CHAPTER 12

Feminist Therapy

Susan is a 30-year-old Korean American woman who is recently divorced from her husband of 2 years. She is a full-time student beginning her third year of medical school and lives with her mother. Susan arrives for sessions neatly dressed, usually in hospital scrubs. She generally appears younger than her stated age, demonstrates poor eye contact, and shows very little emotion.

Susan was referred for counseling following an incident in which she verbally confronted another student during class and was asked to leave the classroom. The counselor at the medical school who referred her suggested that she may have difficulty managing and appropriately expressing anger; Susan does not agree that this is a problem. She says that she was justified in her anger because the other student, a man, had called her "crazy."

Susan is adopted. She has no knowledge of her biological parents. Susan's adoptive father is Caucasian; her adoptive mother is Asian. She is an only child. Her father, who died 2 years ago, had a history of alcohol abuse. Initially, Susan reported having "basically a good childhood." She described her mother as "the disciplinarian, hard working and loving." She further stated that although her father abused alcohol, this was not a stressor; she "adored him" and he "was very good to her." In later counseling sessions, Susan described her home life growing up as uncomfortable; her mother and father argued frequently. She further disclosed feelings of resentment and guilt related to her father's alcohol abuse.

Susan reported having problems with interpersonal relationships for many years. Her ex-husband, who lives in another city, recently told her that she should seek counseling because she has difficulty letting go of relationships. She agreed with his assessment, characterizing herself as "codependent." Susan reports a lack of self-confidence, feelings of numbness during conflict, insecurity with authority figures, and a desire to avoid uncomfortable situations.

Note: In tribute to the egalitarian spirit of feminist therapy, the image I chose for this chapter is intended to represent the many diverse contributors to this theoretical approach.

Susan provided an example of her difficulty with relationships in describing a long-term female friend. Susan and her friend Leah met during their first year of high school, and they immediately became friends, studying together, shopping, having lunch together, and so forth. Susan described her relationship with Leah as "very close right from the beginning," saying that they were "practically inseparable." They decided to pursue careers in medicine, attended the same college, and now are in medical school together. Susan reported that Leah was always very protective of her and that when Susan had a problem with another acquaintance or family member, Leah was there to defend her.

Susan recalled a time when she was dating a man and believed that he was cheating on her. She discussed her suspicions with Leah, who convinced her that the two of them should slash the tires on his car and spray paint the windshield to "teach him a lesson." Susan and Leah went through with their plan and vowed never to disclose what they had done. Susan reported that they engaged in other activities similar to this one throughout the years and that she felt "somewhat guilty" about some of the things they have done to other people. Susan further reported currently feeling "smothered" by Leah; she would like to pursue friendships with other people. However, Susan reports being unable to end her friendship with Leah because she feels it is necessary to remain loyal to her.

With men, Susan says she is unable to express her feelings when she senses disagreement, and describes herself as fearing abandonment. She says these kinds of things happened in the relationship with her ex-husband. Susan reports that a previous significant relationship was physically abusive. She felt responsible for the abuse because she was, at times, verbally abusive toward the man. During the abuse she would feel calm, and when it was over, she would simply leave the situation. She had great difficulty ending this relationship because of her feelings of loyalty to this man.

Susan comes to counseling somewhat reluctantly (mostly because the counselor at school suggested it), although she recognizes her difficulties with relationships. She says that she'd like to work on her "temper" and her feelings of abandonment.

BACKGROUND

> Traditionally, psychotherapy has let women down. The same is true for members of disempowered groups. Created by the mainstream to serve the mainstream, psychotherapy has failed marginalized people in fundamental ways. This is not to say women and other minority-group members have never received help or felt more able to cope after counselling or therapy but, rather, that therapy they received made little attempt to address the root causes of their problems. In focusing narrowly on the personal and individual, which mainstream psychotherapists insist is their domain, they ignore the big picture and miss the point. A therapy which fails to address power issues in people's lives works, automatically, to reinforce oppression. (McLellan, 1999, p. 325)

Feminist therapy (FT) is a rather different approach to counseling; it is more a philosophical approach than a specific theory and technique (Wyche & Rice, 1997). The preceding quote is a good illustration of the ideology of a radical feminist approach to counseling. However, feminist philosophy spans an ideological continuum that ranges from radical to more conservative positions. These variations of feminist philosophy will be described later in the chapter. If you'd like to see a feminist therapist in action, watch Dr. Linda Moore work with Helen on the *Theories in Action DVD*. You can also read part of an article by prominent feminist therapist Laura Brown in Box 12.1.

Box 12.1

Still Subversive? Where Is the Evidence?

Is feminist practice still subversive? Is this practice still viable as an approach to psychotherapy after all these years? Not only in my opinion are the answers to both of these questions in the affirmative, but I would also like to argue that what feminist practice brings to the table has become more salient and increasingly necessary for the soul of psychological practice in the twenty-first century. Let us discuss, beginning with the hoary old feminist cliché about the personal being political, why and how I see that maxim applying to the evidence of the power of feminist therapy.

Feminist therapy continues to be one of the few approaches to practice that owns and names the politics of the realities affecting us all, client and therapist, student and teacher, researcher and participant, and makes that political analysis central to theory. Other postmodern therapies such as Narrative and Constructivist models join feminist practice in disowning the notions of objective truth claims and diagnostic labels. Feminist practice also converges with person-centered therapies around the importance of meeting clients where they are and valuing the client's voice in the therapeutic discourse. Feminist practice, however, continues to be one of only a handful of therapy domains in which therapists are called upon to acknowledge as central the politics of practice and the impact on practice of the politics of gender, power, and social location on the lives and work of all of us. Feminist practice is joined by liberation psychology (Almeida, 2003; Aron & Corne, 1994), which has been brilliantly synthesized with feminist insights by Comas-Diaz (2000). Yet in the textbooks on systems of psychotherapy studied by our beginning students (Corey, 2004; Prochaska & Norcross, 2003) when liberatory perspectives are included at all, feminist practice stands alone representing the call to acknowledgment of political realities in the psychotherapy office.

When feminist therapists speak of the politics of the personal, we speak of the experiences of power and powerlessness in people's lives, experiences that interact with the bodies and biologies we bring into the world to create distress, resilience, dysfunction, and competence. Foregrounding power and its absence as a central issue in the efficacy of psychotherapy seems particularly necessary today, speaking as I did in Washington, DC not far from places where people with the power to do so are attempting to legislate away from me rights that, as a lesbian citizen of the United States, I have not yet attained. I write this revision a week after Hurricane Katrina came to the Gulf Coast, exemplifying that powerlessness is the defining element in the terrible trauma affecting the poor, the people of color, the old, and the very young who were left behind as waters rose.

Foregrounding the corrosive effects of powerlessness, as feminist therapy has always done by focusing on how to bring "power to the powerless," and as Adrienne Smith and Ruth Siegel described two decades ago in their chapter in The Handbook of Feminist Therapy (Smith & Siegel, 1985), seems to gain new urgency at a moment in U.S. history when the hope of empowerment seems to be drifting ever further out of reach for most ordinary people. Feminist therapy, speaking out loud about power, disrupts the trance of despair that has become so common in today's culture. Feminist therapy requires its practitioners to think in a complex and nuanced manner about

how power and powerlessness are roots of distress. Failing to do so, feminist practice ceases to fulfill its mission and loses its subversive potentials.

This insistence on the personal being political, and the political being deeply and intimately personal, is especially meaningful when we look at what we are teaching our next generations about the nature of the work of psychologists. Students in training to become practitioners are learning that their tasks are to offer empirically supported treatments for disorders that are in turn defined by the DSM. Clinicians are to do this because: (a) it is the wave of the future in health care—everyone (meaning physicians) is doing evidence-based practice and so should we, particularly given our heritage of being based in the science of psychology (Task Force, 1995) and (b) managed care requires these treatments of psychotherapists, thus providing empirically supported treatments is required to make a living. Resistance is futile; we are being assimilated and should stop injuring ourselves by fighting back.

This discourse of constraints on practice, our powerlessness to resist these trends, and the anxieties that these constraints create in our next generation permeated some of the questions that my students raised with their peers and me. How can they call themselves feminist therapists when we still have such a small base of randomized clinical trials supporting feminist practice as efficacious? If feminist therapists are critical of, and generally rejecting of DSM diagnostic categories, how can they bill for their services (or more salient and immediate in their lives, how will they pass their clinical competency exams if feminists do not give DSM diagnoses)? In addition, what managed care company will pay for feminist therapy (an important question for someone who is graduating from school with over $100,000 in student loan debt)?

Feminist practice and theory steps in at this juncture to be subversive to the dominant discourse and I hope a little reassuring to our next generation. We have both evidence and a diagnostic strategy, both of which give feminist therapists powerful tools. They are different sorts of evidence, and radically different ways of conceptualizing pain and dysfunction, but they are not absent.

Excerpted from "Still Subversive . . . " by L. S. Brown (pp. 15–24) 2006. *Psychology of Women Quarterly*, 30.

