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ABSTRACT

This paper reviews the current status of psychotherapy for women from a feminist perspective. It examines the sexist prejudices and biases of traditional psychotherapies and psychological approaches; notes the manners in which therapy has often tended to reinforce the traditional sex role stereotyping and the women's consequent negative self image; explores available corrective theories that would lessen sexist bias; examines possible models of feminist therapies; and places the latter in the broader framework of psychological and Psychotherapeutic theories. The author also relates to emerging alternative support systems increasingly available to women; examples such as crisis counseling, consciousness-raising groups, etc. are also discussed. The author provides an extensive bibliography on methods, research and practices of psychotherapy with regard to women. (NG)

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DIMENSIONS OF FEMINIST THERAPY¹

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Running head: Feminist therapy

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Dimensions of Feminist Therapy

The Women's Liberation Movement has generated continuing examination of the effects of sex-role norms and cultural prescriptions on women's psychological well-being. Freidan's (1963) classic study of middle-class wives strongly suggested that narrowly-defined marital roles produced unhappiness, lowered self-image, and self-defeating behavior among the women in her sample.

Other writers have indicted the mental health profession for its part in perpetuating a view of womanhood that barred many women from personal fulfillment. In particular, psychoanalysis was criticized for its emphasis on women's "innate" passivity and dependency and its belief that motherhood is the only completely-fulfilling role for women (e.g., Gilman, 1971; Miller, 1973). Other clinical theories of personality were examined in light of changing feminine sex-role requirements and found to be outmoded (e.g., see Hertzberg & Lee, 1976). The practice as well as the theory of clinical psychology came under the scrutiny of feminists newly sensitized to subtle forms of sex bias. Studies of psychotherapists (e.g., Broverman, Broverman, Clarkson, Rosenkrantz & Vogel, 1970; Fabrikant, 1974; Nowacki & Poe, 1973) demonstrated sex bias in therapists' diagnostic evaluations and definitions of mental health. The Task Force on Sex Bias and Sex Role Stereotyping in Psychotherapy sponsored by the American Psychological Association (Asher, 1975) collected anecdotes suggesting that the sexual seduction of women clients² by male therapists is not a rare occurrence. The sex bias in the practice of psychotherapy reflects not only the biases embedded in clinical personality theories but also those apparent in the professional literature (Prather & Fidell, 1972; Seidenberg, 1971). Sex bias in the mental health profession is pervasive, firmly-entrenched, and, probably, largely unrecognized by many practitioners.

The evidence of sex bias in clinical theory and practice prompted feminist

researchers and practitioners to seek change on many dimensions within the field. The key areas of feminist activity include 1) corrective theories of psychological health and disorder; 2) feminist psychotherapy; 3) alternative helping systems for women; 4) education and change in the mental health professions; and 5) popular education in the new psychology of women. Developments in each of these areas are discussed below.

Corrective theories of psychological health and disorder

Feminist psychologists have questioned theories of psychological adjustment and feminine personality that rely on women's biology for explanations of their feelings and behavior. In place of biology, feminists have emphasized women's socialization and the cultural values which determine the shape of that socialization. Recent biosocial research corroborates feminists' skepticism toward biological determinism. For instance, the work of John Money and Anke Ehrhardt (1972) on biological and social aspects of gender identity and sex-role behavior supports the position that human neonates are psychosexually neutral. Work by Mary Parlea (1973; 1974) contradicts the traditional belief that women's menstrual cycles have a determining effect on moods and behavior. Finally, the work of William Masters and Virginia Johnson (1966, 1975) supports feminists' contention that such labels as "immature" and "perverse" should not be applied to female sexual activity which does not fit psychoanalytic prescriptions.

Newly-emerging data from epidemiological and sociological studies demonstrate that women's social situations can play a determining role in their psychological well-being (Bart, 1967, 1968; Chesler, 1972; Dohrenwend, 1973; Bernard, 1971; Marecek, 1976). These new data have profound implications for theories about the causes of psychological disorder and, consequently, for therapeutic goals and methods. The findings suggest that, in many instances, women's psychological disorders may be attributable to social conditions rather than psychic

factors. A loosening of female sex-role requirements, the elimination of institutional and interpersonal sexism, and the introduction of greater flexibility in marital and family roles would make social conditions more amenable to women's psychological health. With these changes, women may feel less depressed, frustrated and powerless and, hence, have less recourse to psychotherapy.

