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AN ABSTRACT OF THE THESIS OF Susan Amelia Thomas for the Master of
Social Work presented July 18, 1975.

Title: Moving Toward Integration: A Study of Theory and Practice in
Feminist Therapy

APPROVED BY MEMBERS OF THE THESIS COMMITTEE:

Lynn Thompson, Chairperson

Ann Clarkson

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Nancy Porter

This thesis describes a study designed to explore the emerging field of feminist therapy. The goal was not to test the validity of feminist therapy, to probe the assumptions on which it is based, or to compare it to other forms of therapy but to characterize the theory and practice of feminist therapy as it now exists. Feminist therapy was seen as growing out of the cultural and historical context of the feminist movement, which includes a critique of society with emphasis on the particular psychological consequences for women, and a critique of

psychotherapy, particularly Freudian psychotherapy, as oppressive to women and adhering to a double standard of mental health. The field of mental health responded to these criticisms, and feminism simultaneously began a search for alternatives to therapy. Out of both developed feminist therapy. The literature, both in the field and in the alternative press, was reviewed to present a picture of the development of feminist therapy and to highlight issues to pursue in the research itself. Following this review, a study was undertaken of feminist therapists in three metropolitan areas on the West Coast--Portland, Seattle, and the Bay Area--utilizing a qualitative methodology to gather descriptive data and potential patterns for analysis. A natural network approach was utilized to generate the population, following much the same process a woman would go through in locating a feminist therapist. Potential feminist therapists were surveyed via a questionnaire. Self-identification as a feminist therapist was the primary criteria for inclusion in the sample frame. A random sample of 20 percent of the sample frame (20 feminist therapists) was interviewed, and the results transcribed and thematically analyzed to answer five questions:

- 1) Who are the feminist therapists?
- 2) How do feminist therapists define feminism?
- 3) What is feminist therapy?
- 4) How does feminist therapy perceive and incorporate therapeutic issues?
- 5) How does feminist therapy perceive and incorporate feminist issues?

Analysis of the characterizing data obtained from the questionnaire found little difference among the three areas surveyed. Common themes of non-traditionality and non-institutionalization of theoretical orientations, modes and focuses of practice, practice settings, and

areas of specialization, were noted. Analysis of the interview data found that feminist therapists describe their identification with and awareness of feminism as a profound influence on their lives. They define feminism primarily as a belief system, encompassing what is called in the study a Feminist Critique of society and a Feminist Humanism. As feminist therapists define and describe feminist therapy, it is less a theoretical orientation than a belief system and a series of ways that belief system is put into practice. Feminist therapy is based on the feminist value or belief system, utilized as a filter, on particular changes in the therapy relationship and in the role of the therapist which enable the therapy process to become congruent with the value system, and on two processes--raising consciousness and emphasizing the commonality of all women--which enable the value system to be not merely utilized by the therapist but transferred to the client.

In discussing therapeutic issues (i.e., self-disclosure, diagnosis, the role of values), the primary focus of feminist therapists is the needs of the client. Generally, therapeutic issues are more important to feminist therapists than feminist issues, and issues presented in the literature and issues for feminist therapists are not the same. Within the group of feminist therapists interviewed, there are differences of opinion and perspective on many issues, along a humanistic/radical continuum, particularly with regard to issues of directiveness. Feminist therapy is not inherently radical. The conclusion suggests that feminist therapy, as an example of cultural feminism, emphasizes integration and congruency, the minimization of contradictions and the achievement of connections and internal consistency.

MOVING TOWARD INTEGRATION: A STUDY OF THEORY AND PRACTICE
IN FEMINIST THERAPY

by

SUSAN AMELIA THOMAS

A thesis submitted in partial fulfillment of the
requirements for the degree of

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Portland State University
1975

TO THE OFFICE OF GRADUATE STUDIES AND RESEARCH:

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July 18, 1975

Like so many of us now, I'm experimenting with life, trying to get it right, to do it better, aware how often we're merely rationalizing--but still trying to create a new kind of social existence.

--Kate Millet, Flying

Where do correct ideas come from? Do they fall from the sky? No. Do they spring innately from our minds? No. They come from social practice and from it alone.

--Mao Tse-Tung

Our history has been stolen from us.
Our heroes died in childbirth
from peritonitis, from bottled up rage.
Our geniuses were never taught to write.
We must invent a past adequate to our
ambitions.
We must invent a future adequate to our needs.

--Women in Transition

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CHAPTER I

INTRODUCTION

This study has grown out of my own needs for integration. I have felt my feminism to be an important part of my personal life and social understanding, and I have been searching for ways to incorporate it into other aspects of my life. One of those aspects has been my therapy, both as a client and as a therapist. I was profoundly influenced by Chesler's Women and Madness. Much like the experiences of many of the feminist therapists in this study in encountering feminism, reading that book was a turning point for me. There was finally support for my own perceptions of the ways that therapeutic mystification and institutionalization of the hierarchical power imbalance within the therapist/client roles, particularly if the therapist is a male and the client a female, contribute to--rather than alleviate--emotional distress. I began to try to figure out how I would want to do therapy differently. I knew what it meant to me as a client to be told by a therapist, "You know, a lot of other women feel that way too." I knew what it meant to me as a client to have my perceptions of the therapist's greater power affirmed rather than denied, and the ways in which therapeutic contracts mitigated that power. I knew what it meant to me as a client to feel a therapist as a real person sitting there, often with struggles very similar to my own. I decided that perhaps these things--utilizing therapy to stress the social as well as the intra-psychic nature of women's emotional

problems, "owning" the power imbalance and then building in structures (such as contracts) to mitigate its impact, and self-disclosing--were ways I as a therapist could incorporate my feminism into my therapy.

However, I still kept feeling uncertain and unsettled. I felt conflicted and alone in trying to bring what seemed like a number of vague ideas into therapy. I was unsure how to integrate the training I was getting with my developing ideas about what feminist therapy would be. Were those conflicts between the model of therapy I was being taught and my ideas of feminist therapy as real as they seemed to me, and if they were, how was it that nobody seemed to understand what I was talking about when I discussed the therapist's power? Was answering client questions and self-disclosing really making me less potent as a therapist? How much should I say about my feminist consciousness to my clients? Should I--did I have a right to--did I have a right not to--raise my client's consciousness? Were there some issues which, if dealt with therapeutically, were thereby implicitly discounting social realities? Somehow, I assumed that even if I didn't know the answers to these questions, surely other feminist therapists did.

Thus, the purpose of this research study became an exploration of the newly emerging field of feminist therapy. The goal was to characterize feminist therapy, drawing a profile of its theoretical perspectives, the nature of its practices and descriptions of feminist therapists. Because feminist therapy is at the beginning stages of development, conceptualization, and implementation with little published or otherwise available about its theoretical orientations or the nature of its practice, this study was not designed to test any hypothesis, to

measure the validity of feminist therapy or any assumptions upon which it may be based, or to compare it to other non-feminist forms of therapy. Rather, the research utilizes a series of interviews with feminist therapists to gather descriptive data and potential patterns for an analysis of feminist therapy.

The following chapters contain an overview of the historical trends and theoretical ideas of the late 1960s and first half of the 1970s out of which feminist therapy has developed, as well as a review of the information available on feminist therapy itself, a description of the research design utilized, a tabulation of responses from questionnaires sent to the available part of the population, a thematic analysis of interviews with a random sample of these feminist therapists, and finally, a discussion of the findings and conclusions of the study.

An important struggle for me has been to incorporate within the study a multitude of individual variation in an inclusive rather than exclusive manner. This task was made easier because in each interview, I had the sense of each feminist therapist not in comparison to another feminist therapist more radical or more humanistic, but as her own person with her own integration which I could deeply respect. It also soon became clear to me that none of us really know for sure yet what feminist therapy is, because it is as we develop it; and thus it is constantly changing. However, to the degree that the sample frame is representative of the population of feminist therapists in Portland, Seattle, and the Bay Area--which it was designed to be--the results are generalizable statements about feminist therapy as it exists in these three areas on the West Coast at this point in its development.

CHAPTER II

REVIEW OF THE LITERATURE

I. INTRODUCTION

Because feminist therapy is so much in the process of development, the objectives of the review of the literature are two-fold. First, since much of the literature on feminist therapy or explaining its development is in the alternative rather than academic press, an attempt was made to enable the literature review to be utilized as an annotated bibliography, raising issues and suggesting further reading. Second, the literature review was designed to gather not only the relevant material written about feminist therapy per se but also to provide a background for understanding the historical-cultural context out of which feminist therapy has emerged. Any new phenomenon--such as feminist therapy--which suddenly develops and spreads does so because the historical and cultural context around it has already provided the necessary elements which it needs to be accepted and to grow--and in fact that context has produced it. Feminist therapy is seen as an idea "whose time had come."¹ Thus, this literature review will attempt to trace what are seen as those critical ideological and socio-historical developments which began in the United States in the late 1960s and produced a group of therapists calling themselves feminist therapists

¹This idea of feminist therapy as developing as the women's movement developed was originally suggested to me by Lindsay (1974).

doing something they call feminist therapy. Feminist therapy is of course only one of many developments of that cultural milieu. This literature review, however, is concerned only with the particular development of feminist therapy, and those aspects of the feminist movement and the mental health field out of which it grew. As the literature review begins, its base is broad, including all of feminism, but as it proceeds, it increasingly narrows in on those specific areas of feminism and mental health related to the development of feminist therapy.

Basically, feminist therapy has its roots in the rise of the second wave of feminism, out of which came an analysis of society, here entitled the Feminist Critique, a part of which dealt with psychological effects on women of sex-role oppression. One of the targets of feminist criticism was Freudian psychotherapy and then, increasingly, all psychology and psychotherapy as male-dominated and adhering to a male standard of mental health. In the early 1970s, the field of mental health began to respond to the criticisms and repudiations of the feminists, sometimes disparagingly, at other times supportively. Those who were supportive began to develop and publish new models for working with women in therapy at about the same time that feminism itself was developing alternatives to therapy in the consciousness-raising group, self-help counseling, and transition houses, as well as ways of modifying therapy and women's experiences in therapy, utilizing referral services and calling for a new psychology for women. One of the things that developed from both the responses of the mental health field and the feminist search for alternatives was feminist therapy.

Because so little has actually been written in journals in the field on feminist therapy, a concentrated effort was made to utilize the

feminist and alternative media as well as the academic press. Where possible, all issues of the following newspapers and magazines were surveyed:

- Changing Woman
- Feminist Studies
- Issues in Radical Therapy
- KNOW²
- Ms.
- Notes from the 1st, 2nd, and 3rd Years
- Off Our Backs
- Pandora (a Seattle feminist paper)
- Plexus (a San Francisco feminist paper)
- Radical Therapy
- Second Wave
- Up From Under
- Women: A Journal of Liberation
- Women's Studies: An Interdisciplinary Journal

Aside from the section of the literature review on the responses of mental health to feminism and the evidence of a double standard in mental health, the focus of the literature review is generally not psychological research in general but that research and theory seen as feminist or contributing to the feminist analysis or an understanding of that analysis.