Feminist therapy developed out of deep dissatisfaction with traditional approaches to psychotherapy (Gilbert, 1980), the emergence of a psychology of women and gender, and the feminist movements of the 1960s and 1970s (Contratto & Rossier, 2005; Evans, Kincade, Marbley, & Seem, 2005; Worell & Johnson, 2001). In her book *Subversive Dialogs*, Laura Brown (1994) defined feminist therapy in the following way:

> Feminist therapy is the practice of therapy informed by feminist political philosophy and analysis, grounded in the multicultural feminist scholarship on the psychology of women and gender. This approach leads both therapist and client toward strategies and solutions advancing feminist resistance, transformation, and social change in daily personal life and in relationships with the social, emotional, and political environment. (pp. 21–22)

No one individual developed FT; rather, it emerged from the application of feminist political philosophy (Brown, 1994). It is considered a grassroots phenomenon

(Brown & Liss-Levinson, 1981), and its proponents generally eschew the idea of "experts" (Brown, 1994). Feminism in counseling actually has a long history, beginning with Alfred Adler, who recognized the cultural effects on women's behavior (but who still saw women as needing to adjust to the role of mother). Another early feminist was Karen Horney, a psychoanalyst who rejected the idea of penis envy and substituted the woman's envy of men's privileged, power-wielding position in society (Forisha, 1981; Nutt, 1979). Many writers and therapists are currently active in the FT world, and producing a list of them here would surely lead to leaving someone out, not to mention the fact that creating such a list would be contrary to the egalitarian principles of FT.

Numerous organizations are devoted to feminist psychology, psychotherapy, and the psychology of women. The American Psychological Association (APA) established the Committee on Women in Psychology in the 1970s, and this committee initiated the APA Task Force on Sex Bias and Sex Role Stereotyping in Psychotherapeutic Practice. Division 17 of the APA, the Society of Counseling Psychology, established a Committee on Women and produced *Principles Concerning Psychotherapy of Women* (APA, 1979; Fitzgerald & Nutt, 1986) which have been recently revised as the *Guidelines for Psychological Practice with Girls and Women* (APA, 2007). Division 35 of the APA is the Society for the Psychology of Women, which sponsors the journal *Psychology of Women Quarterly*. Division 35 can be found online at www.apa.org/divisions/div35. In 1993, Division 35 was instrumental in holding the first National Conference on Education and Training in Feminist Practice, which produced the Core Tenets of Feminist Therapy shown in Box 12.2 (Worell & Johnson, 1997).

The Association of Women in Psychology (AWP) emerged in 1969 as a parallel organization to the American Psychological Association. The AWP was instrumental in the creation of Division 35 of the APA. Its members picketed the APA board of directors meeting at the 1969 convention to argue for its creation (www.apa.org/divs/div35). AWP created the first Feminist Therapy Roster in 1971 (Brown & Liss-Levinson, 1981).

Another famous hotbed of feminism is Wellesley College, which sponsors the Wellesley Centers for Women (www.wcwonline.org). The Stone Center, a well-known feminist think tank, is also at Wellesley, as is the Jean Baker Miller Training Institute, which produces research and training centered on the relational model of women's development (see the section "Theory of the Person and Development of the Individual").

Box 12.2

Core Tenets of Feminist Therapy

1. Feminist therapy recognizes that being female always occurs in a cultural, social, political, economic, and historical context and affects development across the life span.
2. Feminist therapy focuses on the cultural, social, political, economic, and historical factors of wom[e]n's lives as well as intrapsychic factors across the life span.
3. Feminist therapy includes an analysis of power and its relationship to the multiple ways women are oppressed; factors such as gender, race, class, ethnicity, sexual orientation, age and ablebodiness, singly or in combination, can be the basis for oppression.

4. Feminist therapy acknowledges that violence against women, overt and covert, is emotionally, physically, and spiritually damaging.
5. Feminist therapy acknowledges that misogyny exists in all women's lives and is emotionally, physically, and spiritually damaging.
6. Feminist therapy's primary focus is on strengths rather than deficits. Therefore, women's behaviors are seen as understandable efforts to respond adaptively to oppressive occurrences.
7. Feminist therapy is committed to social change that supports equality forever.
8. Feminist therapy is based on the constant and explicit monitoring of the power balance between therapist and client and pays attention to the potential abuse and misuse of power within the therapeutic relationship.
9. Feminist therapy strives toward an egalitarian and nonauthoritarian relationship based on mutual respect.
10. Feminist therapy is a collaborative process in which the therapist and client establish the goals, direction, and pace of therapy.
11. Feminist therapy helps girls and women understand how they have incorporated societal beliefs and values. The therapist works collaboratively with them to challenge and transform those constructs that are destructive to the self and helps them create their own perspectives.
12. Feminist therapy empowers girls and women to recognize, claim, and embrace their individual and collective power as girls and women.
13. Feminist therapy expands girls' and women's alternatives, options, and choices across the life span.
14. Feminist therapy is a demystification process that validates and affirms the shared and diverse experiences of girls' and women's lives.
15. Feminist therapy involves appropriate types of self-disclosure. However, because self-disclosure may be harmful, it must be both value and theory driven and always in the client's best interest. Therapists must develop methods of continually monitoring their level of self-awareness.
16. Feminist therapists are committed to continually monitoring their own biases, distortions, and limitations, especially with respect to cultural, social, political, economic, and historical aspects of girl's and women's experiences.

BASIC PHILOSOPHY

Feminism is, according to Laura Brown (1994), "the collection of political philosophies that aims to overthrow patriarchy and end inequities based on gender through cultural transformation and radical social change" (p. 19). Patriarchy refers to the pervasive norms of most cultures that favor men over women, give them power automatically (i.e., male privilege, particularly white male privilege) while at the same time devaluing women and keeping them in subordinate positions. This political perspective translates into a core

belief for feminist therapists that the ultimate cause of psychological dysfunction resides in the oppression of the individual by society (McLellan, 1999). Women, particularly, are expected to adhere to a rigid set of expectations, and both overadherence and deviation from these behaviors are labeled mental illness (Chesler, 1972).

Feminists, and feminist therapists, tend to be activists and are pretty noisy about it. For example, Laura Brown, the self-proclaimed subversive (as in the title of her book *Subversive Dialogs* [2002]) evaluates the current state of feminism in this way:

> the most subversive thing that feminist practice still brings to the table after all these years is a belief that the civilization we know as racist, sexist, heterosexist, classist, neglectful, colonizing, occupying, and violent is the problem, for which feminist activisim in and outside of the therapy office, the classroom and the lab, is one solution. (2006, p. 22)

Mary Ballou (2005) calls attention to the hegemony of the medical model, traditional science, health insurance industry, professional associations, and licensing boards (p. 202). She sees the dominance of these institutions as well as the increasing conservative political swing in our current lives as limiting the visions of therapists, feminist or otherwise, in their efforts to understand and help others. So given even these limited examples, you can see that FT writers are not shy in their critical evaluations of the current state of our world.

Feminists are always aware of power differentials and are attentive to features of human interaction that promote such differentials (Gilbert & Rader, 2007). One important influence is language; how we speak is assumed to both reflect and influence our views of the world. Thus, you will *not* hear a feminist using the pronouns *he* or *him* to refer to both sexes. More subtly, feminists argue that those traditionally in power (men) typically are referred to by their last names, whereas women and children are called by their first names. As a consequence, feminist writers often use both first and last names in their references to others' writings. To be true to FT ideology, I will use both names in the first reference to writers in this chapter (other than in parenthetical references).

Feminist theory, which forms the basis of FT counseling, encompasses a wide range of perspectives. Next I will review some feminist philosophies, but you should keep in mind that the boundaries between these categories are not as distinct as you might gather from my presentation of them. Complicating matters, different writers sometimes use different terms when apparently referring to a similar feminist stance. For example, one variant of feminism, woman of color feminism, can be enacted from liberal, radical, or cultural feminist perspectives. For the most part, the feminist stances vary primarily in the degree to which they (a) emphasize unique qualities of women, (b) advocate the rejection of masculine, or patriarchal, models, and (c) integrate issues of culture and class into their viewpoints. For a more detailed review of these philosophies and their histories, read Carolyn Zerbe Enns' (2004) book, *Feminist Theory and Feminist Psychotherapies* or Laura Brown's *Subversive Dialogs* (1994).

Liberal feminists emphasize women's equality within a rational framework (Worell & Johnson, 2001). Also called reformist feminists, advocates of this perspective emphasize equality of women and men and tend to focus on changing legal structures and interventions to promote access for women. Betty Friedan, who identified "the problem that has no name" (i.e., the malaise of the traditional 1960s "housewife"), can be seen as a liberal feminist because she meant by this phrase that women were blocked from reaching their potentials, and that the patriarchal society did not want to discuss these issues (Friedan, 1963). Friedan was

instrumental in establishing the National Organization for Women (NOW), which worked for the passage of the Equal Rights Amendment (ERA) to the U.S. Constitution. The ERA, of course, failed, but other initiatives did not (such as paid maternity leave and the right of women to control reproduction). The liberal position is criticized by other feminists for encouraging women to become members of the male club and, by doing so, denying the paternalism in societal structures. It is dangerous, in this view, to teach women to be "more like men" because this view inherently assumes that women are deficient (Brown, 1994, p. 54).

