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“An Existential Place of Pain”: The Essence of Despair in Women

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While there is a substantive body of knowledge on depression, little is known about the experience of despair. Though the terms depression and despair are often used interchangeably, studies of despair suggest that it is distinguishable from depression as experienced by women. This study explored women’s experience of despair through qualitative interviews with 14 women ages 28 to 55 (M = 45) who self-identified as experiencing despair. Three themes emerged: “Crippling and Debilitating,” “Nothing You Can Do,” and “It’ll Never End.” The findings suggest that there are common elements of despair among women, there are also unique experiences of despair.

Historically, the term “despair” was used to describe a distinct life condition, but in the late nineteenth century the term was replaced by the term “melancholia” (Hagan, 1997) and viewed as a mental disorder for which the only treatment was psychotherapy. Thus, the condition of despair became subsumed by other mental conditions. Limited research has been conducted on despair (Beck et al., 2005) and most studies have used the term to describe a reaction to a life event or an emotional state of mind. Most have made no attempt to explore how despair is experienced or defined by individuals.

Women in their midlife years enter a stage of internal awareness and introspection (Howell, 2001) in which, according to Howell (2005), they examine the impact of the changes occurring in their lives and may experience periods of emotional distress that imitate depressive episodes. Even though these episodes are not true clinical depression, many times they are treated as such because of the lack of understanding of and treatment approaches for despair (Havens & Ghaemi, 2007; Howell, 2005).

Descriptions of depression and anxiety in the most current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR) American Psychiatric Association, 2000, do not reference despair as a symptom or include despair as a diagnosis. The following articles focused on the experience of despair. These studies suggest that despair is more than the opposite of hope, and more than synonymous with depression.

From the social sciences, and using a tool to measure despair over time, Hagan (1997) studied the linkages between adolescent delinquency and despair in the life-course. Hagan’s findings suggested despair to be an evolutionary process that comes about through transition from juvenile delinquency to adult unemployment. The participants in Hagan’s study experienced despair when they found themselves either unemployable or unable to compete or interact appropriately within the work environment. The most compelling conclusions from the study were that: “(1) cultural attitudes interact over time with structural circumstance to reduce life chances, and (2) when there is cultural and structural contradiction, the subculture that has provided confidence in the past may be a source of loss of confidence or despair in later life” (Hagan, 1997, p. 133).

From the field of psychotherapy, Beck et al. (2005) conducted a qualitative study examining the lived experience of psychotherapists actively engaged in treatment of clients in despair. Interestingly a finding from one of their previous studies, that “despair was difficult to tolerate either in oneself or in others,” (Beck et al., 2005, p. 187) was what had motivated a later study. Their extensive overview of literature within the field of psychotherapy supported their belief that psychotherapists need to recognize and face the despair they experience while working with clients. This is due primarily to the difficulty in maintaining a therapeutic stance without entering into despair.
themselves. Findings from their current study demonstrated that the psychotherapists who actively engaged in treatment of clients in despair had similar experiences as their clients during sessions. Some experiences noted by the therapists were “the feeling of responsibility for bringing the client into the place of despair, resulting in self-doubt, anger or waiting helplessly” (Beck et al., 2005, p. 194). For others, it was an emerging theme of despair that they had not acknowledged before. An earlier study on despair by Beck et al. (2003), suggested despair, for some therapists, to be a place of profound aloneness and alienation.

In their work with persons with bipolar disorder, psychiatrists Havens and Ghaemi (2007) identified despair as a “complete loss of hope for the future and a loss of any grounding in the world” (p. 111). This despair is, in part, brought about after living with bipolar disorder for many years (Havens & Ghaemi, 2007). From the field of nursing, two studies on the experience of despair were found. In her meta-analysis of qualitative research findings on despair and hopelessness in patients with HIV, Kylma (2005) described despair as a process with dual dimensionality that consisted of upward and downward subprocesses. In the downward dimension the person referred to “stopping and being stuck in a situation, losing grip, and sinking into a narrow existence, focusing on impossibility and losing perspective of the future” (p. 813), which could be called hopelessness. The opposite dimension, or upward subprocess, implied fighting against sinking and rising above the despair. Within this process is a glimmer of hope or possibility of overcoming the despair.