II. THE RISE OF THE SECOND WAVE OF FEMINISM

In the mid-1970s in the United States there began a social movement called the "second wave" of feminism (Firestone 1970:15), so labeled because it was a re-awakening, albeit in somewhat different form, of the feminist movement of the late 1800s and early 1900s. The socio-cultural and economic conditions of the fifties and early sixties made this a ripe time for such a movement to catch hold and develop (Dixon

²KNOW is a feminist press in Pittsburgh (P.O. Box 86031). Many of its publications are undated, and those utilized were included in following citations with KNOW in place of a date.

1972; Doeneka 1972; Firestone 1970; Freeman 1971; Kontopaulos 1972; Mitchell 1971), and in 1966 the National Organization for Women (NOW) was formed to focus on the legal and economic difficulties women face. In the years shortly thereafter, what Freeman (1971:3) calls the "younger branch" of the feminist movement formed, composed of women who often had had experiences in the New Left and civil rights movements. Unlike the "older branch," represented by NOW, this "younger branch" eschewed structure and took pride in its lack of organization. "One result of this style is a very broad-based, creative movement, which individuals can relate to pretty much as they desire with no concern for orthodoxy or doctrine."

In their search for support and direction, women formed "rap" groups, which soon became formalized into consciousness-raising groups. Although originally designed as a technique for mutual support and education, consciousness-raising became more than that. It became alternately described as the heart and soul, the cornerstone or the foundation of the movement (Gornick 1972; Tennov KNOW; Walker KNOW). In the consciousness-raising groups women struggled to "understand their lives and problems in terms of the pressures which impinge on all women in the society" (Polk 1972:323). The purpose of the groups was to develop a socio-political analysis of the society based on one's own experiences of being female. At the same time, by bringing women together in structured interactions to share common experiences, the consciousness-raising group challenged the individual isolation to which women have traditionally been subjected and provided feelings of identity, self-respect and collective consciousness. Different

perspectives emphasized different aspects of consciousness-raising. Some saw its primary functions as personal change. "Once one has gone through such a 'resocialization,' one's view of oneself and the world is never the same again, whether or not there is further active participation in the movement" (Freeman 1971:5). Some viewed personal liberation as the strategy for the liberation of all women; others saw it as merely the initial stage of awareness preceding entry into a mass political movement (Tennov KNOW). White and Goode (1961:56) saw the consciousness-raising group itself as the microcosm of the new society. "The organization we build [internally in our groups] is the society our revolution will create." Allen (1970) stresses group adhesion, while Tennov (KNOW) feels that group dependency can impede personal autonomy and the ultimate development of sisterhood. Nonetheless, all seem to agree on certain results of consciousness-raising groups, as articulated by Freeman (1971:5):

From this public sharing of experiences comes the realization that what was thought to be individual is in fact common; that what was thought to be a personal problem has a social cause and probably a political solution. Women learn to see how social structures and attitudes have molded them from birth and limited their opportunities. They ascertain the extent to which women have been denigrated in this society and how they have developed prejudices against themselves and other women.

Studies were done comparing women involved in the feminist movement with non-feminists (Kirsch 1974). In 1970, Steinmann (1974) found feminists perceived themselves as extremely self-achieving, particularly rejecting those stereotypic role behaviors related to marriage and family and emphasizing self-realization and activities outside the home. Tavris (1972) analyzed 20,000 responses to a questionnaire appearing in Psychology Today. She found women indicated as effects of participation

in women's groups that they were more self-confident about combining marriage and career, most optimistic about working, more resentful of male prerogatives, angry at men more often, and liked women more. Dempewolff (1974b) found few differences in family background between supporters and opposers of feminism. However, differences were found on personality measurements. Supporters of feminism demonstrated less need to maintain distance from those they considered an outgroup, suggesting security about self-worth. On a measure of independence of judgment, whereas opposers of feminism valued conformity and were highly influenced by group consensus, supporters of feminism valued creative work, placed particular value on the person as an individual, were independent, tended to be intraceptive rather than extraceptive, and had the ability to resist group consensus. On a measure of autonomy, supporters of the women's movement tended to be more independent and individualistic as well as having a modern rather than traditional outlook on life, with modernism defined as including feelings of control over one's destiny. Doeneka (1972) studied the effects of consciousness-raising groups on individuals, and found identity change, new self-confrontation experiences, physical and/or behavioral modification, and changes in perceptions, attitudes, goals, and political strategies for goal attainment. She also found that exposure to some of the values and goals of feminism resulted in an emotional identification with the movement. Cherniss (1972:117) commented upon the profound influence of participation in the movement, describing it as a "striking experience . . . of great personal significance to the women involved." He concludes that the women's movement is more than anything else a style,

a way of relating to the world which includes an active, outgoing approach, a high degree of achievement striving, and a strong valuation of autonomy and independence.

In 1969 and 1970, accelerated press publicity and publication of such books as Sisterhood is Powerful (Morgan 1970) and Sexual Politics (Millet 1969) carried consciousness-raising to the public as a whole. At the same time, divisions began to be apparent within the feminist movement. NOW incorporated consciousness-raising as a regular activity (Bonetti 1974) and the divisions based on age (i.e., the older and younger branches) seemed less significant than differences in focus and political analysis, primarily around the issues of individual liberation vs. collective liberation and reform (or working within "the system" vs. counter-systemic activities or revolution). In the early 1970s, alternative institutions began to emerge and proliferate: women's bookstores, magazines, health clinics, restaurants, and switchboards sprang up across the country, and Women's Studies began to be recognized as a valid intellectual course of study.

III. THE FEMINIST CRITIQUE

Because of the varying origins, motivations and philosophical and political stances of the feminist movement, it is difficult to synthesize a set of beliefs or political perspectives that can be labeled "feminist." Freeman (1971) suggests that there is agreement on two theoretical issues: 1) the feminist critique of society, and 2) the idea of oppression. In somewhat expanded form, that distinction will be used here.

The feminist critique of society sees a traditional view stating women differ biologically from men and therefore that they should serve different social functions and engage in different social roles. Feminism rejects these assumptions, believing that men and women are constitutionally equal and therefore that differing roles and functions are the result of social conditioning and an institutionalized sexual class system--it is socio-cultural determinism as contrasted with biological determinism. Following closely from the feminist critique of society is the idea that social conditioning and institutionalized sexual roles (particularly as played out in marriage and the nuclear family), while oppressing both men and women, have oppressed women in particular by preventing them from functioning and contributing according to their potentials, relegating them to an inferior status, and enforcing their second-class citizenship. The basic argument is that women are the way they are because that's how they were trained to be, and how they were trained to be dehumanizes them, thwarts their potentials, and further maintains their already inferior position.³ Thus, the movement seeks an end to the myth that men are superior to women and an end to those practices and institutions of the society perpetuating that myth. While the classic works presenting this view are De Beauvoir's The Second Sex (1952) and Freidan's The Feminine Mystique (1963), there is a plethora of literature explaining--all from varying points of view--the feminist critique (i.e., Bem and Bem 1970; Greer 1970; Janeway 1971; Polk 1972; Westervelt 1973).

³Some writers, such as Bardwick (1973), stress more the role of female physiology and physiological differences but still acknowledge the role of social conditioning.

Given this basic perspective, however, there are divisions within the feminist movement in emphasis and strategy (Cook and Stone 1973; Diggs 1972; Firestone 1970; Freeman 1971; Greer 1970; Polk 1972). Three main political tendencies are distinguishable, which Diggs labels liberal feminism, cultural feminism, and socialist feminism.⁴ Liberal feminism (as articulated by Friedan 1969, among others) seeks the establishment of women's rights and the liberation of women through legal, economic, and political reform. It identifies the sources of women's oppression as sexist ideas, habits, prejudices and laws that are a part of the society, in particular Freudian psychology, functionalist social science, consumerism, and sexist educational theories and practices. The political objectives are full equality for women within this society based on an acceptance of the idea that the focus of change are ideas, prejudices, habits and laws but not basic political or economic institutions (Diggs 1972).

Cultural feminism (as articulated by Firestone 1970, among others) defines the cause of women's oppression as two-fold: psychologically, as sex roles and any institution that supports a division according to sex roles; and politically as any hierarchical structure or institution. Cultural feminists emphasize the common oppression of all women and argue that female oppression is not merely the result of economic oppression and therefore would not disappear even after a revolutionary overthrow of capitalism. Cultural feminism utilizes a triple strategy

⁴Firestone labels them conservative feminists, radical feminists, and politicians; Dixon (1971-72) calls Diggs' cultural feminists radical reactionary feminists. To go into the arguments and counter-arguments more than superficially is impossible here, but Dixon's attack on the "radical reactionary feminists" and their reply seems the most illustrative.

of re-education through consciousness-raising, socio-political action and internal organizational liberation (Polk 1972). Consciousness-raising begins with personal liberation and expands to include criticisms of the basic institutions and power relationships in the society as male-dominated and therefore oppressive to women. A goal of consciousness-raising is change in those institutions and relationships, often beginning at a personal level, thus combining the personal with the political (Firestone 1970:38). Cultural feminists are particularly concerned with being non-elitist, non-hierarchical, and non-competitive internally, believing that "in order to overcome oppression a person must not participate in oppression herself" (Diggs 1972:11). In their groups, they attempt to build "within the Women's Liberation Movement a new form of [non-authoritarian] organization and new ways of living which does not import the oppressiveness of traditional male-dominated forms in the society" (Polk 1972:325).

Socialist feminism (as articulated by Mitchell 1971, among others) asserts a fundamental correlation between capitalism and the oppression of women, and assumes a social or communistic system is a necessary, but not sufficient, precondition for the liberation of women. They view women's oppression as both psychological and economic, but in both cases consider capitalism as the basic source of that oppression. Therefore, their strategy and tactics emphasize the connection between class oppression and women's oppression, between economic and psychological oppression of women and capitalism. Duxbury and Haeney (1975) state:

An important aspect of feminism is that the personal is the political; every time a woman decides not to enter into a power relationship with either sex, every time a woman learns to defend her physical space against assault, that is a political

statement. But we must not stop there: we must begin to understand the connection between the sexist institutions of this culture and how they create and perpetuate oppressive sex roles for women and men. Rape of a particular woman is on the same continuum as the rape of Viet Nam or Chile. An individual woman might possibly learn to defend herself against the individual rapist, but she cannot individually destroy the ITT conglomerate which has killed thousands in Chile.

Unlike the cultural feminists, they tend to emphasize the necessity of internal structure and discipline.