Radical and social change (or *socialist*) feminists are those who see oppression based on gender as the most fundamental and stubborn form of injustice and seek to eliminate all forms of male domination (Enns, 2004; Worell & Johnson, 2001). Socialist feminists, who base their arguments on Marxism, add that capitalism is a second major factor in the oppression of women and would prefer communal living environments that would emphasize equality of work roles for men and women (Enns, 2004). Radical and socialist feminists point to the many ways that society represses women, including violence and harassment and restricting their reproductive rights. The liberal feminists' efforts to promote women into positions of power in society are seen by these feminists as tokenism (Brown, 2000) because this practice is more likely to change the woman to fit male norms than to change the patriarchal, capitalist system. Nothing less than abolishing patriarchal systems is acceptable to the radical and socialist feminists, so they are likely to advocate separatism, or the refusal to participate in institutions that perpetuate the patriarchy. For instance, engaging in all-women events, businesses, and consciousness-raising groups is seen as refusing to conform to male-favoring cultural values (Enns, 1997). *Lesbian* feminists would add heterosexism to the list of cultural dominations, defining this bias as the heteropatriarchy (Brown, 1994; Worell & Remer, 2004).

Cultural feminists revere women's unique qualities such as relatedness and cooperation. They tend to emphasize the differences between men and women in such values (Moradi et al., 2002). Unlike radical and socialist feminists, who are critical of norms of femininity, cultural feminists celebrate what they would see as qualities unique to women (e.g., connectedness, cooperation; Worell & Remer, 2004).

Woman of color feminism, or *womanism*, is a reaction to mainstream feminism's neglect of the experiences of women of color, or to put it a little more bluntly, the racism inherent in early feminism. These feminists reject the primacy of gender as a category of oppression, arguing that the gender interacts with race, social class, and other categories in affecting individuals' lives (Evans et al., 2005). Although some authors equate womanist with Black feminism, Enns (2004) points out that this term is also used more broadly, to refer to one who loves all things woman. Some woman of color feminists prefer the term *colonization* to *oppression* as a way of emphasizing that people of color are pressured to adopt the values and norms of white, Eurocentric culture (Comas-Diaz, 1994, p. 288). Lillian Comas-Diaz argued that "colonized individuals are not only exploited and victimized for the benefit of the colonial power, but also serve as the quintessential scapegoats" (p. 289). Much as other feminists might emphasize examining one's internalized sexism, woman of color feminists advocate distinguishing between internal and external colonization (Comas-Diaz, 1994). Supporters of this orientation sometimes see men and women of the same race or ethnicity as more similar to each

other than women from different ethnicities. This position is probably the most widely endorsed in recent years (Moradi et al., 2002; Wyche & Rice, 1997).

Another FT ideology is labeled *postmodern* feminism (Brown, 2000; Enns, 2004). Postmodernists reject the idea that there is one real, objective truth out there in the world. Instead, postmodernists contend that reality is constructed in relationships and that truth is often determined by who is in power. Some versions of lesbian/queer feminism can be classified as falling into postmodernist approaches. Finally, Enns (2004) describes *third-wave* feminism, a postmodern approach that although appreciating the contributions of earlier feminisms, struggles to deal with the backlash against feminism and to push for further progress in combating violence, problems in health care, and economic and environmental concerns.

Postmodernism is difficult to describe, because within it are views that vary from mild to radical on the notion of whether there is a reality to be comprehended. Among the postmodernist approaches are those who view radical relativism (i.e., the view that there is no one reality only shifting views) as problematic because it would disallow statements about historical (and present) oppression of women and other marginalized individuals. Social constructivists adopt this perspective so that problematic constructions of gender, race, and so forth, can be addressed (Enns, 2004). The point of all postmodernists, as I see it, is to emphasize that we and our clients can bring many ideas in to counseling that we treat as "truth" that can be profitably considered as products of social reality training (Hare-Mustin, 1994).

Chandra, Susan's feminist therapist, is first aware that Susan is a woman and of Asian heritage in a culture infused with the values of European men. Characterizing herself as a womanist feminist in the broadest sense, who also respects the contributions of radical and cultural feminisms, Chandra recognizes that Susan's female sex and Korean heritage will likely have a significant impact on who she is and how she operates in the world, and how the world reacts to her. Chandra assumes that Susan experiences the power disparity in mainstream culture, and that the behavior that others label "dysfunctional" is a reaction to these inequities.

HUMAN MOTIVATION

FT counselors don't spend a lot of time discussing human motivation—they are too busy intervening. According to Mary Brabeck and Laura Brown (1997), the lack of theory in FT can be partly attributed to the fact that FT developed in the field rather than within the confines of academia.

In considering motivation, FT counselors might draw their views from an existing theory of human behavior, provided that it was not sexist. Nancy Chodorow modified classic psychoanalytic theory to eliminate the "penis envy" bias (Chodorow, 1978, 1989). She focused on the role of mothering in child development and particularly on the individuation of boys and girls. Modern versions of psychoanalytic theory such as attachment theory have received feminist criticism, as has the evolutionary perspective (Contratto, 2002). Ultimately, the issue of motivation partly turns on the question of the origins of sex differences (if they exist), which is a controversy far from settled as you will see from the following discussion under development.

Another way of addressing motivation might be to adopt a system associated with humanistic (e.g., Gestalt or Person-Centered) orientation because an actualization

perspective is compatible with a feminist orientation (Enns, 1997). However, Person-Centered Theory, for example, has been faulted for its lack of attention to the social factors that contribute to the development of the self. Also, the emphasis placed on individualism in humanistic/existential approaches is reflective of traditional American values (rugged individualism or the John Wayne syndrome) and can obscure commonalties in women's experiences in the oppressive culture (Enns, 2004).

Chandra sees Susan as motivated to grow to her full potential as a human. An advocate of humanism, Chandra views Susan from a positive perspective but is careful to attend to social influences that are significant in Susan's life.

CENTRAL CONSTRUCTS

GENDER

No matter what FT ideology one adopts, gender, considered the social manifestation of sex, is a critical construct. Feminist therapists use the term *sex* when biological differences are the subject (such as anatomical ones). *Gender* is the term used to emphasize that differences between men and women are more than the product of biology and that social learning and social context are important influences on what our cultures define as "male" and "female" (Yoder, 2003). As you might suspect, liberal feminist therapists are adamant that gender is a construction of culture and that most apparent psychological differences between men and women are a product of societal influence rather than biological sex (Gilbert & Scher, 1999). I have friends who are parents who are convinced that raising boys is different from raising girls. Boys are active and aggressive and girls are sweet and compliant—you know, the "boys will be boys" phenomenon. Liberal feminists would point out that many of these behaviors are known to be differentially reinforced by parents when children are very young (Paludi, 2002). Female and male infants are treated very differently from one another from very early on. Baby boys wear blue and girls, pink; boys are given toy trucks or tool kits, and girls are given dolls or kitchen sets.

Cultural and to some extent radical and socialist feminists are more likely to see gender differences as inherent to the sexes. This position is sometimes called the *essentialist* stance (Brown, 1994). For instance, the traditional female emphasis on relationships is to be celebrated, not to be treated as an artifact of socialization (Enns, 2004).

Janice Yoder (2003) presents an integrationist perspective on these arguments. Noting that although biology seems to be more "basic" than environment and so more immutable, she asserts that research is amassing that experience can affect physiology. She writes "I believe that as the flexibility of biology becomes more and more acknowledged, feminist psychologists will find it useful to let go of the presumed distinction between sex and gender, nature and nurture. This opens the door to regarding *sex and gender as inseparable and intertwined* so that a holistic understanding of women and men, girls and boys, will include biology (sex) and what our culture makes of our biological sex (i.e., gender)" (2003, p. 17; italics in original).

In any case, all feminist therapists recognize that society has devalued women and the qualities typically associated with them. Power and gender are therefore tightly bound in most cultures in the world (Brown, 1994).

Chandra works to identify multiple influences on who Susan is now. Some of the important factors are her biological sex, family background, social class, and the fact that she is Korean. Chandra does not know how much each of these factors influences Susan, but she guesses that gender is a powerful influence. Susan has probably been reinforced for exhibiting traditionally "female" behaviors and punished for displaying traditionally "male" behaviors.

The Personal Is Political

In contrast to traditional psychological theory, which tends to focus on internal determinants of behavior, this basic principle of FT emphasizes that women's experiences are connected to factors external to them, embedded in social norms and traditions (Enns, 2004). FT theorists are very conscious of the traditional gender imbalance in society, which dictates that power and status are bestowed on men. Women's problems are seen as resulting from social, political, and legal systems that oppress and disempower women (Worell & Johnson, 2001). Feminists believe that the "personal experience is the lived version of political reality" (Brown, 1994, p. 50). In other words, the distress of the individual woman (the personal) is a function of the social and political rules and norms of the culture in which she lives (the political).

Chandra assumes that the difficulties Susan brings to counseling are a product of factors in her environment and especially the cultural context in which she was raised and now exists. She suffers from society's disempowerment of women, and some of her current behavior is likely in reaction to these very real feelings of helplessness. For example, her low self-confidence is surely influenced by the societal devaluing of women.