The new consciousness about women has also generated research on topics heretofore overlooked. An example of such research is the study of single parents' experiences carried out by the Women's Research Center of Boston (Brandwein, Brown & Fox, 1974). Such new studies provide data on modern women's experience, interpreted within a non-sex-biased perspective. Such evidence is a useful antidote to the myths about women that appear in the classic personality and psychotherapy literature.

Feminist therapy

The major contribution that feminists have made to clinical psychology is in the practice of psychotherapy. Realizing that psychotherapy training generally confirms traditional sex-role values and assumptions, feminist practitioners grew concerned about psychotherapists' interactions with their women clients. Therapists who are not aware of their own sex bias may systematically limit their clients' choice of work and family roles, interpersonal relationships, and personality styles.

All therapists enter the therapeutic relationship with a view of reality based on their personal experiences. This view of reality provides them with a system of assumptions and values. Beliefs about sex-roles comprise part of this assumptive system. These beliefs are often not articulated because they are deeply engrained and so widely shared that they are seldom challenged. Interactions with clients are interpreted and evaluated within this assumptive system. Despite advice to the contrary, it is highly unlikely that an assumptive system could be set aside in the therapy situation. Furthermore, it is not

clear that such a suspension of values would improve the quality of therapy.

A more sound course of action might be that therapists identify their assumptive systems insofar as they can and inform clients when those values and beliefs seem to be influencing the therapeutic process.

The defining characteristic of feminist therapy is the shared assumptive system of feminist practitioners, not the form of the therapy they practice. Feminist therapists work within any of a number of schools of psychotherapy, including the humanistic therapies, behavioral therapies, and psychodynamic therapies. However, they share the following principles:

1) Judgments about clients' needs, wishes, capacities and goals must rest on an understanding of the individual, not on traditional sex-role requirements. It should be mentioned that this principle is not limited only to therapy with women, but is equally relevant to men. In fact, masculine sex-role requirements may permit men even less latitude than is granted to women.

2) Therapists should become sensitized to the powerful effects that the sexist culture has on the feelings and beliefs of women. Therapy should question women's negative attitudes about themselves and expand the range of options that they open to themselves.

3) Therapists should recognize that women's relative lack of power can generate feelings of passivity, dependency and submissiveness. In light of this, therapies which define the client's role as active and autonomous will be more helpful to women.

4) Feminist therapists must foster an awareness of the differences in the socialization and life experiences of women and men. Even if they are in similar social situations, women may have very different self-images, aspirations and personal preferences than men. Therapists who ignore these critical differences in order to be "nonsexist" will have a very limited understanding of their clients.

Methods of therapy. By way of putting feminist principles into practice, feminist therapists have experimented with new techniques of therapeutic intervention. The implementation of new therapeutic techniques is still at an early stage. However, such developments promise to be important contributions to the field of psychotherapy as a whole.

Feminist therapists frequently use therapeutic techniques which equalize the power and responsibility shared by client and therapist. By so doing, they hope to counter the prevailing view that the therapist should have authority and control over the therapeutic relationship. Therapists' expertise in the area of human behavior and emotions is acknowledged, but it is not regarded as grounds for asserting power over clients. In contrast to those systems of therapy which encourage fantasies of the therapists' omnipotence, feminist therapists encourage clients' autonomy and self-determination by providing an active and assertive role for them in treatment. One way of equalizing the balance of power in therapy interactions is the contract system. At the outset of therapy, a contract is negotiated between therapist and client. The contract specifies the needs, goals and responsibilities of both parties and may include a timetable stating when commitments will be met. The discussions preceding the contractual agreement and the implementation of the terms of the contract facilitate clients in assuming an autonomous, active stance in the treatment relationship.

Another way of equalizing power relations between client and therapist is giving clients access to their files and records. Therapists who use this strategy share written information—including diagnostic reports, progress notes and evaluations—with the client. Sometimes, the client may be responsible for writing portions of this documentation. The use of open files can foster honest communications between therapist and client and emphasize the sharing of responsibility between them.

A third mechanism for equalizing the client-therapist balance of power is through group therapy. In the group setting, therapists can de-emphasize their leadership posture and encourage group members to take responsibility for several functions usually undertaken by the therapist.