However, all three divisions, in one way or another, point to the institutions and practices which support male supremacy and women's secondary status--in the economic, political, religious, psychological, social, and family realms women are oppressed. To explore all these aspects of oppression is peripheral to the topic under consideration, and therefore this review will focus on the psycho-social institutions and the psychological oppression women face.

IV. PSYCHOLOGICAL EFFECTS OF SEX-ROLE OPPRESSION

Because an attempt to review the literature dealing with the psychological effects of sex-role conditioning and oppression on women is a thesis in itself, this discussion will merely attempt an overview of the key ideas (see also Bardwick 1972; Hochschild 1973; Nadelson 1974; Pierce 1974).⁵ Feminists begin by criticizing much of the research done in the social sciences and in psychology in particular for reinforcing the pre-existing sex-role stereotypes "that women are essentially nurturant/expressive/passive and men instrumental/active/aggressive" without analyzing the origins, values and effects of those stereotypes

⁵Walstedt (1972) and Henley (1973, 1974) have both compiled extensive bibliographies on women and psychology.

or the researcher's own socially conditioned bias against women (Freeman 1970:1; also Laws KNOW; Millet 1969; Silveira 1972). They go on to argue that the characteristics psychology attributes without question to women originate in the socialization process, which in turn trains women to behave in ways which damage them psychologically, leading Weisstein (1969:208) to conclude that "psychology has nothing to say about what women are really like, what they need and what they want, essentially, because psychology does not know."

One area where women have been psychologically damaged is in their self-concept. Millet (1969) cites studies in which from one quarter to one half of the women admitted they would have preferred to be born male, with much higher percentages among girl children who, she says, have not yet learned to disguise their true feelings. Freeman (1970:2) discusses studies of women's self-perception showing that women themselves believe in their own inferiority. Among other things, women described themselves as "uncertain, anxious, nervous, hasty, careless, fearful, dull, childish, helpless, sorry, timid, clumsy, stupid, silly, domestic, . . . understanding, tender, sympathetic, pure, generous, affectionate, loving, moral, kind, grateful, and patient." However, self-concept develops if one possesses those attributes that have social meaning, in other words which are labeled and evaluated positively by significant others (Laws KNOW). Women's self-concept, while corresponding to the social stereotypes for women, does not correspond to attributes which have social meaning. Instead, both sexes tend to value men and male characteristics more highly than those of women (Broverman et al. 1972; Rosenkrantz et al. 1968), which in turn means that women develop the ego characteristics

of other oppressed minority groups (Bernard 1971). Millet (1969:55) explains:

When in any group of persons, the ego is subjected to such invidious versions of itself through social beliefs, ideology, and tradition, the effect is bound to be pernicious. This coupled with the persistent though frequently subtle denigration women encounter daily through personal contacts, the impression gathered from the images and media about them, and the discrimination in matters of behavior, employment and education which they endure, should make it no very special cause for surprise that women develop group characteristics common to those who suffer minority status and a marginal existence.

Indeed, Millet (1969:57) explains that in the ascribed attributes of both blacks and women common traits are identified for both.

Both groups are forced to the same accommodational tactics: an ingratiating or supplicatory manner invested to please, a tendency to study those points at which the dominant group are subject to influence or corruption, and an assumed air of helplessness involving fraudulent appeals for direction through a show of ignorance.

Furthermore, the literature on the psychological effects of victimization and on sex differences in young children shows in both victimized minority groups and girl children common traits of sensitivity, submission, desire for protection, ingratiation, conformity to or identification with dominant group norms, compassion for the underprivileged, passivity and self- and group hatred. Freeman (1970:2-4) concludes that in the results of female socialization, there is "a strong similarity between what our society labels, even extols, as the typical 'feminine' character structure and that of oppressed peoples. . . . There seems to be a correlation between being 'feminine' and experience status deprivation." Status-deprivation leads to negative self-concept, which in turn leads to psychological deprivation (Dixon 1972).

Not only do women learn to hate themselves, but they learn to hate other women as well. Goldberg (1968) gave college women articles

to read and rate on value, persuasiveness, profundity, writing style, professional competence, professional status, and ability to sway the reader. Half received articles they thought were written by a woman (Joan T. McKay), the other half identical articles they thought were written by a man (John T. McKay). Goldberg found that if the article was thought to have been written by a woman, it received significantly lower ratings, leading him to conclude that "women are prejudiced against female professionals and, regardless of the actual accomplishments of these professionals, will firmly refuse to recognize them as the equals of their male colleagues" (1968:28).⁶ Keiffer and Cullen (KNOW) found similar examples of intro-punitive responses (in particular denial of membership in the discriminated-against group or aggression against that group) among hostile respondents to a questionnaire about discrimination in academia. Staines, Tavris and Javarante (1973) label this the Queen Bee Syndrome, a countermilitancy to feminism they believe has roots in a woman's personal success within the system.

In addition to the effects of status deprivation, there is the corresponding psychological debilitation of a constant double bind which exists for women. At its simplest, it is as follows: Women are socialized to behave in certain ways which the culture prescribes and rewards, for women. However, at the same time, those very behaviors are not desirable in and of themselves--in fact they are seen as less desirable and less valuable. Steinmann (1974) found that while women feel they are balanced between active and passive role behavior, they are conflicted because

⁶The conclusions of the Goldberg study are repeatedly cited in the literature, yet the study itself contains certain methodological problems, in particular the utilization of interrelated outcome variables.

they feel that how they are is not at all the "homebodies" men would like them to be. Bardwick and Douvan (1971:56) explain:

Ambivalence is clearly seen in the simultaneous enjoyment of one's feminine identity, qualities, goals, and achievements and the perceptions of them as less important, meaningful, or satisfying than those of men. . . . Society values masculinity; when it is achieved it is rewarded. Society does not value femininity as highly; when it is achieved it is not as highly rewarded.

In other words, the culture regards women for being inferior--"health" consists of accepting a devalued status. If a woman rejects a devalued status (and becomes, for example, a feminist), she is not healthy by the standards of our culture.

The work of Horner (1969, 1972) on the effects of women attempting intellectual achievement is an example of this double bind.⁷ Although success is an important means of attaining a positive self-concept in this culture, women are motivated to avoid success by their fear of the negative consequences of social rejection and role conflict. She writes (1969:38):

A bright woman is caught in a double bind. In testing and other achievement-oriented situations she worries not only about failure but also about success. If she fails she is not living up to her own standards of performance; if she succeeds she is not living up to societal expectations about the female role.

Similarly, feminist writers discuss how patriarchy and a consumer society tend to objectify sexuality and convert women into sexual objects. However, women are not allowed to enjoy the sexuality fated for them but instead are taught to suffer for and be ashamed of that

⁷It must be noted that Tresemer (1973) criticizes Horner's methodology and in his review of the literature on the "fear of success," found that this fear is not at all unique to women, nor is it the only explanation for why people inhibit their own growth.

very sexuality while nonetheless confined to a sex-bound existence (Millett 1969). A woman is used to reinforce male "superiority" and she in turn quickly learns to use her body as a commodity and to be used as a commodity to get the things she has been taught to want and value as well as the things she needs to survive. In so doing, she becomes irretrievably trapped by the double messages inherent in the current societal values which still sanctify the marriage relationship, extol the beauty of sex, virginity and monogamy, condemn the use of sex as a commodity, as a medium of exchange, and simultaneously hold out respectability, status ascendancy, material security and dependency as ultimate goals, by any means. This socialization to be an object rather than a person is compounded by women's prescribed dependency for self-identity on her role as a mother or wife--an identity formed by another.

Some carry the consequences still further, suggesting that in order to survive with these basic contradictions and the anger they engender, women learn to separate out body from mind while continually monitoring the environment⁸--living a kind of "female schizophrenia" (Naffziger 1973; Tax 1970). Chesler (1971, 1972, 1973, and as quoted in Feldman, Gabel and Taylor 1973) explains that if a woman attempts to be "healthy" and acts out the feminine role, not only is she therefore immediately accepting a definition of herself as subordinate, but functionally she must be self-deprecatory, dependent, confused, without self-confidence, live through others, and be objectified sexually. By doing so, however,

⁸Rosenthal et al. (1974) found women more sensitive than men to non-verbal messages and Anthony (1970) argues that this is because women's survival has depended on correctly assessing the mood of men as communicated through their actions. The work of Henley (KNOW) on the politics of touch supports this.

she becomes increasingly vulnerable to such self-destructive "female" forms of madness as depression (Bart 1971a), frigidity, paranoia, anxiety and suicide attempts (which Chesler argues are just another form for women's learned inactivity and incompetence, in that women attempt suicide while men commit suicide). If, on the other hand, she rejects the female stereotype and persists in "male" activities, if she becomes hostile and aggressive rather than depressed, sexually active rather than passive, successful rather than dependent, if she allows herself to perceive clearly and verbalize those perceptions,⁹ she is so frightening both to herself and to society that she is labeled as "mad" until she "reasserts" her femininity. Madness becomes not a psychological problem but a "sane" response to one's social role.

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. (p. 75)

All this information would lead one to suspect that women would experience psychological distress out of proportion to their numbers, and there are statistics verifying this imbalance (Fidell 1973). Chesler (1973:79) cites National Institute of Mental Health figures showing that from 1964 through 1968, 125,321 more women than men were psychiatrically hospitalized and/or treated on an outpatient basis. Women also outnumber men in private therapy two to one, and in a random survey of the national population report greater distress than men "in all adjustment areas, in their self-perceptions, and in their marital and parental functions," as well as "more worry than men, more fear of breakdown, and

⁹Chesler (1972:88) cites a study in which the majority of female patients reported that men were "persecuting" them.

more need for help." Gove and Tudor (1973) similarly found that more women than men are mentally ill, regardless of whether the comparisons are made based on admissions to mental hospitals, treatment by a general physician for mental problems, or community surveys.

Feminists argue that this discrepancy is not merely because sex roles damage women psychologically, although the real oppression of women is an important reason. It is also more conventionally acceptable for a woman to be in therapy--women are expected to be weak, dependent and emotion-ridden and thus it is fitting that they would need (or see themselves as needing) the "strength and direction" of a psychotherapist, as Chesler (1972:131) explains:

Many factors . . . would suggest . . . a large female involvement with psychiatric facilities. For example, the real oppression of women--which leads to real distress and unhappiness; the conditioned female role of help-seeking and distress-reporting--which naturally leads to patient "careers" as well as overt or subtle punishment for such devalued behavior; the double or masculine standard of mental health used by most clinicians . . .; the comparatively limited social tolerance for "unacceptable" behavior among women--which leads to comparatively great social and psychiatric pressure to adjust--or to be judged as neurotic or psychotic; . . . and finally, the female nature of the psychotherapeutic and hospital institutions--which leads to their being accepted more easily by women than by men.