In the second study from the nursing discipline, Cowling (2004) provided a different conceptualization of despair. In his work with women in despair using unitary appreciative inquiry, despair was appreciated as being embedded within the contexts of each individual’s life situation. This approach supported the unitary view that despair could not be separated from its context and that it is within the context that the phenomenon exists and is experienced. As a result, each individual has a distinct life pattern profile associated with despair. Approaching despair in this way avoids the pitfall of subsuming the concept of despair in other conditions. In addition, Cowling (2005) suggested that despair could be distinguished from depression and indicated a need for further studies that could lead to specific interventions for despair. A phenomenological study of the experience of despair was warranted. Therefore, the purpose of this study was to explore women’s experiences of despair.

METHOD
Design
The study was a secondary analysis of data from interviews (Szabo & Strang, 1997) conducted with women who had experienced despair (Cowling, 2004). The original study was approved by the university’s Institutional Review Board and focused on a pattern of life associated with despair. The study report did not specifically examine women’s experiences of despair, though the interviews provided rich data on that topic.

Sample
Transcripts from interviews with 14 participants provided the data for this study. Participants were English-speaking women aged 28–55 (M = 45 years); 12 (80%) were Euro-Americans and 2 (20%) were African-American; 3 participants (21%) had a high school diploma or its equivalent; 2 (14%) reported having some college, 7 (51%) were college graduates, and 2 (14%) had a master’s degree. Incomes ranged from $30,000 to $110,000/year. All the women self-identified as having experienced despair related to some life-changing event, such as infertility, sexual or physical abuse, and alcohol or drug addictions. Most had received some type of psychological intervention including therapy by counselors or psychiatrists. None of the participants had ever attempted suicide. Medical or psychiatric diagnoses and psychopharmacological treatment data were not collected.

Data Collection
Participants in the original study responded to flyers placed in a medium-sized city in the southeastern United States (Cowling, 2004). The third author (Cowling) interviewed each participant. Most of the participants were interviewed once, although two were interviewed twice because their story required more time than one interview session would allow.

Data Analysis
Interview transcripts were analyzed to explore the experience of despair, using an existential phenomenological approach informed by Merleau-Ponty (1962) and described by Thomas and Pollio (2002). Each transcript was analyzed for meaning units. Transcripts were then read from the part (meaning units) to the whole (entire transcript). Meaning units were aggregated into themes, or recurring patterns that constituted important aspects of participants’ descriptions of their experiences. In phenomenology, deciding what is thematic does not rely on quantification, such as the frequency of word use, but on researchers’ reflections about the deeper meaning of the words and the context in which they were spoken (Gaillard, Shattell, & Thomas, 2009; Thomas & Pollio, 2002). A research group composed of faculty and students, in a line-by-line analysis to ensure rigor and validity, analyzed four transcripts. The authors analyzed the remaining transcripts individually. A thematic description was developed for each transcript, and once all of the transcripts had been analyzed, the meaning units were aggregated into interconnected and interdependent themes, to represent women’s experience of despair.
**FINDINGS**

**Theme One: “Crippling and Debilitating”**

Despair was crippling and incapacitating, rendering participants unable to fulfill their normal work duties. One woman experienced despair as a type of paralysis that interfered with productivity; she said, “I seem to be paralyzed as far as my ability to work or have productive relationships or a productive life in general.” Another woman described the despair as not being able to “take care of basic needs.”

There was a sense of active engagement with the force of despair that affected their energy levels and led to their feelings of incapacitation. Suggesting her constant struggle with despair, one woman claimed, “After a while, it [despair] just wears you down, like a kind of battle fatigue.” Another woman described multiple ways she expended energy in her interactions with the force of despair and its crippling effects: “It’s been debilitating. It’s so much of my energy goes into coddling it, or babying it, or tolerating it, or wallowing in it.”

**Theme Two: “There’s Nothing You Can Do”**

Participants accepted despair as something that they could not change. They believed that there was nothing that they (or anyone) else could do to eliminate despair from their lives. This acceptance or resignation related to their powerlessness and aloneness.