THEORY OF THE PERSON AND DEVELOPMENT OF THE INDIVIDUAL

There are a number of ways of examining personality and development from the FT perspective. First, the FT approach attends closely to theory and research on sex differences. Liberal feminists assume that males and females do not differ in any important psychological ways at birth (Brown & Liss-Levinson, 1981). Subsequent experiences in the social environment are thought to account for any later observable differences.

What is the outcome of this lifelong process of learning to be a gendered person? Stereotypically, men are thought to be independent, assertive, competitive, unemotional, and invested in their careers. Women are seen as emotional, relationship oriented, passive, and willing to put others' (particularly men's) needs before theirs. Men are dominant, and women are submissive. Men are career and work oriented; women are family and child oriented.

Arguments over the "reality" of gender differences began as early as 1914 and have continued to this day (Hyde, 2005). Alice Eagly (1995) maintained that enough evidence existed to conclude that there are real sex differences and in the directions indicated by stereotypes (for instance, women are more relationship oriented than men; men are more independent and controlling than women).

In contrast, in a recent review, Janet Shibley Hyde (2005) looked at 46 meta-analyses of such differences and found that 78% of these differences were in zero to small range. The categories she reviewed included ones in which differences are traditionally expected,

such as math and verbal ability; in these latter two cases, differences again were small or nonexistent. Three general areas did show moderate or large differences: motor performance, some sexual behaviors/attitudes (but not sexual satisfaction), and aggression, particularly physical aggression. Surely of interest to many feminists is Hyde's assertion that the reported difference in relationality between men and women (women are nurturers and men are not) is not supported by the data. Yoder (2003) also summarized a large body of these difference-testing efforts and she concludes that it is frustrating that so much research has been done with so little agreement about the results. She noted that the really important question in this debate is, what causes the differences? It is not enough to know that men and women are from different planets—we need to look at the workings of the spaceships in which they fly around.

Evidence exists that children are treated differently based on their sex, giving rise to the opinion that this learning, termed sex-role socialization, is responsible for observed differences in the behaviors of men and women. Cultures endorse clear values of what it means to be a male or a female, and parents, peers, and teachers tend to treat children accordingly. Yoder (2003) summarized this research as well. For example, parents are likely to describe their male and female children differently (e.g., girls are more delicate); parental preferences for toys appear to be sex-consistent as well (although it is noted that overall "boy" toys are more fun than "girl" toys, so parents sometimes will cross boundaries here). Berk (2007) noted that parents' reactions to violations of stereotypical behavior are more negative for boys than for girls and the same pattern appears among children's peers. Yoder's (2003) summary also demonstrates that boys and girls are treated differently by their teachers; for example, boys get more attention and corrective feedback, whereas girls are generally advised to not fuss about mistakes. Finally, the media, although somewhat more balanced than in the past, still depicts males in more prominent and dominant roles than females. Perhaps you've noticed that many cartoon characters are male (think about the Road Runner and Scooby Doo). Shannon Davis (2003) content analyzed cartoons and found that major characters were more likely to be male, and they were more likely to be depicted in an occupational setting. Lots of central characters in popular movies for kids are typically male (think *Harry Potter* and *Star Wars*). So, the next time someone tries to tell you that our society is now gender-neutral, you can tell them to spend a Saturday morning watching television or to go to a kid's movie.

A second perspective on development is offered by Jean Baker Miller of the Stone Center at Wellesley College. The Stone Center is known for its studies of women's issues and feminist intervention. Miller (1991) proposed a model of feminine development that could be loosely called "self-in-relation." Although initially developed to explain the experiences of girls and women, the model has been broadened to include all human experience (Jordan & Hartling, 2002). Both boys and girls first develop a sense of self that is tied to relationships because parents (most likely mothers) are continually attending to the infant's well-being. The infant learns to attend to the caretaker's emotional state, but the link of relationship to self largely disappears for boys as they develop because they are encouraged to become active and separate from mom. In contrast, girls are encouraged to maintain their focus on the feelings of others. The girl's sense of self-esteem thus becomes linked to maintaining relationships. Miller wrote about the Oedipal conflict in girls: "We may ask whether one reason that people, beginning with Freud, have had such trouble delineating this stage in girls is that it may not exist. There is no major crisis of 'cutting off' anything, and especially relationships" (1991; p. 18). However, at this

stage, girls likely get the message, based on cultural beliefs, that they should turn their relationship focus to men (check out the cartoon).

In adolescence, boys are encouraged to explore and expand their sense of self. Girls, however, are taught to contract their identities because achievement and sexuality are not acceptable. These natural strivings are diverted to relationships, so that a girl's sense of who she is and how she achieves is once again linked to relationships. Thus, Miller described very different paths to adult identity for men and women, which produce values and characteristics consistent with traditional roles.

Another perspective on female development is Feminist Identity Development Theory (FIDT; Downing & Roush, 1985; Moradi, et al., 2002). In this model, women are thought to traverse five stages in the journey to a feminist identity. It is important to note that women can recycle through the progression multiple times (Downing & Roush, 1985). The first stage is *passive acceptance*, in which women accept the status quo, not recognizing or denying oppression and discrimination. They tend to endorse traditional gender roles and gender-based (patriarchal) power structures.

Women move into the *revelation* stage, according to Downing and Roush, when they experience either positive feminist experiences (e.g., consciousness-raising groups) or adverse experiences that seem gender related (e.g., divorce, denial of a credit application). A primary characteristic of women in this stage of identity development is anger at the sexist society and at themselves for their participation in the system.

The third stage of FIDT is *embeddedness–emanation*, and it is composed of two phases. In the first phase, embeddedness, women tend to immerse themselves in women's culture, adopt feminist ideology wholesale, and become involved in very close relationships with female friends. However, because most women are involved with men on a daily, if not intimate, basis, they realize that uncritical adherence to feminist theory and the associated anger may not be the most productive stance to take. They move on to the emanation phase, becoming more relativistic and flexible, but are still tentative in their relationships with men.

Even more flexible perceptions of life are evident as women move into the *synthesis* stage. Their reactions to men are less "automatic," and they are more flexible in their evaluations of life events and therefore less likely to attribute sexism.

Few women reach the final stage of FIDT, *active commitment*. The hallmark of this stage is the energy devoted to eliminating all forms of oppression through social change action.

Chandra sees evidence of sex-role socialization in Susan's behavior, but also notes that some of her behavior is contrary to stereotypical norms. The angry outbursts, for example, are not within the traditional female role of being sweet and nice. On the other hand, low self-confidence, worries about abandonment, and loyalty to relationships (even "bad" ones) are embodiments of the stereotypically feminine woman. Chandra guesses that Susan's parents reinforced these behaviors as unwitting agents of the paternalitic society. In addition, the world in which Susan grew up is fraught with sexism and oppression. Susan complies to some extent with these pressures, feeling insecure and helpless. Occasionally, though, her anger comes through, and she acts in ways contrary to traditional roles. This behavior tends to get her in trouble with others, even the authorities. Susan may be in the passive acceptance or the revelation stage of feminist identity development, but she clearly is not in the embeddedness–emanation stage.

HEALTH AND DYSFUNCTION

An important aspect of the FT approach is its critique of traditional approaches to psychological-dysfunction and intervention (Ballou & Brown, 2002, Worrel & Remer, 2003). A powerful statement was offered by Phyllis Chesler in her classic book *Women and Madness* (1972):

> What we consider "madness," whether it appears in women or in men, is either the acting out of the devalued female role or the total or partial rejection of one's sex-role stereotype. Women who fully act out the conditioned female role are clinically viewed as "neurotic" or "psychotic." When and if they are hospitalized, it is for predominantly female behaviors such as "depression," "suicide attempts," "anxiety neuroses," "paranoia," or "promiscuity." Women who reject or are ambivalent about the female role frighten both themselves and society so much that their ostracism and self-destructiveness probably begin very early. Such women are also assured of a psychiatric label and, if they are hospitalized, it is for less "female" behaviors, such as "schizophrenia," "lesbianism," or "promiscuity." (p. 56)

FT theorists charge that society devalues traits and behaviors that are typically associated with women, labeling them as unhealthy in comparison to male-associated traits (Worell & Johnson, 2001). Thus, the standard of health resides in male qualities, such as independence, competition, assertiveness, objectivity, and activity (Chesler, 1972). Also, both Chesler and more recent FT writers recognize that gender is not the only influence on perception; qualities and behaviors stereotypically associated with women from nonwhite, non–middle-class backgrounds are deemed dysfunctional by traditional psychotherapeutic approaches. Generally, society views the problems of women as stemming from internal factors (i.e., something is wrong with her) rather than from social and cultural inequality (Worell & Johnson, 2001).

Traditional diagnostic categories, such as those found in the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*-IV-TR) are also the targets of FT criticism. Feminists see as problematic the assumption that every form of distress is abnormal, when in fact, it is often a normal response to the problems inherent in an oppressive society (Brown, 2000). For example, the proposed diagnosis masochistic personality disorder (a.k.a. self-defeating personality disorder) was rejected by feminists because many women in abusive relationships display the characteristics of this category. Pathologizing this behavior ignores the adaptive value of passive or pacifying behavior in abusive relationships (Enns, 2000). This disorder was eventually removed from the *DSM*-IV.