The following two sections will discuss those feminist arguments that the field of mental health contributes (some say particularly) to the psychological oppression of women.

V. FEMINIST CRITIQUES OF FREUD

Within the fields of mental health, psychology, and psychotherapy, a particular focus of feminist criticism is Freudian psychotherapy, specifically its assumptions and theories about women. Millet (1969:178)

has described Freud as "beyond question the strongest individual counter-revolutionary force in the ideology of sexual politics during the period [of the sexual revolution]." Much of the feminist literature argues that his ideas have served to crystallize the feminist mystique (Friedan 1963), justify male chauvinism (Gilman 1971), heighten the split between mind and body (Mander 1974), perpetuate unwarranted myths about female sexuality (Sherfy 1966) and reinforce the authoritarian hierarchy of the nuclear family (Mander 1974; Seidenberg 1971). However, it is not so much that Freud was a male chauvinist--history and psychology have produced others before and since--but that his chauvinism was manifested in his theories, which have been used by those who followed him to further maintain their own mythologies. As Mander (1974:39) explains:

I have criticisms of Freud's original outlook and writings, but mostly what I am critical of and concerned with is the social mythology that has become "Freudian psychology" in our culture, as it is practiced in the minds of families, advertisers, industrial consultants, and psychiatrists and psychologists day to day.

Feminist criticisms of Freud center on two of his basic assumptions--that anatomy is destiny and that sex is unrelated to power--as played out in three of his central constructs--penis envy, the Oedipal complex, and the idea of clitoral-vaginal transfer of female sexuality.¹⁰

¹⁰Mitchell (1974) argues that Freud has been misinterpreted by his feminist critics who, she feels, have studied his writings devoid of their context within the main concepts of psychoanalysis. Firestone (1970), while in agreement with some of these feminist criticisms of Freud, argues that if reanalyzed within a feminist context, Freud has valuable insights for feminism because he grasped what she sees as the crucial problem for modern life--sexuality. Firestone reinterprets the Oedipus complex as follows:

From the beginning [the boy child] is sensitive to the hierarchy of power [in the family]. He knows that . . . he is completely

As a biological determinist, Freud assumed that a woman's sexual organs (or lack of them) had inherent and intrinsic effects on her ultimate personality development. Many feminist writers argue that his perspective ignores the impacts of society on personality development. Generally, what is at issue is not Freud's observations, but rather the interpretations and prescriptions for feminine character he based on those observations. The women Freud saw were the "unadjusted" women of their time, those dissatisfied with the role of the Victorian woman and envious of the power and freedoms of men. However, rather than understanding this dissatisfaction as arising from the social situation which was for women in fact self-limiting, anger-inducing, inferiority-invoking and sexually repressing, Freud substituted the symptom for the cause. Thus feminists reject the notion of penis-envy, arguing that it is not the penis itself which is enviable but the power the penis represents (Gilman 1971; Mander 1974; Millet 1969). De Beauvoir (1952:44)

dependent on . . . his two parents. . . . Between the two of them, though, he will certainly prefer his mother. He has a bond with her in oppression: while he is oppressed by both parents, she, at least, is oppressed by one. The father, so far as the child can see, is in total control At the age of six, . . . suddenly now he's expected to identify with this brutish stranger. Of course he doesn't want to. He resists. . . . [However,] most children aren't fools. They don't want to be stuck with the lousy limited lives of women. . . . But it is hard. Because deep down they have a contempt for the father with all his power. They sympathize with their mother. But what can they do? They "repress" their deep emotional attachment to mother . . . It is no wonder that such a transition leaves an emotional residue, a "complex." The male child, in order to save his own hide, has had to abandon and betray his mother and join the ranks with her oppressor. (pp. 46-52)

In a third reinterpretation, Torrey (1971) posits the existence of patriarchy on men's inability to bear children and their need to achieve legitimate paternity.

writes that "the phallus assumes such worth as it does because it symbolizes a dominance that is exercised in other domains." Similarly, Millet (1969:247-8) describes the Oedipus complex as "rather less a matter of the son's passion for the mother than his passion for attaining the level of power to which adult male status is supposed to entitle him." Freud's definition of mature sexuality as transfer of erotic focus from the clitoris to the vagina and his definition of frigidity as woman's failure to have vaginal orgasms is seen as a definition of women "in terms of what pleases men" (Koedt 1971:168). From these three constructs--penis envy, the Oedipal complex, and the transfer of female sexuality--Freud developed his theory of the personality of women.

However, feminist criticism of Freud runs deeper than the erroneousess of these three ideas. Underneath the theories and the constructs they point to Freud's radical bias against women--in other words, his sexism. Freud does not see the "normal" woman as different from man in any positive sense because she is already by definition a-normal when compared to the male standard of normality and because she is already by his definition inferior when compared to the male's superiority. Femininity is for Freud the absence of masculinity; but since masculine traits are the approved-of traits, the presence of femininity is always ultimately negative. Thus, he describes women as passive, masochistic, narcissistic, jealous, suffering from self-contempt, opposed to civilization, less intelligent, less ethical, less judicious, psychologically rigid, often sexually frigid, and tending toward hysteria (Yurmark 1972)--as Ash (1971:325-6) concludes, "a sour, disappointed, envious, castrated male."

Freud . . . emphasizes that women come into analysis looking for a penis as well as relief from symptoms. They leave analysis perhaps improved a great deal but unreconciled to the fact that they can't achieve a penis. I wonder. Is it that women come into analysis looking for a feeling of self-worth, one might say an honorable identity, which they think is a masculine identity? Do they leave analysis not having found a satisfactory feminine identity because for the male analyst, too, the only honorable identity is a masculine one?

Earlier feminist writers (De Beauvoir 1953; Freidan 1969; Shainess 1969) explain Freud's misunderstandings of women as unconscious perpetrations of his own cultural imprisonment and the rationalizations of his own unacknowledged fears and resentments. More recent feminist writers believe that Freud's oversights were not mere naivete. They point to his repeated condescending barbs against those feminists who criticized him, and his continual refusal to take their arguments seriously despite a changing cultural climate which was giving increasing credence to their views. Freud's hypotheses, they argue, are "weighted with expedient interest" for only with such a perspective could he maintain his "gross male-supremacist bias" (Mander 1974; Millet 1969: 182-7). By ascribing pejorative terms to women Freud was merely justifying--not explaining--the cultural norms of his own society; by sanctifying male supremacy he was in essence sanctifying himself; by giving credence to the Oedipal situation he was maintaining his own familial position. For Millet (1969), this is the essence of sexual politics.

What Freud did, ultimately, was justify and sustain the status quo. His theories sanctified the oppression of women because within his system all alternatives were labeled "neurotic." All those characteristics which Freud attributed to women in turn have perpetuated their

secondary status when used as patronizing rationales for ignoring women's perceptions of their reality. Freud began with descriptions of the women around him, descriptions often based on observations of accuracy and sensitivity. However, what he did was declare that what he saw was inevitable, and in so doing, his descriptions became prescriptions, forcing women to adjust to an inherently unhealthy position, to accept a subordinate role, and to submit to an inferior fate.

Also criticized are those followers of Freud who accepted and/or expanded upon his position on women adhering to a masculine model of personality: Deutsch for her pejorative cataloging of anatomically determined "feminine" traits; Erikson for his theory of "inner space" as the counterpart of male externality, his naive "experiments" with towers and fortresses, and his insistence on generation as the criteria for mature female identity; and Reik for his crassness, insensitivity, and contempt for women, among others (Barrett et al. 1974; Brogan 1972; Doherty 1973; Fields KNOW; Firestone 1970; Mander and Rush 1974; Millet 1969; Walstedt 1971; Wesley 1975; Yurmark 1972). Schwartz (1973) illustrates how social work curriculum to present a sexist view of women. Chesler (1972) presents overviews of the work of Reich, Laing, Cooper and Ssasz, finding that none of them have a frame of reference in which what is human is also female.¹¹

It is on the cumulative basis of all this misinterpretation, distortion, and justification for the continued subordination of women that some feminists came to repudiate psychology altogether.

¹¹Mitchell (1974) is critical of both Reich and Laing, but less for their positions on women per se than what she sees as their misunderstanding of Freud and their misconceptions of the unconscious.

VI. FEMINIST REPUDIATION OF PSYCHOLOGY AND PSYCHOTHERAPY

In the early 1970s, a number of articles appeared lambasting the institutions of psychology and psychotherapy (and all related fields) from a feminist point of view. Chesler's Women and Madness (1972) is the classic work, but others advanced similar views (Etzkowitz 1971; Gardner 1971; Hartman 1970; Redstockings 1971; Rush 1971; Walstedt 1971; Webbink 1972). Basically, they argued that the field of psychology as a whole has not only failed to understand women but has actually contributed to their oppression. The basic thesis is two-fold.

First, psychology, and in particular, psychotherapy, does not acknowledge the consequences of societal demands and discrimination upon women and therefore does not focus on changing the causes of women's emotional distress in the society. Instead, they assume there is something wrong within individuals, labeling their symptoms "neurotic" or maladjusted and encouraging women to take personal blame and responsibility for their unhappiness. In essence, it is demanding that a woman adjust herself to the society, as Chesler (1971:746-52) explains:

Women's unhappiness is viewed and "treated" as a problem of individual pathology, no matter how many other female patients (or non-patients) are similarly unhappy . . . Woman's inability to adjust to or be content by feminine roles has been considered a deviation from "natural" female psychology rather than as a criticism of such roles. . . . Psychotherapy . . . enable[s] women to safely express and defuse their anger by experiencing it as a form of emotional illness, by translating it into . . . frigidity, chronic depression, phobias and the like. Each woman as patient thinks these symptoms are unique and are her own fault. She is neurotic, rather than oppressed.

Thus, clinicians attempt to bring their patients to terms with the female role. However, adjusting to that devalued role merely perpetuates the double bind women experience, which in turn brings its own emotional

"madness." At the same time, adjustment for women to the feminine sex role stereotype also means that they manifest those behaviors clinicians label mental illness.

This is the "adjustment" notion of mental health, the idea that one must "'adjust' to the specific racism or sexism that limits one's potential from the beginning" (Firestone 1970:64). If a person becomes too angry, she is labeled mentally ill even though "it may be an indication of mental health to feel a natural anger toward [one's] oppressor" (Bonetti 1974:29-30). As Heide (KNOW:3) explains, "Adjustment psychology and psychiatry help keep people 'in their place,' when it is really the 'place,' rather than the people, that should be changed." Accordingly, some feminists argue that therapy not only encourages adjustment to an unhealthy society but defuses women's collective energy into futile attempts to heal oneself individually. Some point to the studies showing the ineffectiveness of therapy (Firestone 1970; Tennov 1973), but most explain that therapy is merely an individual solution which cannot affect the larger social structure. "In all fairness to therapy, it is sometimes necessary, but it is limited in that there is always the same sexist society to which we return where limited roles are imposed upon us as women" (Leah and Mary Jane 1971:52). These authors also criticize the fee structure of therapy for reinforcing the values of the culture.