**Powerlessness**

Powerlessness was experienced as loss of control, described as a sense of disorder in the self for which there was no remedy. One woman who had survived child abuse, and who was estranged from her parents and divorced from a husband addicted to alcohol, described the disordered self thus: “I felt like a jigsaw puzzle that somebody threw up in the air and when the pieces fell back down, they fell back in a different order.” For her, despair seemed to “take over your whole brain.” Experiencing the power of despair, she described an inability to find a remedy for it. Other participants shared this experience of looking for help or ways to regain control to no avail. One participant, who had suffered from multiple losses of loved ones and was currently trying to overcome addiction, described how she “wanted to fix it” (despair) but was unable to because it was “out of my hands, completely out of my hands.”

One woman attributed her continued loss of control to ineffective treatment programs: “I don’t understand why I’m working successfully and not getting any better . . . that’s the beginning of despair is that I’m doing everything I can . . . and I’m falling apart.” Another participant described her loss of control as “feeling trapped.” Identifying her struggle with infertility as the source of the despair, she described loss of control as “it’s like your body just becomes immobile, you just try to shut down . . . you can’t move forward with things you’d hoped to.”

For some participants, the experience of despair seemed both within themselves and elusive, “as if you tried to pick it up, it would just slip through your fingers.” In addition, it was an “existential place of pain” where relief was nowhere in sight.

Women in despair were hopeless and helpless. They had no hope for their situation and no hope that their life would get better despite their attempts. In the words of one participant, “You feel like nothing you do is ever going to make a difference no matter how hard you try or pray or think positively or read and study books.” For some, a sense of futurelessness contributed to their loss of hope. As one woman put it, “not to be able to function and have any hope for the future, see any light at the end of the tunnel when you’re experiencing it.” Though hopelessness was prevalent, there were times when a faint bit of hope could be seen, though it was eventually overtaken by more despair, more hopelessness. One woman said, “At first you’re just like it’s hopeless, but there’s a glimmer of hope . . . then it’s total hopelessness.” Even participants whose religious beliefs were strong had a feeling of hopelessness that their faith did not relieve. As noted by one participant, “Knowing that He [God] is in control and knowing that I’m going to heaven does give me hope for eternity, but it doesn’t give me hope for here.”

Hopelessness was associated with a sense of helplessness—no one could understand their despair, and therefore no one could help them. One participant described this as being in a different reality where “no one can come into, no one can help me.” One participant said that despair was like an emotional kind of wound that was large and there was no way to sew it up. It was a gaping kind of, it felt like an emotional tear in the psyche somehow. You just felt helpless. There was no one to help because you just can’t see that kind of wound.

Participants often expressed the belief that when they felt their despair most acutely, there was no one who could help them.

Perhaps the most poignant experience described by participants was the acceptance of despair as part of their lives that would be with them forever: “The most discouraging for me is coming to the realization that this is the way I’ll be indefinitely.” There was a general sense of acceptance. As one participant acknowledged, “It’s always going to be, and you have to accept it.” For some participants, the acceptance of despair was accompanied by futility. For example, one said, “You just throw up your arms and give up because there was nothing to be done for it.” For others, there was an undercurrent of fatality associated with the futility. As one woman put it, “I call it dying—day by day, minute by minute.” While none of our participants had ever attempted suicide, those who mentioned it said, “I could never do that.” They did, however, speak of death as an almost welcome alternative. One woman suggested that “Ninety percent of the time I would really rather be in heaven,” though this participant also claimed that she had not totally given up on life. One participant said she could never commit suicide, but “if somebody was to happen to run through that red light and hit me . . . it would be okay . . . I couldn’t do it myself though.” Another compared her experience of despair to that of those in concentration camps: “I’ve often said that if I was in a concentration camp I would
have been one of the people who would have walked right up to the wire. It’s like, that’s it, it’s like [there’s] no way out, gotta stop this, too painful.”

Aloneness

Aloneness was experienced as being imposed either by self or society. Two different aspects of aloneness were identified: it was desirable on the one hand and the result of being the victim of despair on the other. Women experiencing despair wanted to escape from it. They expressed a need to withdraw from the pain of the despair by going to another place or into themselves. To escape the pain of despair, one woman wanted to pretend it didn’t exist. As said by this participant, “Sometimes I feel if I just go to another city and start over and act like it never existed.” Others wanted to protect themselves with a defensive barrier: “You just want to move away from it, kind of put a little, I guess, defensive bubble around yourself.” Or put another way, “You can’t escape it unless you just want to live in a box and, of course, sometimes I want to do just that.” Some participants said their loneliness was related to the isolation that they perceived came from society. They felt alone in their reality, feeling as if no one understood their experience. As noted by one woman, “You just really want to be isolated because you feel almost as if you’ve got a disease. Society treats you a lot that way too.”

