic, religious, and relationship status diversity.

CLINICAL IMPLICATIONS

Implications for therapists respecting the feminist lens include the following caveats: (1) The traditional focus of making the responsibility of the female-male relationship the woman's, while simultaneously critiquing how women's self-esteem and emotional health

affects the female-male relationship, places the burden on women for adjustment and eliminates the need for the relationship itself to adjust to the needs of women; (2) There is a danger in focusing specifically on women's self-esteem and emotional health without viewing women's social context as an integral participant both in how their mental health is perceived and defined by others and by women themselves; and (3) How the clinician/researcher defines mental health is clearly political and where one falls on the political line may depend on one's own gender and social context.

First, women traditionally have been reared to focus on relationships both as goals and identity. In a society where;

> law and custom deny the full range of public expression and economic opportunity that men claim for themselves, a woman must place much of her hopes, dreams, her feminine identity and her social importance in the private sphere of personal relations, in the connective tissue of marriage, family, friendship and love (Brownmiller, 1984, p 218).

She then has high expectations for relationships and the reality that she alone can not control her partner's input or responses. Women who have not focused on relationship as an identity have been seen as enigmas. Characteristically male traits of social boldness, self-confidence, and self-sufficiency may not be real for all men but they are seen as realistic goals for all men. For women to move toward the masculine definition of emotional health is a risky proposition for most women in most female-male relationships (Caldwell, Bloom, & Hodges, 1984).

Second, traditionally women have been defined and judged "through the lens of a culture which for centuries has barely seen them as 'second class' psychologically, certainly as less than the standard of 'normality'" (Hite, 1989, p. 134). Woman is seen as either "warm or hysterical, responsive or irrational" (Tavris, 1992, p. 268). Her female traits are negatively valued and labeled as codependent (Beattie, 1987) or self-defeating (American Psychiatric Association, 1987), and movement toward masculine traits makes her deviant (Williams, 1977). She will never be normal because the norm is male and she can never be a man. The paradox, therefore, becomes the double-bind. This is the double standard of mental health: what is good for the gander is not necessarily seen as good for the goose. When women conform to female criteria they are seen as less healthy

by definition. On one hand, saying women have low self-esteem is like blaming the victim. It has been all too easy for therapists to label women in low satisfactory relationships—especially those seen as abusive, demanding, or overtly power unbalanced—as dependent and/or excessively self-sacrificing. All too often the characteristics observed are merely the "blueprint of the obligations of a good woman"—putting others first—and "consist of expectations for proper behavior that form the basis of most women's self esteem" (Tavris, 1992, p. 192).

However, there are two points to be made here: One, we must value for ourselves what we know to be valuable about ourselves. Two, we must give ourselves permission to make gender-trait addendums for growth. Stake, (1992) states that while men rate themselves higher on measures of "giftedness, power, and invulnerability" women rate themselves higher on the "self concept measures of likeability and morality" (p. 349). Is the problem that women have low self-esteem or is it how their self-esteem is measured; what criteria do we use; and do we use the criteria women value or the criteria they are socialized to value most?

Third, therapy is political. Researchers and therapists must explore further the role men play in maintaining homeostasis. At least the following questions need to be asked. What rewards do men get from being in relationships with women who are sad, depressed, and feeling hopeless? What function does a woman's low self-esteem serve in the male-female power imbalance? How does a woman's feeling worthless, useless, and/or unworthy affect the structural hierarchy at the spousal level? How is it that transgenerational histories reflect women's depression and poor relationship satisfaction repeatedly and how does both gender and context reinforce that pattern? How do we move away from the labeling and blaming of one gender as somehow deficient or deviant or dysfunctional towards second order change? Poor emotional functioning or depression for women may be reframed as a creative, adaptive coping strategy and may be nothing less than a "universal aspect of the female condition" and whether it is loss of self or anger it is an "indirect form of protest" which "obscures its sources" (Lerner, 1988, p. 221). What must be exposed is the reality of the loss and the source of the justified anger.

If the therapist is sensitive to the strains that are placed on women and men because of the unrealistic expectations and attitudes regarding the female role, it is possible to open up previously closed options in therapy. Consider the following case studies:

Helen and Marc, both 22 and living together for a year, and were now parenting their two-month-old daughter and arguing much of the time. Their therapist was struggling to join with Helen who she said "whined, cried, and complained a lot in the first session" about being on welfare, "not having a life outside of motherhood," and feeling "unsuccessful." The therapist felt more connected to Marc who quietly and directly said he had been "forced to grow up and act responsible" by this unplanned pregnancy. Helen, the therapist thought, had low self-esteem and looked disheveled. She understood Marc's not feeling romantically involved with her. Supervision helped the therapist formulate new questions about the couple. What did Helen's feeling "unsuccessful" mean? What were Helen's tears really about? Did she ever feel powerful in her relationship with Marc? How did Marc respond to Helen's tears? Did Helen ever identify her pain as anger? What would happen to the relationship if Helen directly expressed anger at Marc?