All too often, the therapist and particularly the psychoanalyst are available only for the few who can afford them. Freud, in fact, insisted that only by paying would the patient be able to take analysis seriously. This is a notion totally in keeping with a culture that values money and individual achievement above the betterment of many. (p. 52)

Yurmark (1972) studied social casework literature on women and their role from 1920 to 1950 and found writings in social work texts and journals consistently supporting and building upon Freudian psychoanalytic theories and prescriptions. She concludes:

With few exceptions, psychoanalytic theoretical perspectives of women have not been challenged as a basis for social casework's theory of human behavior. . . . As seen through a study of its literature on women, social casework changes focus with the times, with prevailing values and mores, rather than examines values and/or questions them. As the society changes, so changes social casework. From this, one might reach the conclusion, that in relation to the role of women, social casework is an agent of social control, rather than an agent of individual growth. (p. 53)

This idea of psychotherapy as a means of social control (or at the least, maintenance of the status quo) by focusing on woman's adjustment to an unhealthy society as the only alternative to "mental illness" is echoed by Anthony (1970), Gardner (1971), the Association for Women Psychologists (1970), and Becker and Krakauer (1973), among others.

Secondly, feminists find the psychotherapeutic relationship itself oppressive to women. In part, this has to do with the power imbalance in the relationship itself, in which the therapist is dominant and the client subordinate (Silveira 1972; Tennov 1973). "The institution of . . . therapy is a patriarchal one--regardless of whether the individual clinician is female or male" (Chesler 1972:120-121). Tennov (1973) carries the argument one step further, asserting that a professional cannot be a feminist. "Psychotherapy and Sisterhood are basically antagonistic to one another, and . . . a woman who 'treats' another woman is not her sister." (See also Agel 1973:67-86.) Chesler (and others) explain that the power imbalance is particularly entrenched when psychotherapy teaches a woman to talk rather than act, further conditioning her

into helplessness and dependency and guaranteeing she will remain in a secondary status, and when the therapist, remaining unknown, is thereby expected to be or perceived to be objective. "Our culture's criteria for an 'expert' are the same for engineers and soul-healers: objectivity, rationality, impersonality" (1972:121). However, Chesler argues that in actuality the therapist is not at all objective and in fact controls what the client says through a subtle system of non-verbal rewards and withheld responses made in congruence with his or her own conscious or unconscious values.

This authority is complicated if the therapist is male, and given the disproportionate number of male as versus female clinicians, it is highly likely that the therapist will be a male. Chesler cites studies which report 90 percent of all psychiatrists to be males, psychologists to be male two to one, and only social workers (the profession with the least prestige and the lowest pay¹²) to be predominantly females, in a two to one ratio. Because a woman in psychotherapy is so often in a relationship with a male, she concludes (1971:746-51) that the same dominant/subordinate roles of male and female that exist in the society and are played out in marriage will be played out in the therapeutic relationship.

For most women the psychotherapeutic relationship 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. Both psychotherapy and marriage isolate women from each other; both emphasize individual rather than collective solutions to woman's unhappiness; both are based on a woman's helplessness and dependence on a stronger male authority figure.

¹²Adams (1971) describes how women are socialized into the compassion trap, and draws the analogy between the roles of women and the professional roles of social workers.

For a woman seeing a male therapist, the authority is doubled: the therapist not only has the authority of his therapeutic role, but has the authority of his sexual role as well. A woman in therapy is subordinate when it comes to confronting or challenging either. To mistrust him as a man can become only further manifestation of her "paranoia"; to want to know that one's problems are problems shared by all women can be called "escapism"; to be angry at his sexism or at the system that oppresses women can be dismissed as transference.¹³ Thus, Chesler (1971:757) concludes that male therapists cannot work with women.

Male psychologists, psychiatrists, and social workers must realize that . . . they know nothing about women; their expertise, their diagnoses, even their sympathy is damaging and oppressive to women. Male clinicians should stop treating women altogether, however much this may hurt their wallets and/or sense of benevolent authority. . . . [As a power-structured relationship,] I wonder how well such a structure can encourage independence--or healthy dependence--in a woman. I wonder what a woman can learn from a male therapist (however well-intentioned) whose own values are sexist? How free from the dictates of a sexist society can the female as patient be with a male therapist?

Finally, among feminist criticisms of psychotherapy as practiced by male therapists with female clients come the "horror stories," the accounts of women confronted with sexually seductive therapists while they were extremely psychologically vulnerable and repeatedly told if they questioned or protested that the problem was not with the therapist but with their projections and emotional conflicts (Anthony 1970; April

¹³In the literature, a number of articles by feminists stress the reality-base of women's anger and encourage women to refuse to allow their anger to be labeled "unhealthy" or paranoid and instead to appreciate it, express it, and utilize it (Bernard 1971; Christeve 1974; Kaplow 1971; Mailhot 1973). As Bart (1974) says, "We no longer blame ourselves for our troubles. For although we are angry, we are no longer mad."

KNOW; Barrett et al. 1974; Chesler 1972; Fields KNOW; Miller 1971; Walstedt 1971).

In their repudiations of psychology and psychotherapy as yet two other institutions which oppress women, feminists point to the research on the attitudes of clinicians about women and ways those attitudes are incorporated into therapy--described often as the "double (or masculine) standard of mental health." As Chesler (1972:127) says:

Since clinicians and researchers, as well as their patients, adhere to a masculine standard of mental health, women, by definition, are viewed as psychiatrically impaired--whether they accept or reject the female role--simply because they are women.

VII. RESEARCH REGARDING THE DOUBLE STANDARD OF MENTAL HEALTH

Experimental research supports the accusations of feminists that clinicians devalue women. The research in this area most frequently referred to is that of Broverman et al. (1970), but more extensive replications by Fabrikant (1974) and Nowaki (1973), as well as a similar study by Neulinger (1968) obtained similar results. In the Broverman study, a questionnaire consisting of 122 bipolar items (i.e., Very Aggressive / Not at all Aggressive; Doesn't hide emotions at all / Always hides emotions) was developed and each item tested for agreement as to sex-role stereotype and social desirability (Rosenkrantz et al. 1969). The questionnaire was administered to 79 clinically trained psychologists, psychiatrists and social workers. All were sent the same questionnaire, with one of three sets of instructions. One group was instructed to choose the pole on each item to which a mature, healthy, socially competent adult man would be closer. The second group was given similar

instructions, except "adult woman" was substituted for "adult man," and the third group was simply instructed to describe a healthy adult. In analyzing the results, two important conclusions were found. The first was that the clinicians described healthy men differently from healthy women, and further that their judgments parallel stereotypic sex-role behaviors and social desirability (i.e., they ascribed male-valued stereotypic traits more often to healthy men than healthy women). This finding, they argue, conceals a powerful negative assessment of women.

Clinicians are more likely to suggest that healthy women differ from healthy men by being more submissive, less independent, less adventurous, more easily influenced, less aggressive, less competitive, more excitable in minor crises, having their feelings more easily hurt, being more emotional, more conceited about their appearance, less objective, and disliking math and science. This constellation seems a most unusual way to describe any mature, healthy individual. (pp. 4-5)

The second major finding was that while there was no significant difference between the adult and masculine concepts of health, there was between the adult and female concept. They conclude:

These results, then, confirm the hypothesis that a double standard of health exists for men and women, that is, the general standard of health is actually applied only to men, while healthy women are perceived as significantly less healthy by adult standards. . . . Thus, for a woman to be healthy, . . . she must adjust to and accept the behavioral norms for her sex, even though these behaviors are generally less socially desirable and considered to be less healthy for the generalized competent, mature adult. . . . [This] then places women in the conflictual position of having to decide whether to exhibit those positive characteristics considered desirable for men and adults, and thus have their "femininity" questioned, that is, be devalued in terms of being a woman; or to behave in the prescribed feminine manner, accept second-class adult status, and possibly live a lie to boot. (pp. 5-6)

While they do not suggest that clinicians alone pose this dilemma for women, it does seem that clinicians do accept the sex role stereotypes

and by so doing, help perpetuate them.

Similarly, Abramowitz and Abramowitz (1973a) found that non-liberal counselors imputed greater maladjustment to left-oriented politically active females than to an identically described male client.

Overall, the results of the inquiry implicate the assessor's political opinions as a potential source of bias in his clinical decisions. That the target of the bias was a left-oriented politically active woman supports the contention of Szasz and others that certain mental health activities may serve to unfairly stigmatize persons whose behavior or values pose a challenge to the dominant mores. . . . It raises the specter of covert discrimination against the "liberated" woman, unintentional though it may be, on the part of certain workers holding unsympathetic socio-political views. (pp. 388-89)

Schlossberg and Pietrofesa (1973) review several studies on counselor bias and find counselors rate traditionally feminine (i.e., conforming) career goals for female clients more appropriate than traditionally masculine (i.e., deviate) career goals and find female clients with deviate goals in more need of counseling than those with conforming goals.

The literature is less clear about whether or not it is only male clinicians who hold to a masculine standard of mental health. Broverman et al. (1970) found no significant differences between male and female clinicians in their study. Abramowitz and Abramowitz (1973b) found that a woman client's psychological status was judged more sternly by female than male counseling center personnel. In contrast, in the literature reviewed by Schlossberg and Pietrofesa (1973), male counselors generally held the stereotypic views. Female counselors gave higher Acceptance scores to both deviate and conforming clients than did male counselors. Female counselors also described their ideal woman as more extra-family oriented than the ideal projected by the men (who also suggested that career women are less attractive to men) and rejected the intra-family-

oriented ideal more strongly than men did. Male counselors associated college-bound girls with traditional feminine semi-skilled occupations while female counselors perceived the college-bound girl as interested in occupations requiring a college education. In their own study, however, female counselors were as biased as male counselors against women entering a masculine career (engineering). Similarly, Haan and Livson (1973) found female psychologists to ascribe more favorable characteristics to females than did male psychologists.

VIII. MENTAL HEALTH FIELD RESPONDS TO FEMINISM

As the literature cited above began to appear in the media, and, slowly, in various academic journals and as the country as a whole began to feel the impact of the feminist movement, beginning in 1971 and increasingly in the years following, the mental health field began to respond to feminism and to the critiques feminism made of it. The titles of articles themselves are revealing: "The Mental Health Movement Meets Women's Lib" ("Special Symposium . . ." 1971); "What Psychiatrists Say About Women's Liberation" (Cummings 1972); "Psychoanalytic Reflections on Women's Liberation" (Moulton 1972); and "Implications of the Women's Liberation Movement for Psychotherapy" (Rice and Rice 1973), among others. As would be expected, these articles run the gamut from those who labeled the feminist movement misguided and/or paranoid to those which encourage psychotherapists to apply the messages of feminism to their practice.