Equally reprehensible is the late luteal phase dysphoric disorder, which is also known as premenstrual dysphoric disorder. Critics contend that the patriarchal psychiatric community makes women's hormones a source of mental disorders while at the same time ignoring the influence of hormones on men (Tavris, 1993). Terry Kupers (1997) suggested that an analogous disorder in men be named pathological arrhythmicity (p. 345). Because of the controversy around premenstrual dysphoric disorder, it is included only in the appendix of *DSM*-IV, among disorders in need of further study (Ross, Frances, & Widiger, 1997). Others have provided critiques of the personality disorders, such as histrionic, dependent, and borderline personality disorders (Kaplan, 1983; Kupers, 1997; Walsh, 1997). An interesting perspective on the common label "codependent" is described in Box 12.3.

FT sees psychological distress, or "dis-ease," as a communication about unjust systems (Brabeck & Brown, 1997, p. 28). Symptoms are seen as normal responses to oppressive environmental conditions (Enns, 2004). They are signs of health and strength because they are attempts to resist patriarchy. Consequently, feminist therapists focus on clients' strengths, not dysfunction (Wyche & Rice, 1997). They see human behavior as resulting from a complex combination of factors, both internal (biological and psychological) and external to the person. The latter set of variables, the social context, is considered critical to understanding individual experience.

Box 12.3

Codependent, Female, or Simply Low Power?

Laura Brown and other feminists have critically examined a term we all seem to love to throw around, *codependent*. The term was coined in the late 1980s to recognize that alcoholics were part of a system, and that those around them, the codependents, shared some responsibility for the drinking behavior. By protecting the alcoholic from the consequences of his or her abuse, the codependent *enabled* the drinking behavior. Typically, the codependent was a white, middle-aged wife of a white male alcoholic. Based on this conceptualization, the focus of intervention became both the alcoholic's and codependent's behaviors. Since that time, the term has been used in a much broader way. Feminists have taken exception to this term. Here I present some of their views, based mostly on the writings of Laura Brown and Kay Leigh Hagan.

There are many definitions of codepencency, but most commonly, these definitions carry a common thread of descriptions of relationship dynamics of the codependent and significant others. Some of the characteristics offered are as follows:

1. Sacrificing one's needs for those of others
2. A sense of powerlessness
3. Gaining self-worth through being needed by others
4. Low self-esteem
5. Avoidance of conflict

The problem, according to Laura Brown (1994), is that no attempt is made to take social and cultural factors into account in understanding the "codependent's" behaviors. She

pointed out that women in a sexist society are awarded responsibility for taking care of the emotions of men, and that codependent behavior very much resembles the expected heterosexual female behavior. The woman's sense of failure in the relationship may indeed cause significant personal feelings of guilt and shame, but again, this dynamic is based on the cultural rules rather than on some defect in the individual. Also, this "diagnosis" is likely to be racist because the behaviors described are very typical for individuals in cultures of color.

Kay Hagan (1993) began her dissection of the term by linking codependency and family dysfunction. Dysfunctional families are characterized as oppressive; they have rigid rules, discourage honest expression of feelings, and emphasize perfection among the members. These qualities might logically result in low self-esteem and other characteristics associated with codependency. However, she noted, "Most American families might qualify as dysfunctional in that they practice similar oppressive rules whether or not a chemical addiction is present" (p. 31). Thus, codependency really becomes a convenient label for submissive roles inculcated by traditional Western family life. "The oppressive rules of the patriarchal family system train us to accept and expect the paradigm of dominance and subordination. Even the most benign of patriarchal families operates in a manner that cultivates the characteristics of *codependency*, a term that is much more acceptable than *internalized oppression*, which might encourage us to question authority or even to rock the boat" (p. 32; italics in original).

Another way of saying it is that behaviors labeled as codependent very much resemble those of individuals in low-power groups toward the powerful (Brown, 1994). The behavior of the subordinate group members will look like overattentiveness, mind-reading, enabling, and so forth. In reality, this approach is adaptive; it helps the individual survive because survival is dependent on the rules and desires of the powerful.

Nowadays, the term *codependent* is used very globally to describe anyone who seems dependent, or "addicted," to relationships. Unfortunately, Brown maintained, because of the description's resemblance to stereotypical female roles, thousands of women adopt the diagnosis. Sadly, the term has become a stigma associated with addiction and disease, when the set of behaviors it describes appear to be those that are adaptive for members of a low-power group. One can also see the use of this term as one more instance of blaming women (wives) for their partners' problems.

> Codependency is no accident, nor is it a disease or an individual character disorder afflicting us in a random manner, as popular self-help books and current therapeutic treatment would have us believe. A society of dominance trains the oppressed to be subordinate so that dominance may continue. For women this conditioning begins when we are born and extends throughout our lives via our family models, the images we see in the media, and interactions with institutions infused with male dominance. When we do not recognize the relationship codependency has to the culture, we risk falling prey to another aspect of our training in which we accept personal responsibility and blame for having somehow developed "unhealthy intimacy patterns." In a culture of dominance, the oppressed is always at fault.

From Kay L. Hagan [1993], *Fugitive Information: Essays from a Feminist Hothead*, p. 34. New York: HarperCollins. Reprinted with permission of the author.

For example, depression is diagnosed more often in women than in men. Yoder (2003) pointed to several possible explanations for this finding, all of which are linked with low self-esteem. Is it possible that women get depressed more often than men because characteristics that are deemed typically female (e.g., orienting toward relationship, cooperating rather than competing) are devalued by society? Yet another explanation focuses on the discrimination women face. Achievement behaviors are typically less acceptable in women than in men. Think for a moment about an aggressive woman. Is she evaluated differently from a man labeled aggressive? The stress of maintaining multiple roles is also exacerbated for women. When was the last time you heard anyone ask whether a man could "have it all," meaning a successful career and family life?

Not surprisingly, FT theorists are also interested in the development of eating disorders, and have advanced several hypotheses about these types of behavior (Enns, 2004). For an individual client, a combination of these factors might be operative, which include the cultural pressure of the thin body as ideal, body control as a way to gain power from a powerless position, ways of coping with achievement-related anxiety, and remaining small to avoid threatening men.

The origins of the feminist movement lie in the establishment of battered women's shelters and rape crisis centers in the 1960s. Thus, feminist therapists are especially attentive to problems that are more likely to affect women than men and problems that are linked with patriarchal cultural norms, and particularly with physical, sexual, and emotional violence.

Susan appears to be experiencing some distress associated with the pressure to maintain traditional female roles and behaviors. Chandra will not use any formal diagnostic system to understand her presentation because she believes these to be androcentric. Instead of seeing Susan as "dysfunctional," Chandra sees Susan's strengths in expressing herself when treated badly by others (the guy in class) and in her persistent attempts to care for others. That Susan is pursuing a traditionally male-dominated career is not lost on Chandra, either.

Chandra wonders what effects Susan's experiences with her alcoholic father have had on her perceptions of the nature of women and men. Her struggles in relationships with men are probably connected in some way because she likely learned very early that men can't be trusted. Susan has been the object of both verbal and physical abuse by men, and the effects of these traumas cannot be ignored.

NATURE OF THERAPY

ASSESSMENT

FT counselors are unlikely to use formal assessment methods. In fact, radical feminist therapists would completely reject formal assessment and diagnostic systems, seeing them as rooted in the patriarchal system that controls access to services and reinforces hierarchical systems within society (Enns, 1995). Other FT counselors, most likely liberal feminists, might use traditional diagnosis if it is a means to provide services to their clients.

Judith Worell and Pam Remer (2003) point out that traditional approaches to diagnosis and assessment minimize the effects of environment and culture. Further, as noted

earlier, traditional approaches compare women's behavior to a male standard. Carolyn Enns (2000) gave the examples of "women have low self-esteem" as compared to "men are more conceited than women" (p. 619). Traditional approaches may also support the notion that differences between women and men are biological in nature. Just think for a minute about the popular book *Men Are from Mars, Women Are from Venus* (Gray, 1992). Not only are women and men unalterably different, but they are possibly different kinds of life forms!

Laura Brown (1993) proposed an alternative, a biopsychosocial model of distress, with emphasis on the social. This model emphasized the strengths of the client while also acknowledging the influences of culture, such as political forces and traditional social structures (e.g., heterosexuality, notions about "normal" families). As for traditional diagnosis, Brown (2006) contends that although *DSM*-IV labels are sometimes used by FT counselors, it is in the context of a much more detailed and broader approach that includes the factors above and an awareness of the therapists' own input into the process.

Chandra does no formal assessment or diagnosis with Susan. She sees these systems as confining and limiting, probably distorting the role of cultural norms in Susan's current distress.

Overview of the Therapeutic Atmosphere

Traditional approaches to psychotherapy are assumed to maintain the androcentric, patriarchal status quo by assisting women to "adjust" rather than to challenge stereotypes and oppression (Worell & Johnson, 2001). In Phyllis Chesler's words, "For most women the (middle-class-oriented) psychotherapeutic encounter is just one more instance of an unequal relationship, just one more opportunity to be rewarded for expressing distress and to be 'helped' by being (expertly) dominated" (1972, p. 108).