By their second session, Marc had distanced further from Helen by moving out. With the therapist's support, Helen was able to calmly and directly tell Marc that being with him felt like a "job;" she felt she worked double-time on the relationship, and was angry about being undervalued and overloaded. Marc listened but the therapist noticed his clenched fists. She asked Marc if he were angry and how he usually expressed his anger at Helen. Marc responded that he "tried to hold back" his anger but "explodes and hits" Helen. "I don't want to hit her; if only she would get out of my way." Marc refused additional help, and Helen made the decision to continue to take care of herself and her daughter.

As long as the the therapist was trapped in her view Helen as a whining, complaining woman with low self-esteem she could not uncover the battering that was underneath the symptoms. When the therapist began to connect with Helen by trying to understand her, something Helen probably had not experienced much from a person in authority, the details emerged and options opened for Helen that she had not previously considered.

In other circumstances simply helping a woman discover the attitudes she has adopted about her gender roles allows her to challenge these attitudes and explore new ways of interacting.

Maria, 26 and pregnant with her third child, was having trouble sleeping, a problem that always increased in the summer. She was also experiencing both marital stress and pain from an ulcer. In therapy Maria stated she had been sexually abused by her now deceased paternal grandfather in the summer of her tenth year. Maria still felt

distant from her father who had neither protected her nor confronted his father about his daughter's abuse. In addition, she often felt distant from her husband who dismissed her complaints of feeling unprotected while he worked the graveyard shift, (after all, he bought her a gun), and was impatient with her inability to sleep on the summer nights he was at home.

Maria had learned from her mother and grandmother how to protect the men in her life. Acting as emotional gatekeepers they had filtered information and feelings, excusing or ignoring their husband's behaviors, and prevented direct discussions from taking place between family members. Maria thought the men in her family were "fragile." She found some evidence for this in two of her brothers who had previously attempted suicide. Maria, the only daughter, felt it her responsibility to hold both her brothers and the family together. Like her mother before her, Maria was sure that directly expressing her true feelings or asking for what she needed would tear her family apart.

Maria came to learn that "stuffing" her anger at her grandfather, father, and husband, led to somatic symptoms and that gate keeping interfered with family closeness. Maria began to understand her mother's and grandmother's pain and how protecting "fragile" men did not guarantee happiness for anyone. She identified her own feelings and then began to share them with others. She has now made the connection between her summer sleeplessness, abuse, and feelings of vulnerability. Maria's satisfaction level in her marriage increased as she and her husband shared their feelings more fully and honestly. Not surprisingly, he had often stuffed his anger also! Maria no longer feels solely responsible for her whole family and no longer feels that men are fragile. She sleeps at night, without the gun, and her ulcer is under control. Feeling more empowered, she is optimistic about her marital future, and she also knows now that she can protect herself.

When therapists are addressing the important issue of gender and the concomitant roles and responsibilities that go along with them, the narrative and social constructionist theories can be effective. In early sessions the therapist can try to understand the narratives that people use to describe their relationships. The therapist will learn how the narratives are closing down alternatives for the clients. In addition there are usually many exceptions to the dominant discourse where the females and the males in families decided to break free from limited views about roles and relationships. If done carefully, and with the clients' language, the therapist can begin to

expand on the exceptions and the existing solutions so that the clients move from a restricted view of what female, wife, mother, or male, husband, and father mean. Most people have some awareness of, and resistance to, views of self and other that are restrictive and limiting. Given the opportunity and the pathway many clients will let go of these views as long as they feel respected and understood by the therapist and their partner. These language based approaches, which place a high level of respect on the clients' inherent strengths, also seem more consistent with the feminist ideals of cooperation and nonhierarchical exchanges.

We have attempted here to provide some level of empirical evidence that relationships may be a place where women's self-esteem is eroded when their expression of affect is limited and their relationship is not satisfying. Rather than assume that low self-esteem erodes satisfaction, we have taken the converse stance and assumed that low relationship satisfaction erodes self-esteem, especially in women. We have used the feminist lens to explain these results by suggesting that some women are placed in the double-bind of being responsible for the quality of the relationship without having sufficient power, autonomy, and respect to significantly influence the outcomes of the relationship. It is our hope that therapists will consider the unique pressures placed on many women today. By challenging and elucidating some of the attitudes and behaviors that increase demands but decrease satisfaction therapists can assist women and men to enhance their lives and their relationships.

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