Among those in the former group, there were criticisms of feminists themselves, refutation of their theoretical positions, and espousal of

the strengths of psychotherapy. While some acknowledge certain gains that the women's movement had achieved, particularly in areas of legal reform, there is a focus on the damage done to many women by the more "militant" members of the movement, who they characterize as misguided and going "overboard" in a "blame syndrome" which confuses women, arouses their often-misdirected anger, and antagonizes the public, thereby polluting efforts to secure reforms. One psychiatrist (quoted in Cummings 1972) said:

This illusion that you are right and the fault is in someone else comes very close to mental illness. I'm not saying advocates of Women's Lib are mentally ill, just that there is a definite paranoia that runs through some of the thinking.

They deny that psychoanalysis has "put down" women or had as a goal adjustment to society's norms (Rolph 1972; Seeman 1973).

Secondly, they disagree with many of the theoretical positions of the Feminist Critique. Rolph (1972) characterizes the feminist dismissal of the clitoral-vaginal transfer theory by pointing to the absense of sensation in the vagina as "a half-truth distorted for political ends." They feel that feminists disregard or distort valid and important biological differences (Beesley 1973; Moulton quoted in Cummings 1972; "Special Symposium . . ." 1971). Rollo May (quoted in Cummings 1972) writes that the idea of equality of the sexes "is clung to at the price of denying not only biological differences, which are basic to say the least, between men and women, but emotional differences, from which comes much of the delight in the sexual act." Seeman (1973) and Shainess (quoted in Cummings 1972) both stress the importance of the mother-child symbiosis, and Seeman also believes that little girls do feel envious of the boy's urination abilities, an envy which if

channelled can lead to such "achievements" as the Women's Liberation movement itself. She cautions against too much self-scrutiny on the part of psychotherapists if it means they lose sight of such old but valid truths. Finally, she suggests that since women have entered into a massive crisis of identity, perhaps psychotherapy would do well to adapt the attitudes and techniques of adolescent psychiatry to the psychotherapy of the role-questioning woman.

Some of those who were less critical of feminism, emphasizing the importance of feminism to women, are however concerned by its hostility towards men, what Moulton (1972) calls this "venting of rage against men in a blind, diffuse manner" which merely perpetuates the estrangement of men from women and further polarizes the sexes. Symonds (1972:227) describes this as "one of the neurotic aspects of women's liberation":

Another type of reaction in the women's liberation movement has been to express intense hostility, even hatred towards men. For some this hostility is felt as valid goal in itself. They feel justified and righteous in their anti-male feelings, not realizing that this in itself is an expression of their continued, self-imposed dependency. . . . A neurotically dependent person feels helpless and hopeless about ever being strong enough to stand alone. The only thing he or she can do with impunity is to blame his caretakers for not taking care of him in the right way. We sometimes call this "hostile dependency" or "morbid dependency." That is the quality of some of the feminist literature I have seen, and that is the message of some spokeswomen for the women's liberation movement.

They stress that not only women but both sexes are oppressed by sex roles and need to work together to achieve the liberation of all people from sexual roles. Moulton (1972) discusses how the ambivalence men have toward women is an important issue in their analysis. Stevens (1974) feels that the "problem is not simply that women have been denied their

assertive, intellectual selves; it is also that men have been denied the opportunity to develop their dependent emotional selves." As a woman therapist struggling to move out of prescribed roles herself, she feels she can be particularly helpful to such men.

Within the literature, there is a third group of articles which, while never using the term "feminist therapy," takes a clear position of advocacy for the women's movement and attempts to explain the feminist critique of society and psychotherapy, suggesting training and practice alternatives for clinicians (Barrett et al.; Cook and Stone 1973; Rice and Rice 1973; Stephenson 1973; Stevens 1971; Wesley 1975). These writers emphasize that the critical thing is for clinicians to acknowledge the impact of the social context and become sensitive to the psychological effects of sexual roles and their own sexual biases, perhaps participating in consciousness-raising groups themselves. They argue that no matter how hard the therapist attempts to be neutral, one's attitudes and values are communicated in subtle and uncontrollable ways. Stevens (1971:14-15) explains:

Insofar as a therapist accepts society's role prescription for women, he is implicitly accepting the value judgment that underlies it: that women are basically inferior to men. . . . This attitude will permeate his whole stance--the areas in which he seems most interested and on which he chooses to focus, his demeanor, tone of voice, posture, and the most minute facial expressions. . . . Thus even when no specific role conflicts are at issue in therapy--when "women's issues" are never mentioned--the therapist's unconscious attitude toward his patient is to some extent antitherapeutic. . . . [and] he cannot help her to develop her human potential.

In other words, they reject the idea of therapeutic neutrality, arguing that in any theoretical orientation there are clear values (Brogan 1972). Bart (1971b) calls this the myth of a value-free psychotherapy. Stevens

(1971:15) stresses that since values are communicated to clients in one way or another and clients in turn model after the therapist and incorporate their values, therapists should acknowledge their values to themselves and directly communicate them to their clients.

By the time a [woman] starts therapy, she has introjected many . . . destructive stereotypes. . . . This means that the therapist must frequently watch for hints of intellectual and societal strivings that have long been repressed and denied.

Many therapists believe that the therapist must not impose values on his patients. If a patient is happy being exclusively a wife and mother, the therapist must not challenge her because he feels that a woman cannot be fulfilled in these roles. Thus watching for hints of frustration is interpreted as imposing values on a patient. This author believes that concern about imposing values is a diversion from the real issues involved. . . .

The value judgment underlying [women's liberation] is that women have as much potential and inner worth as men. This author wants to impose that value judgment on her patients since one of her major goals is to enhance the patient's self-image. . . . [and believes that] it is incumbent on [all] therapists to examine and acknowledge their values instead of to pretend a nonexistent neutrality.

Rice and Rice (1973) explain the importance of the therapist recognizing that the generalized hostility many women feel toward men, including the male therapist, is a natural result of increased awareness and cannot be merely interpreted as transference.

Since it is likely that male therapists (as a product of our society) share certain chauvinistic attitudes at present, part of a woman's greater feelings of hostility toward men, including her therapist, seem appropriate and justified. Such feelings should be honestly acknowledged and dealt with in the therapeutic relationship. (p. 192)

In this as in other areas, they stress the importance of clinicians not labeling role conflict as psychopathological and interpreting it in intra-psychic terms but rather viewing it as healthy and encouraging women to question, even though doing so may threaten the therapist's elevated social power.

A more fruitful therapeutic course would be to help a woman question, probe, and recognize the historical, environmental, familial, and societal antecedents that can often precipitate and perpetuate feminine conflicts; aid her with the restructuring process necessary in her primary and personal relationships, especially her marriage; provide a place where feelings toward men and about women who stand for the traditional feminine role patterns can be ventilated and explored; and assist her in exploring new roles and models. (p. 193)

In other words, rather than the traditional blank-screen, silent approach of the analytic mode which a number of writers feel merely reinforces the behavior patterns of regression, dependency, and distortion already distressing women or the non-judgmental client-centered approach which they feel fails women who come to therapy already goal-less, lacking inspiration and information, they suggest that the therapist be a knowledgeable, active participant in the therapy process. In this role, the therapist would directly communicate her values to her clients, support a woman's questioning of sex-role stereotypes and her attempts to change her social situation whether personally or politically, sanction intellectual and social assertiveness, openly advocate alternative life styles and roles, confront women who have introjected destructive visions of the traditional feminine role, educate women clients about crisis situations of life cycles such as marriage-career conflict, abortion, menopause and widowhood, and, recognizing that psychotherapy is not always the answer, refer women to consciousness-raising groups and work themselves as community change agents (Barrett et al. 1974; Rice and Rice 1973; Stevens 1971; Tiedt 1972).

One issue discussed is whether a male therapist can even work with women, a concern Schwartz (1974) found notably overlooked in social work literature. Carter (1971) uses what are in essence traditional

stereotypes to argue that a woman's developmental experiences, which have taught her to be emotionally responsive, nurturing, and understanding, make her the better choice for certain types of clients. Others, however, explain that the important thing is for therapists to understand that based on women's experience, they perceive men not to understand women and therefore that there are distinct advantages at this time for women therapists to work with women clients because of a woman therapist's greater sensitivity to issues, her ability to empathize with a woman client's feelings and experiences, the client's greater willingness to explore sexual issues with a female therapist, the therapist's provision of a positive female role model, and her ability to offer solutions from her personal experience (Barrett et al. 1974; Krause 1971; Kronsky 1971; Rice and Rice 1973; Trout 1973). However, some point to the research showing that many women therapists hold to stereotypic views of women as strongly as men do. Fabrikant (1974) found that female therapists disagreed with the feminist argument that women work better with women, while Lazarus (1974) argues that there are some situations in which a male therapist is preferable to a female one for women.

Women, as a particular group and with particular problems, began to receive more attention in the literature, sometimes with an accompanying analysis of societal impacts on their symptoms and other times merely stating new research and/or new techniques in the psychotherapy of women. Krause (1971) and Moulton (1972) discuss their work with neurotically dependent women, a problem Krause labels the "femininity complex": women who have internalized the patriarchal ideal of womanhood. Schlossberg (1972) explains that women have been limited in their

decision-making potentialities because of societal conditioning and suggests a change agent model for counseling that supports a woman in expanding her scope of choices, enables her to make decisions, and helps her to implement them. She explains that there is a delicate balance between using consciousness-raising to free women to see expanding options for themselves and imposing one's views on the counselee. Pincus, Radding and Laurence (1974) describe their development of a counseling service for women, focused particularly on career counseling. Meador, Solomon and Bowen (1972) and Whiteley (1973) experimented with therapy groups for women only, finding that without men women discarded superficial role behavior and talked differently about those things most important to them. Similarly, Barrett et al. (1974) advocate women being in all-women groups to break down women's isolation from each other and provide new self-definition based on an awareness of the social source of one's problems.

Proceeding from a modified Freudian base, Kronsky (1971) presents a psychoanalytic model for dealing with women's self-assertive strivings and the guilt thereby engendered in which she communicates an explicit attitude of acceptance and support for women's desires for self-assertion as primary rather than as derivative from competition with men, even if this means she contradicts the biases of other therapists (see also Menaker 1974). Butler (1973), Cummings et al. (1974), Gilmore (1973), Jakubowski-Spector (1973a,b) and Withers (1975) deal with the issue of women's self-assertion much more from a learning theory model. Butler explains the differences between the assertive problems of men and women, with women having particular problems in

expressing negative feelings (disagreeing and expressing anger) and in nonapologetically expressing competency, power and authority. Women have received negative societal reinforcements for self-assertion, and in turn learned to punish their own assertive behavior. Gilmore finds depression to be a result of this sub-assertion. Jakubowski-Spector explains that at this time it is women who are demanding assertive training, and has developed a model which combines a stimulus film with behavior rehearsal.