Marecek and Kravetz (1998) suggested that, in fact, the feminist therapist is really in a dilemma because she is supporting an enterprise that focuses on the self apart from history and culture, assumes free choice, and assumes that individualism is realistic and to be desired. Feminist therapists who see therapy as a patriarchal, class-bound system that simply perpetuates the status quo advocate consciousness-raising groups and social action instead of traditional psychotherapy (Enns, 1995). Laura Brown (1994), on the other hand, carefully considered the merger of feminist politics and therapy and concluded that feminist therapy is not an oxymoron.

Some FT counselors argue that therapy is best done in groups because this approach minimizes power differentials between therapist and clients (Enns, 1995). Worell and Remer (2003) add that groups allow women to become empowered through helping heal each other and collectively engaging in efforts to promote social change.

Chandra has given a great deal of thought to the feasibility of feminist therapy. She has examined her own beliefs about what counseling is about, and blends an empowerment approach with a relational one. She seeks to help Susan accept her "feminine" tendencies, while at the same time accepting her own power as a person.

Roles of Client and Counselor

One thing all FT theorists agree on: the promotion of an egalitarian relationship between therapist and client is essential to FT. Because of the therapist's professional qualifications, an inherent power imbalance in therapy is assumed; the counselor must acknowledge this imbalance and discuss it with the client (Enns, 2004). That the counselor determines the time and place of meetings and that clients pay counselors for their time means that *egalitarian* does not mean *totally equal.* At the same time, the client and counselor are assumed to be equally expert (Enns, 2004; Gilbert, 1980). The client is an expert on herself, and the therapist owns her professional knowledge and expertise. The therapist's power is temporary and lies in knowledge of the change process and assisting client empowerment (Brown, 2000).

Brown (2000) pointed out that "the empowerment of the client, is not, after all, the disempowerment of the therapist" (p. 372). She suggested that one of the ways in which feminist therapists use power is to remind clients of their own power. Also, feminist therapists see power in the ability to nurture and care and to listen calmly to the terrifyingly painful stories of their clients (Brown, 2000).

Part of the client's power stems from her willingness to enter the therapy relationship. Acknowledging this temporary form of dependency represents resistance to the patriarchal dictate that dependency needs be expressed only indirectly or in socially sanctioned ways (Brown, 2000). Further, the client is seen as possessing unique knowledge of herself (Enns, 1995). Feminist therapists emphasize that the client has the power to define herself within a personal and cultural context (Brown, 2000).

Chandra discloses her own sense of power to Susan, saying that she will do her best to help Susan find her own way in life. Emphasizing Susan's strengths and struggles, Chandra lets her know that she respects Susan's willingness to come for help. Chandra also lets Susan know that she (Susan) is the expert on her life and that she expects Susan to contribute this expertise to the counseling process.

Goals

The most important objective of FT is simple: to empower clients (Gilbert & Rader, 2007). FT counselors work to help clients accept their personal power in life and to teach them the difference between power within and coercive power, or power over others (Enns, 2007). They do not encourage the client to adjust to circumstances, unless the client has carefully explored her options and freely chooses to do so. Thus, an important part of empowering the client is the therapist's acceptance of the client's goals. However, the therapist helps the client explore a wide range of life possibilities.

Laura Brown (2000) offered a more radical view when she argued that "each act of feminist therapy must have as a goal the uncovering of the presence of the patriarchy as a source of distress, in order to name, undermine, resist, and subvert such oppressive influences" (p. 367). Woman of color feminists see the development of *conscientizacao,* or critical consciousness, as the goal of counseling (Comas-Diaz, 1994). Increasing the client's awareness of colonization and accompanying internalized racism leads them to be aware of their

location in society and consciously criticize social norms and structures. They take action in the environment aimed at transformation.

Chandra is committed to helping Susan find her way in life and helping her recognize that she has the personal power to do so. Part of her task is to help Susan look at the forces in her life that both support and hinder her journey, particularly societal attitudes and structures that keep women and individuals of non-Caucasian cultures oppressed. These are Chandra's general goals; she also is very careful to discover what Susan's goals are, make these clear and concrete, and devise ways to reach them.

Susan wants to "get the world off her back." Chandra empathizes with Susan and supports Susan's goal.

PROCESS OF THERAPY

The principles of feminist therapy, as developed by the 1993 National Conference on Education and Training in Feminist Practice (Worell & Johnson, 1997) are shown in Box 12.2.

FT counselors believe that value-free counseling is impossible (Enns, 2004). Therefore, the FT counselor must be aware of her own values and beliefs, particularly those that involve sex, gender, race, and class. Yet another important realization is that we are embedded in a heterosexist culture (Enns, 2000). Some feminist therapists will directly communicate their feminist perspective to their clients; others hesitate to use the term *feminist* because of the stereotypes associated with it. Most important, however, is that the FT counselor not impose her value system on clients (Enns, 2004).

One important way the feminist therapist attempts to enhance equality and collaboration with her clients is to give the client information about FT counseling and request the client's informed consent (Enns, 2000). The *therapy contract* was developed first by feminist therapists and has since been widely adopted by adherents of other theoretical orientations (Brown, 1994). Contracting involves the client and therapist in a collaborative process of determining the goals and pace of the counseling process. The FT counselor explains her approach to helping, the costs and benefits of counseling, the roles of client and counselor, and other features of the process that she deems relevant (Enns, 2004). These points, along with agreed-upon goals, may be put in writing or handled more informally.

One intent of informed consent and contracting is to *demystify* the therapeutic process. To make the FT process accessible to the client, FT counselors avoid jargon. Another way to demystify the therapy process is the careful use of self-disclosure on the part of the therapist (Wyche & Rice, 1997). Such disclosure is meant to emphasize the shared experiences of client and counselor, and of all women and to equalize power in the relationship (Worell & Remer, 2003). However, the counselor must be careful not to discount the very significant effects of other factors associated with oppression, such as race, sexual identity, and ableness.

In FT, resistance is defined as the person's healthy attempt to defeat oppression (Brabeck & Brown, 1997). In fact, Laura Brown (1994) endorsed teaching clients resistance to the patriarchy as one aspect of FT. Client feelings about or reactions to the therapist and therapy are not typically labeled as "transference" and considered problematic. Instead, FT counselors welcome client feedback about the process, and especially,

expressions of anger because women are taught to supress such expression (Worell and Remer, 2003).

The question often arises whether men can be feminist therapists, and if FT is appropriate for men. Box 12.4 presents a perspective on this question. Radical feminists would answer emphatically no! In 1994, Laura Brown, for example, suggested that although men could not truly be feminist therapists, they could be profeminist and antisexist in their approaches to counseling. However, she has since come to see this position as "essentialist and problematic" (Brown, 2006, p. 20). She now asserts that "if one can think as a feminist, think about gender, power, and social location, and if gender is socially constructed, then neither the biology or the gender of the person thinking like a feminist in the therapist position ought to matter" (p. 20). Espin (1994) argued that the best therapy for women of color is "ethno-specific," which means that the therapist is of the same ethnic or racial background as the client (p. 275).

Chandra and Susan develop a therapy contract, in writing, which specifies the goals that they have jointly developed. The contract is written in everyday language and includes the following agreements and goals:

1. *Susan and Chandra will actively work toward a useful therapy relationship with input from both parties.*
2. *The role of social and political factors in Susan's distress will be explored.*
3. *Susan and Chandra will explore Susan's thoughts and feelings about relationships, with the goal of helping Susan assume her own power in relationships so that her rights are not violated.*
4. *Susan and Chandra will explore the sources of Susan's anger, with special attention to its roots in social structures, attitudes, or practices that contribute to it.*

Box 12.4

Can Men be Feminist Therapists?

At first glance, the terms *feminist* and *male* seem to be contradictory. However, recent discussions of feminist therapy suggest that men, too, can adopt feminist perspectives that inform their counseling behaviors.

Szymanski, Baird, and Kornman (2002) decided to find out what these feminist male therapists were like. They surveyed 91 male counselors, finding that 18 of these counselors self-identified as feminists. They found that feminist male counselors differed from nonfeminist counselors on attitudes toward the women's movement and gender-role attitudes. They also endorsed counseling behaviors associated with feminist therapy. Self-identified feminist male counselors were more liberal in their gender-role attitudes, more positive toward the women's movement, and more likely to endorse therapy interventions such as establishing egalitarian relationships with clients and emphasizing the social construction of gender. Basically, these male therapists looked very much like female feminist therapists!

THERAPEUTIC TECHNIQUES

FT has few unique techniques. Any technique or approach is acceptable if it is used in a gender-fair way (Enns, 1995). Some therapists adopt and modify traditional counseling theories to fit feminist principles. Thus, there are psychodynamic, Jungian, and cognitive-behavioral approaches to FT (Enns, 1995). In this section I present several techniques that are the most closely identified with FT.

Gender-Role Analysis

Gender-role analysis is practically synonymous with FT. Clients are supported in a personal examination of cultural rules about female and male behavior and how these relate to client distress (Worell & Remer, 2003). Socialization processes are discussed in terms of how they relate to the client's current behaviors in the interest of detoxifying them. For example, what might be labeled "dependent" behavior can be construed as behavior that is powerfully reinforced by our society as being appropriate to the female role (Philpot, Brooks, Lusterman, & Nutt, 1997). The client is helped to understand the origins of her behaviors in social norms and oppressive environments, and the possible consequences of changing them (Enns, 2004).