A sense of being victimized by despair was related to the feeling of isolation. There was a perception of isolation resulting from having no one to turn to or the feeling that no one had ever experienced this kind of despair. One woman said, “I feel totally isolated. I’m by myself, I guess I feel I’m a little bit of a victim, too, you know, this hasn’t happened to anyone else.” Another woman claimed, “It [the despair] cuts you off from other people, makes you feel very isolated” and “you withdraw from friends and social activities—sleep a lot, cry a lot.”

Theme Three: “It Will Never End”

Women’s experience of despair was conveyed by a sense of permanence or constancy. Most indicated that despair had been with them for a very long time, some for as long as they could remember. In addition, even though some had received treatment for depression, most felt that the despair would always be with them. One woman said, “Talk about baggage...this is my bag that I carry with me all the time...it doesn’t go away.” The despair was both constant and cyclical. The cyclical pattern of despair was exemplified by one woman’s description: “I’ve been dealing with it for a long time and you know I’d get better for a couple of years...then it seems like it just hits me again severely.” Another woman described her cyclical experiences of despair in terms of having been there before: “People who have seen me go through these cycles say ‘you’ve been here before’.”

While despair was both constant and cyclical, the awareness of the experience was not always in the forefront of the women’s mind. Rather, it was felt as “an undercurrent, something that can turn up very quickly, at any point, even when things seemingly are going pretty well.” Most of the participants reported that some event or something “deep inside” caused the despair to be brought to their consciousness. They also alluded to the unpredictable nature of these triggers. As one woman said, “It comes very quickly... things can trigger it that I’m aware of and things can trigger it that I’m unaware of...it’ll happen with conscious awareness of why and then it’s a question of...getting deeper...getting some sense of where it’s coming from or what triggered it.” As one woman clearly pointed out, “It’ll bounce back in there when you least expect it.”

DISCUSSION AND IMPLICATIONS

This phenomenological secondary analysis of transcripts of women’s experiences of despair extends the findings from the original unitary study of despair in women (Cowling, 2004) and serves to expand our understanding of despair. The emergence of the three themes “Crippling and Debilitating,” “There’s Nothing You Can Do”, and “It’ll Never End” helps to elucidate the nature of despair as experienced by women and offers implications for practice and research.

The study reported here contributes to continuing discussion of the experience known as despair and, in particular, this experience in the lives of women. The findings reported here are consistent with the findings of Anderson-Nathe (2008) whose study of youth workers revealed some of the same features: helplessness, hopelessness, and feeling out of control. Despair appears to be a more expansive notion of a life experience than previously thought. Because of this, despair might provide a richer context from which to explore potential interventions specific to the lives of women. These women related to the term “despair” as a distinctive life experience.

For these women, there was sometimes a desire to be alone; at other times they felt that other people isolated them. Recognition of the relationship of aloneness and isolation to despair is not new. An earlier study of despair by Beck et al. (2003) suggests that despair for some was a place of profound aloneness and alienation. A later study found that psychotherapists engaged in treatment of clients in despair had experiences similar to their clients during their hourly session. Beck et al. (2005), who examined the lived experience of psychotherapists actively engaged in treatment of clients in despair, found that “despair was difficult to tolerate either in oneself or in others” (Beck et al., 2005, p. 187). These therapists’ descriptions of their experiences might, in part, explain the tendencies of others to want to avoid or distance themselves from individuals experiencing despair. While the women in this study experienced despair as always with them, most referred to its cyclical nature, wave-like pattern, or the “ups and downs” of despair, which is consistent with Kyllma’s (2005) description of despair as an upward and downward process.

Havens and Ghaemi (2007) recognized in their study of persons with bipolar disorder the existence of existential despair. Despair was different from clinical depression because it did
not respond to antidepressants over the long term. They suggested that the “clinical despair” might actually be the result of the chronicity of the patient’s bipolar condition as well as the ineffective use of medications for the condition. Despair might “grow out of the experience of suffering for years from bipolar illness, and from the methods used to treat the condition” (p. 111).