Fodor (1974a,b) includes assertive training in utilizing a behavioral approach in the treatment of women's sex role conflicts and accompanying symptom formation. She explains that even when cases were not originally perceived as sex role conflicts, when reevaluated this is often seen to be a core issue, and gives examples of conflicts around achievement, phobias centered in leaving home and becoming independent, depression, and sexual problems, stressing the societal learning that accompanies the development of all these problems for women. In addition to traditional behavioral techniques, she emphasizes the value of modeling by an independent female therapist who shares her own experiences with the client. Burtie, Whitlock and Franks (1974) focus on female alcoholics, utilizing a behavioral approach to extinguish maladaptive guilt and restore self-esteem. However, while these techniques enabled them to promote guilt-free self-perception in 12 hours of behavioral treatment, these gains were eradicated or diminished after 16 weeks in the community, emphasizing the critical role of societal reinforcement on behavior. Beck and Greenberg (1974) present a model of time-limited cognitive therapy for depressed women.

Barbach's (1975) work with pre-orgasmic women¹⁴ views the presence of a sexual problem as an issue of learning and practice and has developed a group treatment model which incorporates a structured masturbation program in the context of group discussion, psychological information about female anatomy and sexuality, and homework exercises. Results are dramatic: 93 percent of the women who completed the program were consistently experiencing orgasm, usually through self-stimulation, five weeks later, a change which led to other changes in their attitudes and feelings about themselves. The group modality seems a critical aspect of this success, for the sharing that occurred broke down individual isolation and confusion and fostered support and insight.

In the early 70's, various professional journals put out special issues focused on women and sexism (i.e., American Journal of Orthopsychiatry, October 1971; American Journal of Psychiatry, October 1973; American Journal of Sociology, January 1973; Counseling Psychologist, No. 1, 1973; Journal of Marriage and the Family, August 1971; Journal of Social Issues, No. 2, 1972). In the years following, books began appearing focusing on women's emotional distress and various treatment approaches. Examples include Franks and Burtle's Women in Therapy (1974)¹⁵; Weissman's The Depressed Woman (1974); Osborne and Harris'

¹⁴In another article Kerr (1975) calls this "feminist sex therapy," but it is not included in the section of this chapter on feminist therapy because its focus is specifically limited to sexuality.

¹⁵Perhaps one of the most comprehensive anthologies in the field to date, it includes, in addition to works cited elsewhere, articles on therapeutic approaches to women historically (Osmond, Franks and Burtle), on women in institutions (Howard and Howard), on therapy with lower-class women (Siassi), on a Gestalt therapist's view of women in therapy (Polster), and on female homosexuality (Riess).

Assertive Training for Women (1975); Matthews et al.'s Counseling Girls and Women Over the Life Span (1972); as well as several collections of articles on psychoanalysis and women, in particular Women in Analysis edited by Strouse (1974) and Psychoanalysis and Women, edited by Miller (1973). Again, however, aside from the work of Kronsky (1971) discussed above who speaks of the "feminist-oriented therapist," these works only imply what feminist therapy would be.

IX. THE FEMINIST MOVEMENT IN SEARCH OF ALTERNATIVES

Concurrently the feminist movement itself,¹⁶ at least as indicated by the literature, seemed to move beyond attacks on Freud and traditional psychotherapy (which at a certain point seemed taken for granted) into a quest for alternatives (Malone 1971). Some suggested that consciousness raising could be an alternative to therapy for women (Brosky 1973; Eastman 1973; Hanisch 1970; Kirsch 1974; Walker 1970; Zweig 1971). As Bonetti (1974:10) explains:

In effect, a successful consciousness-raising group is therapeutic to the extent that women understand that their condition is political, women experience the personal growth and individuation that also happen to be objectives of psychotherapy.

Gerson (1974) used the model of the consciousness-raising group in work with 4th and 5th grade girls. Others, frustrated with their experiences in consciousness-raising groups or dubious from hearing of them from their clients, criticized consciousness-raising for its inability to move beyond individual liberation to collective liberation, beyond

¹⁶Those articles included in this section as feminist alternatives are distinguished from those in the previous section (as responses of the mental health field) by where they were located (i.e., alternative vs. academic or "established" press), and/or their focus (i.e., feminism as vs. therapy).

awareness to concrete action, beyond anger and damning critiques to institutional change (Cobble, Etta and Florika 1972; Fodor 1974b; Moulton 1972; Payne 1971).

Kreiger (1974) explains that even though women become aware of and talk about modifying socialized feelings, responses, actions and reactions through consciousness-raising, it is something else to actually transform one's behavior. "The knowledge that a woman is socialized to be submissive, for example, does not by itself help her to overcome her servility. She might need to experience [through therapy] how she holds back the dynamic parts of herself, or to deal with her fears of being assertive" (p. 5). She describes her attempt to combine consciousness-raising and Gestalt in a weekly women's group which she led, and explains the dilemma involved for her in attempting this synthesis.

I have had to constantly question the effectiveness of what I am doing. How well is this fusion working? Does concentrating on therapy detract from the effectiveness of a consciousness-raising group? Does emphasizing therapy hinder the process of raising people's consciousness. After someone has worked on something important about her personal life, does talking about how her work related to women in general take away from the intensity of her experience? By not putting total energy into either method, am I cheating the women involved? By attempting to do both, am I, in effect, doing neither adequately or thoroughly enough? These are just some of the questions I've asked myself.
(pp. 1-2)

Tennov (1972; 1974; and Payne 1974), rejecting the professionalism of psychotherapy, developed a self-help counseling project (C_1C_2) to be used in conjunction with consciousness-raising groups. The model is somewhat akin to the co-counseling model, for roles of interviewee (C_1) and interviewer (C_2) are interchangeable (at times decided by the flip of a coin), and the C_2 does not give advice, analyze or interpret but

is an accepting attentive listener, an advocate for the C₁. As Tennov (1974:1) explains, "To talk about one's problems is not sick, and to listen to someone talk is not psychotherapy."

Another alternative developed by feminists are Women in Transition Houses, now in existence in several larger cities. Some function as a place for women in transition to stay, while others function more as therapeutic communities for women (Raffini 1975; Sohl 1974; "Women in Transition" 1972). The book Getting Clear: Body Work for Women (Rush 1973) is an important example of self-help for women. In it are included interviews with 14 Bay Area therapists and collectives specializing in such diverse aspects of the growth movement as Gestalt Therapy, Adult Play Therapy, Massage, Food Awareness, and Women's Health, as well as numerous techniques and exercises (particularly focused on women and the reality of being female) "which are easily and safely used by anyone and can be useful tools in daily life" (p. 6).

Some articles began to appear in the popular and alternative press encouraging women to be selective about their choice of a therapist, explaining to women that a therapist's theoretical orientation and personal politics do influence therapy to a large degree and that it is incumbent upon therapists to explain to prospective clients their values and orientations. These articles explain the therapeutic pretense of power and authority, attempt to demystify therapy, and encourage women to choose a therapist based on recommendations from feminists and their own experience during an initial consultation (Cleveland Woman's Counseling n.d.; Rush 1973; Women in Transition KNOW). Krakauer (1972:35) advised women:

Don't assume or let a therapist tell you that your assessment of the interaction is less valid than hers or his. You're not dealing with the Divine Omniscience, just someone with a different opinion. Trust your judgment about what's best for you. . . . Question closely anything the therapist says that you don't think she or he would say to a man. If a therapist doesn't see more options for you than you do for yourself, maybe you should be her or his therapist. . . . Look for nondefensiveness and unpretentiousness. Ask whatever you want, and see how you feel about the answers. Finally, arm yourself with a healthy irreverence and the understanding that, regardless of politics, a therapist who implies that you should be a certain way (whether that way is "normality" or that therapist's particular notion of acceptable "deviance") might make it harder to explore who you are.

In response to the argument that politics have no place in therapy, Krakauer concludes: "Understanding the connections between objective conditions, the myths that support them, and personal experience is psychology. Sharing these understandings is therapeutic" (p. 34). In November 1972, the first advertisement appeared in Ms. for a referral service to feminist therapists, in New York City.¹⁷

Feminists began to call for a new psychology of women, and in so doing to articulate fantasies and expectations of what a therapist using the new psychology would believe and do. Some returned to the work of such theorists as Alder, Horney, Jung, Klein and Thompson for new perspectives on women's psychology as developing from the social context (Brogan 1972; Rojas 1974; Walstedt 1971; Yurmark 1972). Brien and Sheldon (1975) discuss the applicability of Gestalt to work with women. Silveira (1972:15) says that a new psychology of the oppressed and oppressor is needed as a basis for a new psychology of women.

¹⁷These services have developed in several larger metropolitan areas, providing lists of feminist therapists and encouraging a woman to "shop around" before she decides on someone. For a description of the one in Berkeley, see Appendix E.

You have to have, and we badly need, a psychology of the oppressed and the oppressor. We need guidelines of mental health for a person whose environment is totally opposed to her personal fulfillment because she is a member of a class. We need an analysis of the self-destructive and the creative ways of dealing with this environment. For women in particular we need a psychology which understands the results of being trained from the day you are born to live intimately with your oppressor, to have no home away from him, and to seek your total personal fulfillment through him.

Chesler (1972), on the other hand, argues that "'political' insight about one's own oppression is no more a sure road to paradise on earth than is the achievement of 'personal' insight a guarantor of individual happiness" (p.124). Instead, she suggests a new female psychology based on a shift in women's primary ego identity.