Chandra is very interested in Susan's belief that she has trouble letting go of relationships. She guides Susan through an analysis of this characterization and its potential roots in an exaggeration of traditional sex roles that are reinforced by the dominant culture. Chandra and Susan also explore the values of Susan's adoptive mother, who was raised in a very traditional society. How these influences shaped Susan's view of herself and her behavior are examined in an attempt to depathologize Susan's behavior and move the locus of the problem to the political realm.

Self-Disclosure

Another approach to equalizing power imbalances in FT is for the therapist to use self-disclosure (Enns, 2004). Wyche and Rice (1997) suggested that there is no current consensus on the use of this technique. As noted earlier, therapist self-disclosure is helpful in demystifying the counseling process and in emphasizing the shared experiences of women. Any self-disclosure by the therapist must be in the interests of the client rather than to satisfy any need of the therapist (Wyche & Rice, 1997).

Chandra considers whether disclosure on her part would be helpful to Susan. She decides that because Susan doesn't seem to have a sense of community with other women, some disclosure is appropriate. Briefly, Chandra speaks of her struggles with autonomy in a world that gives power to males. Susan reacts positively to this disclosure and goes on to a productive examination of her own experiences.

Assertiveness Training

Popular in the 1970s, assertiveness training teaches the pursuit of one's rights without violating the rights of others (Jakubowski, 1977a). Assertiveness is distinguished from

aggression, which involves the violation of others' rights, and nonassertiveness, which is allowing one's own rights to be violated. Patricia Jakubowski, a well-known writer in this area, commented that assertiveness "is a direct, honest, and appropriate expression of one's thoughts, feelings, and beliefs" (1977a, p. 147). Respect for self and other is an important element of assertive behavior. You might have noticed that nonassertive behavior fits the stereotypical female behaviors such as putting the needs of others first, withholding opinions, and "being nice."

Assertiveness training was developed to teach women to abandon their culturally approved nonassertive behaviors. Most often, assertiveness training was conducted in groups (and typically, women-only groups), although it can be used in individual counseling as well. Jakubowski (1977b) identified four components of assertiveness training: (a) teaching the distinctions among assertive, nonassertive, and aggressive behavior and helping clients observe their own behaviors; (b) teaching clients a philosophy that respects individual rights and supports assertive behavior; (c) removing or reducing the salience of factors that inhibit assertive behavior; and (d) teaching assertive skills through practice (p. 169). A combination of teaching and group discussion is used to teach clients the differences among assertive, aggressive, and nonassertive behavior as well as to promote basic assertive philosophy. Many Behavior Therapy techniques are used in assertiveness training, including role-playing and self-observation. Systematic desensitization is sometimes used to reduce the anxiety around the new behaviors (Jakubowski, 1977b).

Chandra decides to work with Susan on increasing her assertive behavior and decreasing the angry, aggressive behavior that she occasionally displays. However, Chandra is very aware that Susan's anger is a form of strength and stems from her resistance to confining societal norms. For this reason, Chandra does not want to take Susan's anger away; it is a valid and healthy emotion. Susan and Chandra role-play situations in which Susan is likely to be nonassertive as well as those in which she is prone to anger.

EVALUATION OF THE THEORY

Criticisms of FT come from both within and outside of the women's movement. Most of you are probably familiar with the so-called backlash against feminism: feminists are man-haters engaged in male bashing. FT can also be criticized for being a political stance rather than a theory of therapy. The diversity of views within FT leads to the charge that it is not clear what FT actually is, beyond a set of beliefs.

Radical feminists reject FT because *any* kind of therapy is a tool of the patriarchal, oppressive society (Chesler, 1972). Cultural feminists charge that FT is based on the experiences of white, middle-class women and therefore neglects discrimination and disempowerment based on race, social class, sexual orientation, and other factors (Alleyne, 1998).

Sharon Baron Spiegel (1979) questioned the usefulness of a special, separate set of principles for counseling women. Arguing that such an approach was not yet justified empirically, she pointed out that other client characteristics could be more important than gender (e.g., social class). Developing separate sets of principles for the various groupings of clients could prove divisive to the profession of counseling, according to Spiegel. Also, nonsexist values and knowledge about women's experience is important for

men, too. Spiegel advocated a generalist model for counseling that adopts nonsexist values, but that does not replace one set of biases with another.

Qualities of the Theory

Precision and Testability. FT is not very testable in terms of a theory of human behavior. It does rely on volumes of research on sex roles and gender issues, however. Aspects of FT can and have been operationalized, such as assertiveness training, gender-role analysis, and therapist self-disclosure. However, some of these activities are not unique to FT.

Empirical Validity. Outcome research on FT as a counseling approach is sparse. The basic tenets of the approach, such as sex-role issues and socialization, are empirically supported.

Research Support

Very little research has been conducted on the actual practice or outcome of FT. Because of its philosophical basis and tendency to be technically eclectic, it is difficult for proponents to agree upon what exactly constitutes the theory of FT. This situation, of course, is a major factor in the lack of research bearing directly on the theory and practice of FT (Murray, 2006). For these reasons, I will present a broad selection of research relevant to the FT approach, and in doing so, will dispense with my usual distinction between outcome and theory-testing research.

Some of its proponents would argue that FT is not unique—it is simply good therapy (Worell & Johnson, 2001). Nonetheless, Worell and Johnson maintained that FT is an identifiable approach, basing their arguments on a series of survey studies of therapists and clients. Using an instrument called the Therapy with Women Scale (based on the principles in Box 12.2), differences in philosophy and goals can be documented between feminist and nonfeminist therapists (Worell & Johnson, 2001). Important factors underlying these differences were (a) affirming the client, (b) women-centered activism, (c) the use of self-disclosure, (d) adopting a gender-role perspective, and (e) an egalitarian stance. In contrast, Andrea Chester and Diane Bretherton (2001) found less agreement about the essential elements of FT in their sample of Australian feminist therapists. In their research, the largest area of agreement was that FT involved woman-centered concerns (e.g., sociopolitical analysis of problems, understanding sex-role stereotypes, critique of the patriarchy), with 85% of their sample listing these issues as essential to FT.

Looking at client perceptions, Gail Hackett and Carolyn Enns (Enns & Hackett, 1990; Hackett, Enns, & Zetzer, 1992) demonstrated that feminist therapists are perceived positively by samples of college students. In Enns and Hackett's (1990) study, college women who were either feminist or not viewed either liberal feminist, radical feminist, or humanistic-nonfeminist counselors on videotape. The researchers also varied the type of problem for which participants were judging the acceptability of the counselor. Somewhat surprisingly, Enns and Hackett found that all participants, regardless of attitudes, preferred the feminist counselors to the nonfeminist counselors when career decision making, sexual harassment, or assault was the issue. Using a similar method, Hackett and colleagues varied the mode of presentation of the counselor (videotape or written materials) and found no effect of presentation. Overall, the liberal FT counselor was perceived more favorably

than nonsexist or radical FT counselors. Of course, the generalizability of the results of these studies beyond college women is risky.

Jill Rader and Lucia Albino Gilbert (2005) attempted to test whether counselors who identified as feminist exemplified their orientations in terms of egalitarianism, here defined as power sharing and collaboration. Forty-two female therapists were recruited, and 34 clients of these therapists participated as well (some of the clients recruited did not return their materials). Nineteen of the therapists identified themselves as feminists; interestingly, when clients were asked if their therapists were feminists, their identifications matched their therapists' about 50% of the time. The study confirmed the centrality of egalitarianism to FT: power sharing was reported more frequently by therapists identifying as feminist and also by the clients of these therapists, when compared to therapists who did not identify as feminist. Another interesting aspect of this study was that when all of the therapists were asked if they used the behaviors considered characteristic of FT (similar to those identified in Box 12.2), no differences were found between the groups of therapists, mainly because all of them reported that they consistently acted in those ways with their clients.

Some of the research that is relevant to FT focused on the effectiveness of consciousness-raising groups and assertiveness training. This research is dated and can be criticized on a number of methodological grounds (Enns, 1993). In one study of actual FT, Ronald Mancoske and colleagues (Mancoske, Standifer, & Cauley, 1994) produced somewhat disappointing results for advocates of FT. Groups of battered women were offered either grief counseling or feminist counseling (after crisis intervention). Clients in FT did not show statistically significant improvement, whereas the clients who underwent grief counseling did. However, this study used a very small sample of clients (20 per group), and two therapists (the study's authors) conducted all of the therapy groups. These factors (plus the lack of definition of the approaches) very likely limited the power of the study to find significant differences.

Studies of feminist identity development theory (FIDT) indirectly address FT because it is often used as the basis for thinking about women in counseling. Several measures of FIDT have been developed, but unfortunately, although some psychometric data on these scales are supportive, other data do not confirm the proposed stage structure built into the instruments (Moradi & Subich, 2002a). One study suggested that an often-used measure (the Feminist Identity Development Scale; Bargad & Hyde, 1991) produces a different factor structure when used with other than traditional white Caucasian female groups (Flores, Carfubba, & Good, 2006).