Limits of feminist therapy. The principles and practices of feminist therapy should lead to more successful treatment experiences for many modern women. However, like any other psychotherapy, feminist therapy is not a panacea for all behavioral and psychological disorders. In addition, feminism is not a sufficient criterion of a therapist's competence. Finally, psychotherapy is not the appropriate mode of intervention for problems which have their basis in the social structure.

Psychological disorders which have physiological or biochemical components cannot be cured by psychotherapy alone. These disorders include schizophrenia, manic-depressive illness and disorders due to neurological damage. In such cases, psychotherapy within a feminist perspective will be beneficial only when it is part of a comprehensive treatment program which is aimed at biological as well as psychological change. Here, feminist therapy may help women regain their self-esteem and find a lifestyle in which psychological stress is minimized. In addition, feminist therapy can support a woman whose personal relationships have been upset by her psychological problems.

A feminist perspective does not replace a therapist's education in psychopathology and human relations. Therapy is a process of growth and change. The therapist's tasks include clarifying and interpreting the client's experiences; making judgments about the origins--biological, psychological or social--of the client's problems; and helping the client plan changes in lifestyle and behavior. While a feminist perspective may enhance the therapist's performance, it cannot supplant knowledge of the social sciences and training in therapy process.

What is the value of feminist therapy in a world that remains highly sexist? Serious critiques of feminist therapy are offered by those who believe that women's social condition breeds their psychological disorders (Bart, 1974; Chesler, 1972). Changes in the social structure are needed to eliminate psychological disorders; therefore, individual psychotherapy is viewed as a diversion of energy from appropriate goals.

These arguments against psychotherapy take a shortsighted view. If women's psychological problems are due to their cultural roles, then the effect of these roles is mediated by their internalization. To the extent that women internalize negative attitudes about their capabilities and personalities, self-destructive behavior need not be prompted by external pressures; but can also be internally generated. Feminist therapy helps women identify their own sexism and that of society. In making women aware of personal and societal sexism, therapy can raise their desire to eliminate it. By providing women with the tools for self-directed and assertive behavior, feminist therapy can lead women to actively combat sexism. Feminist therapy hastens rather than retards social change.

Some critics of feminist therapy have complained that the term "feminist therapy" is defined so loosely that it has little meaning. The feminist movement covers a broad spectrum of ideas, values and beliefs. Consequently, feminist therapists may disagree with one another's ideology. Feminist therapists are as aware of this diversity as others. Some advocate formal screening and evaluation of prospective feminist therapists. However, unanimity of viewpoint is not necessarily desirable. Diversity stimulates new ideas and continuing dialogue. Furthermore, it offers a greater range of treatment options to the client.

Alternative helping systems for women. The new psychology of women favors societal and cultural explanations for psychological disorders over personal causation. It follows from this that helping systems emphasizing socio-cultural pressures

would be devised as alternatives to individual psychotherapy. These include self-help groups, consciousness-raising (CR) groups and awareness workshops.

These alternative helping systems differ from therapy in several ways. First, they focus less on the individual's behavior (as in traditional psychotherapy); instead they analyze behavior as a product of women's self-images and social roles. Second, the alternative helping systems are oriented toward personal growth rather than recovery. They are not meant for women with serious psychological disorders (such as psychoses). Finally, the alternative helping systems concentrate power among their members, not in the therapist. In many groups, there is no designated therapist or leader. Members join such groups to explore feminist issues with other women, to gain self-awareness through introspection about the group process, or to find mutual support. These alternative helping systems are often, informally constituted groups and have little contact with the mental health establishment. Thus, data concerning the number of women using these helping systems and their rate of satisfaction are scarce.³

Another group of alternative helping systems for women is designed to provide counseling and support during crises. These include rape crisis centers; counseling and referral centers for women with unwanted pregnancies; services for women in marital crisis or for victims of wife-abuse; and job counseling and placement agencies. Many of these services are affiliated with national or local women's organizations. Information about the use of these services is scant, although many agencies report waiting lists and new agencies are constantly being formed.