Cowling’s previous studies of despair (Cowling, 2004, 2005) using a method of inquiry that has both appreciative and participatory strands was initiated as a non-gender specific inquiry. However, women were the ones who came forward to talk about despair. The women in that study consistently reported that the term ‘despair’ provided a clearer reference point to identify their experience than the limited clinical perspective of depression.

Cowling (2004) revealed that women experienced despair in a variety of different contexts. The lead in the advertisements for recruiting participants was “Despair: Your Story?” Women were invited to reflect on despair and its broader relationship to their lives and their health care experiences, and were told that the study sought to explore a pattern of life associated with despair. Cowling’s (2004, 2005) conceptualization of despair in women was related to the inexactriability of despair and the women’s situation. The study placed despair within a larger landscape of life, revealing connections to unique life experiences as well as experiences common or universal to women.

While the strategies of synthesis and synopsis associated with unitary appreciative inquiry revealed common features across the women’s lives, Cowling noted, “these do not fully account for the depth and breadth of despair in each woman’s life” (Cowling, 2004, p. 298). The features of despair shared by women in the original study were a lack of hope and a sense of futility; sense of powerlessness and a lack of control; feelings of isolation and aloneness; a sense of fragmentation and lack of coherence; a sense of life constriction and a narrowing or elimination of options; an inability to fully express inner experience or to be understood by others; and a sense of the pervasiveness and constancy of despair (Cowling, 2004). These common features of despair have some resonance with the findings from the analysis of despair in this phenomenological study. Each of the features could be viewed as expressions of the three themes: “Crippling and Debilitating,” “There’s Nothing You Can Do,” and “It Will Never End.”

The primary limitation of this secondary data analysis is the obvious lack of control over the direction and nature of the interviews. The research team had to rely upon their ability to analyze the transcripts for the kind of information relevant to a phenomenological interview. In a typical phenomenological study, the participants would have had an opportunity to share more details. In spite of this limitation, the study provides some important information that extends our understanding of despair.

While the experence of despair has been subsumed for decades by the symptoms of depression, therapists more recently are beginning to recognize despair as its own experience. In their multisite, longitudinal study of depression in 242 patients with advanced cancer, Jacobsen et al. (2006) described despair as an aspect of “demoralization syndrome.” Demoralization syndrome is comprised of despair, hopelessness, helplessness, and loss of meaning of life. Jacobsen et al. believe that this syndrome captured the experience of these patients more than the diagnosis of depression. For example, less than 15% of the patients who experienced demoralization syndrome also met the DSM-IV-TR (American Psychiatric Association, 2000) diagnostic criteria for major depressive disorder. They concluded that despair, while it might be a part of depression for some individuals, was indeed a different phenomenon that required a different approach for therapy.

The women who participated in the original project (Cowling, 2004) provided clues for the development of potential interventions based on their experiences with health care providers and family and friendship networks. In addition, they spoke to the value of self-care and self-empowerment as factors in the quality of their lives. This information coupled with the secondary phenomenological analysis suggests that care for women experiencing despair is most successful when it is shaped to assist women in understanding the factors and forces that contribute to despair and how despair influences life experience in both negative and positive ways. From this understanding women might be helped to identify individual strategies that support self-determination and guidance in asking for and receiving what they need. The findings suggest that women desire to have their experiences recognized and validated while simultaneously receiving acknowledgment of their ability to overcome the past and to shape their own destinies. Using the knowledge gained from the original study and subsequent phenomenological analysis, nurses are in a position to help clients and other health care providers find the delicate balance between provision of support and creation of empowerment.

Despair warrants further investigation. Avenues of exploration might include a focus on the experiential nature of despair to determine if despair provides a more relevant context in which to assist women than the clinical label of depression. Another potentially rich avenue of study could be the differences in despair as experienced by men and women. There may be ways to gain the perspectives of men experiencing despair and thus to gain a full picture of despair for both men and women and the impact of it on their lives. Additionally, expanding the research into different cultures could add clarity to the relationship of cultural perspectives on perceptions of despair.

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REFERENCES