Given the measurement problems, then the results of studies of FIDT should be viewed cautiously. One study related to the feminist therapy behaviors of women psychotherapists (Juntunen, Atkinson, Reyes, & Gutierrez, 1994) found that revelation stage attitudes were the best predictor of whether a therapist self-identified as a feminist therapist. Further, therapists who had high scores on synthesis and revelation attitudes and low scores on passive acceptance endorsed more feminist therapy behaviors than did those with the opposite pattern.

Studies of feminist identity development and psychological distress have produced inconsistent results. For instance, Bonnie Moradi and Linda Mezydlo Subich (2002b) looked at the relationships among the stage of feminist identity development, experience with sexist events, and psychological symptoms. Passive acceptance attitudes, which these researchers conceptualized as evidence that the participant was denying the existence of sexism, were related to greater occurrence of symptoms given the occurrence of sexist

events over the past year. Natalie Sabik and Tracy Tylka (2006) also examined the relations between FIDT and perceived sexist events, but they were interested in dysfunctional eating patterns. Only Synthesis and Active Commitment attitudes predicted problematic eating (that is, women lower on these scales tended to score high on disordered eating), and these attitudes explained some of the relationship between experiencing sexist events and the eating issues. Ann Fischer and Glen Good studied FIDT, anger, and psychological symptoms, and found that only the identity stage of Revelation related to symptoms. Anger was associated with Revelation attitudes but not with the other FIDT stages, and except for Revelation, did not explain the relationship between FIDT and distress, contrary to Fischer and Good's expectations. However, the authors noted that the anger measured was general, not specific to the patriarchy or other relevant targets. Kendra Saunders and Susan Kashubeck-West (2006) found that feminist identity was related to self-reported psychological well-being: Active Commitment positively, and Revelation negatively. That is, women who scored higher on Active Commitment reported higher levels of well-being than women lower on this dimension and women higher on Revelation reported lower levels of psychological well-being compared to women lower on Revelation attitudes.

In a study that bears on feminist identity and intervention, Rachel Peterson and colleagues tested whether teaching female college students feminist views on body image could affect their levels of body satisfaction and feminist identity (Peterson, Tantleff-Dunn, & Bedwell, 2005). Participants were pre- and posttested, and then exposed to a 15-minute audiotape of traditional psychoeducation about body image, a feminist intervention, or no intervention. No effects of treatment were observed on body image dissatisfaction but the feminist intervention did appear to create change in satisfaction with appearance (without going into tedious detail, these two measures were different in content and form). Although participants showed increased self-identification as feminists when compared to the other two groups, only one effect of intervention was observed for feminist identity: contrary to hypothesis, participants in the feminist intervention group decreased in their Active Commitment scores. Peterson et al. speculated that simply completing the FIDT may have made them realize how inactive they really were, thus causing a decline in the scores at posttest.

Before you read the next paragraph, look at Box 12.5.

Much research has focused on whether counselors are sexist. The "grandmother" of this line of investigation was a study conducted by Inge Broverman and her colleagues (Broverman, Broverman, Clarkson, Rosenkrantz, & Vogel, 1970). They asked practicing therapists to describe a healthy man, a healthy woman, and a healthy person, sex unspecified. To the horror of many, they found that the qualities of the healthy person most resembled the qualities of the healthy male. Healthy women were rated lower on qualities such as independence, adventurousness, aggression, and competitiveness than were men. In addition, healthy women were seen as easier to influence, more excitable, and submissive in comparison to men. As you might guess, this study incited great controversy.

Broverman and colleagues' study has been criticized for a number of reasons (Phillips & Gilroy, 1985; Widiger & Settle, 1987). On a most basic level, the study could be faulted because the counselor participants were rating hypothetical individuals, not responding to a "real" client. Also, Widiger and Settle (1987) provided convincing evidence that the findings of Broverman and colleagues could be almost entirely attributed to characteristics of

Box 12.5

Consider the following adjectives:

Independent

Assertive

Strong

Confident

Do these words describe a male or a female? Are they healthy qualities or not? Here are some more words to consider:

Passive

Easily excited by minor events

Dependent

Cautious

Ask yourself what picture came to mind as you read these words.

These are some of the adjectives presented in the famous study of sexism among counselors conducted by Broverman, Broverman, Clarkson, Rosenkrantz, and Vogel in 1970.

the method used. Subsequent studies have been inconsistent in their findings, and are now somewhat dated. Since *overt* sexism in society is thought to be decreasing (Campbell, Shellenberg, & Senn, 1997), it would seem that counselors would be unlikely to respond in sexist ways to research stimuli. Whether this evenhandedness is a result of a true change in attitudes or "underground sexism" is up for debate. Also, a few studies have suggested that sexism may still exist among therapists (Fowers, Applegate, Tredinnick, & Slusher, 1996; Turner & Turner, 1991).

ISSUES OF INDIVIDUAL AND CULTURAL DIVERSITY

It would seem obvious that FT is a good approach to use with women. However, some radical feminists would object to using a liberal FT approach because they would see it as upholding the patriarchal status quo. A major bedrock of early FT, assertiveness training, for example, has been criticized as based on a model that views stereotypically female behavior as deficient (Fodor, 1985).

FT is grounded in sensitivity to oppression, so it can be considered to be very appropriate for use with individuals from diverse backgrounds. Earlier versions of FT, based on White, middle-class experience, have been accused of racism, but contemporary feminist therapists recognize the influence of other important dimensions on the experiences of women, such as class, age, ableness, sexual orientation, and race/ethnicity (Brown, Riepe, & Coffey, 2005). Feminism recognizes the heteropatriarchy, and lesbian feminism is an alternative for women who are lesbian. Indeed, feminist scholars have

always attended to issues relevant in theory and practice with lesbian and bisexual women (Brown et al., 2005). Increasing attention to issues of diversity have resulted in explorations of the implication of feminism for African American (Williams, 2005), Latina (Lijtmaer, 1998), biracial (Nishimura, 2004), and Japanese (Matsuyuki, 1998) clients, among others. However, some critics of FT continue to remind us of the White female bias present in FT (Espin, 1993).

The question always arises about the appropriateness of FT for male clients. Some feminist therapists argue that it is very helpful for men to examine the social aspects of their existence, particularly for the privileged White male. These types of concerns, along with the recognition that men experience significant gender-role conflict, have prompted the development of gender-aware or gender-sensitive therapy (Good, Gilbert, & Scher, 1990; Philpot et al., 1997). These approaches integrate feminist principles with a broad examination of gender. Men in gender-aware therapy are encouraged to explore the ramifications of traditional male roles, develop stronger interpersonal skills, and decrease their emphasis on career and work aspects of identity.

THE CASE STUDY

Susan seems to be an ideal client for FT. She is engaged in the pursuit of a traditionally male-dominated career. However, the adoption of this career goal may be partly a result of the norm of Asian culture that values scholastic achievement above all. Susan reports relationship difficulties that seem to involve both extreme expressions of femininity and violations of the cultural norms that women should not be angry or aggressive. These characteristics would predict a good fit with FT. She has also been the victim of abuse, an injustice that lies at the heart of the feminist movement.

Susan's Asian heritage raises questions about applying FT. If her adoptive mother heavily reinforced the "proper" characteristics of women in the Asian culture, ignoring this influence would be a serious mistake. The goals of empowerment and liberation may be in conflict with Susan's culturally linked values. However, in other ways, Susan seems to be fairly acculturated to the United States, if the adoption of her nontraditional career goal is any indication.

Summary

Feminist therapy is more of a philosophical approach to working with clients than a defined theoretical structure. Feminist therapists are attentive to the norms of society that confer power and status on men and oppress women. The social pressure to conform to stereotypical notions of what it means to be a man or woman are seen as important influences on how people behave. Feminist therapists also recognize the effects of social class, race/ethnicity, ableness, and sexual orientation on individuals' lives; individuals who are not of the "majority" on these dimensions are subject to oppression by society.

FT counselors believe that the personal is political and that women's (and other oppressed groups') struggles are the result of societal structures and norms that are disparaging of women and celebratory of men. The norm for "healthy person" is based on stereotypically male qualities (e.g., rational, independent, and so forth), whereas traditionally female qualities are seen as less valuable (e.g., emotionality and connectedness).

Women are damned if they do and damned if they don't—social penalties are imposed for expressions of female traits and masculine traits by women.

Feminist therapists approach counseling with an egalitarian attitude, recognizing that true equality will not exist in the therapy relationship. They attempt to recognize and minimize power imbalances in therapy by forming therapy contracts and demystifying the therapy process. The goal of FT is empowering the client so that she can achieve her life goals. Few techniques are specific to FT, although one very closely tied to this approach is the analysis of social roles.

FT has been criticized for being anti-male and for being a political stance rather than a theoretical system. Radical feminists may totally disagree with doing FT at all. Because of the emphasis within FT on societal power imbalances and oppression, it is likely to be a valuable approach for individuals who are of diverse backgrounds.

Visit Chapter 12 on the Companion Website at **www.prenhall.com/murdock** for chapter-specific resources and self-assessments.

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