Because the budgets of these new services are stringently limited, systematic outcome research cannot be undertaken. However, anecdotal evidence suggests that many participants deem their experiences successful. The continued heavy usage of these services is an indirect corroboration of this. It is frequently observed that many users of these alternative systems come to them following an unsatis-

factory experience in traditional psychotherapy. If this proves true, these helping systems may provide models for revamping traditional psychiatric services at some future date.

Education and change in the mental health professions

The ultimate goal of feminist researchers and practitioners is not to develop a parallel system of services separate from the traditional system, but rather to change the traditional system. Because feminist therapy is new, an organized program of education is not yet formulated. Educational efforts to date include symposia presented at conventions (e.g., Marecek & Katz, 1973; Brodsky, 1974; Waskow, Mahon & Marecek, Johnson, Klein, Kravetz, Mc/ 1975); articles and essays in professional journals (cf. Cromwell, 1974); books (e.g., Franks & Burtle, 1974; Chesler, 1972); and workshops and conferences. Feminists who supervise therapy trainees report that a sensitivity to feminist issues can be incorporated into training sessions (Brodsky, 1973). A serious drawback of these educational strategies is that they are heeded primarily by "the converted" and dismissed by those at whom they are aimed. Resistance to feminist intervention may persist until evidence demonstrating the therapeutic advantages of feminist principles and approaches has accumulated.

Popular education

Compared to traditional psychotherapy, the feminist therapy movement is strongly client-oriented. Feminist therapists have written in the popular press on psychological disorders and psychotherapy. A special emphasis has been placed on choosing an evaluating a prospective therapist (Women in Transition, 1973; Krakauer, 1973). This emphasis runs counter to traditional practice, wherein the therapist evaluates the client's suitability for treatment. However, in light of the potential risk and costs therapy clients face, it seems wise to encourage them to take an active and cautious stance in initiating a therapeutic relationship.

Feminist therapists have also established a communications network for identifying themselves to one another and to clients. A national roster of feminist therapists is available from a feminist press (Brodsky, 1972) and many local women's organizations provide referral services. In addition, local women's groups may keep records of members' encounters with sexist or unethical therapists. In metropolitan areas, feminist therapists may work together in a collective practice and can be located through women's agencies.

Summary

The major activities of feminist therapy have been described. These lie in the areas of theory, research, practice and education. The most concentrated efforts have been in theory-building and in the practice of feminist therapy. Research activities and alternative helping systems have been growing, but progress in both has been limited by the scarcity of funds. Feminist projects have not been welcomed by national or local grants agencies. Prompting change in the mental health profession has been the most challenging goal of feminist therapy. However, as increasing numbers of women clients choose feminist therapy, other therapists are persuaded that they must examine their sex biases if they wish to earn a livelihood. In addition, evidence that feminist ideals make therapy better is gradually appearing. These developments will help counter therapists' resistance to change.

What lies in the future for feminist therapy? The political arena of the mental health profession is ripe for feminist activism. One political task is the elimination of sexism in mental asylums. This sexism includes extreme sex role stereotyping in the standards of behavior and appearance set for hospitalized women; sex bias in criteria for release and the terms of discharge (e.g., Taube, 1973); and heavier doses of medication for women than for men (e.g., Brink, 1972; Cooperstock, 1971). Reports of sexual molestation of female inpatients by male

aides and attendants are not infrequent. Feminist therapy cannot ignore the plight of women in mental hospitals. If the feminist therapy movement is to produce viable social change, it must address itself to all levels of the mental health system.

Another political task concerns the status of women in the mental health profession. Patterns of male ascendance are obvious throughout the mental health system. The power base in both psychology and psychiatry is male. Male professionals have access to administrative positions, community prestige and personal incomes which are unavailable to women. This state of affairs must be remedied if feminist goals are to be accomplished.

FOOTNOTES

1. Portions of this paper were presented in the symposium, Liberating psychotherapy: Changing perspectives and roles among women. American Psychological Association Convention, Montreal, August, 1973. Requests for copies should be addressed to the author at the Department of Psychology, Swarthmore College, Swarthmore, Pa. 19081.
2. The term "client" rather than "patient" is used to refer to consumers of psychotherapy. The term "patient" inappropriately implies sickness and helplessness. In addition, it suggests that the person in psychotherapy is the passive recipient of treatment rather than an active partner.
3. A nationwide study of CR groups, undertaken by Diane Kravetz and Morton Liberman is now in progress. Results of this survey not yet available.

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