Woman's ego identity is rooted in a concern for limited and specific "others," and for what pleases a few men. Woman's ego identity must somehow shift and be moored upon what is necessary for her own survival as a strong individual. . . . Any woman who successfully becomes interested in and begins to achieve various powers directly, and not through or for a "man" or a "family," is, within the psychological kingdom of patriarchy, committing a radical act, i.e., an act that risks "winning."
(p. 256)

As early as 1971, many of the articles appearing in the magazine Radical Therapy began to talk about an integration of radical therapy and a feminist consciousness, in varying forms, most of which incorporated a radical critique of the political and economic system with particular emphasis on the position of women in society (for example, Brown 1970; Parun 1971; Pines 1971).¹⁸ Since 1970, the radical psychiatry movement

¹⁸There are many similarities between the assumptions of radical therapy and feminist therapy, in particular parts of their societal critiques, their emphases on power, and their concerns with the relationship between the personal and the political. However, since few feminist therapists in the interviews and few articles in the literature mentioned any relationship, it is not dealt with here except in the ways it relates to women. In addition to the two radical therapy journals, Radical Therapy and Issues in Radical Therapy, both of which were read extensively as part of this research, see Agel (1971, 1973), Anderson (1973) and Halleck (1971).

in Berkeley has been incorporating a Transactional Analysis model in conjunction with a radical political perspective with a goal of demystifying people's oppression, teaching radical political values, and helping people learn to reclaim their power collectively. Much of their work has been in developing an extensive analysis of sex roles utilizing TA theory. Basically, they view men and women as scripted differently, with neither programmed to be whole human beings. Thus, women are programmed to develop their little professor (or adapted child), nurturing parent, critical parent, and not their adult or child. Their therapy is focused in part on comparing these sex roles, both in themselves and in the people they work with. Much of their work is focused on enabling women to be potent, to get what they need without adapting or rescuing, to confront discounting, and to maintain contact with other women, utilizing a group approach ("The group situation is the most auspicious for women since it's obvious that there are no individual solutions for oppressed people and to have strength we must band together" Wyckoff 1970:128). However, although they have developed strategies and techniques for dealing with the particular oppression of women, they refer always to what they do as radical psychiatry and not feminist therapy (Hermes 1970-71; Steiner 1974; Thomas 1971; Vance 1971 a,b,c,d; Wyckoff 1970, 1971, 1972-73, 1973).

Out of the responses of the mental health field to feminism and this feminist search for alternatives, feminist therapy has come.

X. FEMINIST THERAPY

In April 1973 the first advertisement appeared in Ms. for feminist therapy. In the June 1975 issue, under the classified ad heading of Services, half of the advertisements for therapists and therapy referral services listed such descriptions as "feminist therapist" or "feminist psychotherapy." A list published by KNOW in the early seventies included 43 feminist therapists, and Jacobson (1973) listed seven feminist therapist collectives in various parts of the country.

However, given this clear evidence that such a thing as feminist therapy exists (at least to the degree that there are women who label themselves as feminist therapists and their work feminist therapy), there is a notable absence in the literature, particularly the academic and professional journals, of any discussion of what feminist therapy is and even less on what feminist therapists would do. The articles located in the literature on feminist therapy per se number 21, of which two are papers written for courses in graduate school (Boatman 1973; Fashing 1974), seven are speeches presented at conferences and conventions (Feminist Counseling Collective 1974; Lerman 1974; Munter 1975; and five speeches from a 1975 San Francisco Conference on Women and Mental Health, discussed together at the end of this section), and the remainder of which with two exceptions are brief articles appearing in various alternative papers and magazines (in particular Radical Therapy). All are largely theoretical; there are no studies of feminist therapy.

Lerman (1974) and Jacobson (1973) both stress that this absence of any published "how-to" of techniques or theoretical stances and the

lack of clear leadership makes even more impressive the development of feminist therapy. Lerman explains that in talking with feminist therapists across the country, she finds a common philosophy and a common language.

What is happening is truly exciting in that it seems that therapists throughout the country are independently arriving at the same concepts and changing their modes of interaction with clients. It is truly a grassroots occurrence without a "name" leader. It does feel as though there is a commonality about what feminist therapy is and what happens in it.

(p. 1)

Although Edwards, Cohen and Zarrow (1975) speak of "feminizing" techniques from other forms of therapy, most of the literature agrees that feminist therapy is less any set of techniques than it is a set of values or attitudes from which a therapist works. Jacobson explains, "It is more amorphous--an underlying idea, a driving force for change, an attitude" (p. C1). Lerman concurs:

Techniques [in feminist therapy] are quite variable and, in my view, relatively unimportant. What most clearly differentiates feminist therapy for me from other types of psychotherapy is a difference in philosophy.

(p. 1)

Several definitions are presented, mostly fairly vague and circular. For example, Walstedt (1971:10) defines a feminist psychotherapist simply as "someone who supports and understands the desire for female equality," while Silveira (1972:21) explains that feminist therapy is "counseling which affirms women's liberation and proceeds without power differentials between counselor and counseled." In both definitions, however, feminist therapy's roots in the women's movement and overt political position are clearly stated. In the available literature, there are certain common areas of consensus about what feminist therapy is, and other areas where agreement is less clear. The areas of consensus will

be discussed first.

Two basic assumptions are repeated in all discussions of feminist therapy. The first assumption is that the client is competent, worthwhile, of value as a person, and inherently "OK." In this stance, feminist therapy acknowledges the influence of the humanist movement, but this humanism is modified by the second assumption. The second assumption is the idea that a woman's potential is molded and shaped by the society, in particular by sex-role stereotypes. From these two assumptions follow two core concepts of feminist therapy, which are repeatedly reiterated. The first has to do with the therapist's attitude toward the client, the second with the therapist's attitude toward the client's problems. The distinctions overlap somewhat but nonetheless will be used in this discussion as much as possible.

First of all, because feminist therapy views the client as competent, it is concerned with how the therapist relates to the client. A goal is for the therapist to be a nonauthoritarian, nonhierarchical figure, potentially an equal with the client. As Dejanikus and Pollner (1974:10) explain, "It has to do with the whole idea of new models of intimacy between equals." Lerman (1974:3) continues:

The [feminist] therapist does not take the position of expert about her client. She . . . views the client as . . . the person who is most knowledgeable about her own feelings, thoughts and needs. From this perspective, the therapist does not presume to tell the client about herself, diagnose the client or prescribe treatment. Any commitment for psychotherapy arises from an interchange in which the therapist does not assume that her opinions have any greater weight than those of the client.

Rather than emphasizing the therapist's expertise (and power) and thereby the client's dependency, the client's personal power is stressed and the therapist is expected to "open herself up to change" (Dejanikus and

Pollner 1974:11) and attempts to mitigate any hierarchical authority she may possess. It is explained that this is critical because women have been trained to believe (and experience in reality) that they have little power to determine their own values, needs, actions and thoughts and have given away the power to do so to others. A goal of feminist therapy therefore is to enable a woman to re-gain control (power) over her life, to take responsibility for herself. Thus, Lerman (1974:4) explains that feminist therapy attempts "to help the woman client validate her own experiences rather than to undercut this process through the use of the authority position which the therapist can so easily assume." Because of this focus on the therapist as a real person, transference is seen as irrelevant. Because the client is seen as competent and knowledgeable of her own wishes, resistance is similarly dismissed.

Several authors in the last year draw the analogy between women (or feminist therapy) and healing (Mander and Rush 1974; Valliant 1974). Mariechild and Williams (1974) describe a feminist therapist as a therapist who functions as a midwife, helping women heal themselves by guiding them into the unconscious and through the labor of becoming aware of their own positive abilities and delivering themselves of their fears. "We are midwives involved in the process of helping women give birth to themselves" (p. 6).

Several behaviors follow from this position. First, encouraging a woman to shop for a therapist is mentioned (Lerman 1974; Perlstein 1975). Again, this comes from the idea that therapy is a service the therapist offers the client, and therefore that the client is the one

to determine, utilizing her judgment and impressions, the degree to which a particular therapist meets her needs. Secondly, the feminist therapist shares herself, showing that she is not only strong but vulnerable, that she is not godlike and does not have all the answers--thus demystifying "the image of the mind-healer" (Jacobson 1973:C5; Feminist Counseling Collective 1974). Thus, a feminist therapist's life is integrally connected with her therapy. "To talk about feminist therapy you're talking about someone who's living a lifestyle--it's not just a therapeutic philosophy" (Munter 1975). As a woman and as a feminist, a feminist therapist shares her experiences of being a woman in this society, and a bond of commonality develops between client and therapist. As the therapist shares who she is, she serves as a strong role model for her clients of a self-actualized woman who has discarded traditional images of what it means to be a woman and moved in the direction of new norms and lifestyles (Shimkas 1974). The third behavior has to do with values. Feminist therapy is acknowledged from the beginning to be a value position, and several articles stress that a part of feminist therapy is making one's values overt (perhaps in the first session), again to demystify the therapist and the therapy process. As Dejanikus and Poliner (1974:10) explain:

Most therapists don't make their values overt to their clients. They mystify their clients. They won't tell them how they feel about sexuality; they won't tell them about their own present unresolved conflicts. . . . Basically, we think that's a lot of crap. Therapy almost always risks being a process where the therapist lays values on the client. The only way out of that problem is to make the therapist's values so overt that the client has some power to accept them or reject them. Getting rid of that secret mystique is one part of feminist psychotherapy.

As a further means of demystification, Fashing (1974) stresses the importance of having a theory of therapy that is teachable to clients so they will come to rely less and less on the therapist. Lastly, several writers mention utilizing a contract-based or problem-solving approach to the therapy to further incorporate the mutuality they feel is so critical and emphasizing experiencing rather than just talking about new ways of being.

The second core concept of feminist therapy has to do with how it views a client's problems. In essence, feminist therapy accepts the Feminist Critique described earlier in this chapter and, believing that much of a woman's emotional trauma comes from societal pressures, sees a woman's problems in a social context. Feminist therapy rejects the whole concept of "sickness," believing that there exists some distress in a woman's personality for which she is not responsible, but rather has acquired simply by being a woman in a sexist society (Lindsay 1974; Fashing 1974). Thus, part of feminist therapy becomes helping clients to explore those aspects of their social conditioning which have added to their personal problems and to separate those aspects for which they must take responsibility. "The goal of a feminist theory of counseling would be to raise the consciousness of all people and to liberate people from roles that have literally made them sick" (Fashing 1974:9). However, whereas consciousness-raising works to destroy the myth of individual responsibility, feminist therapy focuses on how an individual responds to the world, on what she wants, how she stops herself from getting it and how she is stopped from getting it--on the interplay between the individual and society. Lerman (1974:4-5)

explains:

[An] important philosophical position which plays a large part in feminist therapy is the tenet of the feminist movement that "the personal is political." We help the woman client to differentiate between what she has been taught and has accepted as socially appropriate and what may actually be appropriate for her. . . . Where the more usual therapy encourages clients to introspect and thereby learn to know themselves better, feminist therapy helps its clients look outward as well as inward and differentiate clearly what belongs to the society and is being imposed and what is internal.

Helping a woman separate the internal and the external, in addition to enhancing her self-confidence and sense of personal power, helps her learn that she is not crazy, that what she has been perceiving all along is that real double bind which exists for women. As a corollary, feminist therapy also endeavors to break down sex role stereotypes and help women develop as they wish without the constrictions of societally determined standards of appropriateness, to increase a woman's awareness of her options and her power to make choices for herself. For example, whereas women are taught to nurture others, feminist therapy gives her permission to nurture herself (Lerman 1974). Self-assertion is also a focus.

At times, this newfound consciousness may lead to rage, anxiety or guilt, and feminist therapy is concerned not to discount or invalidate the reality base of these feelings, by labeling them irrational or out of proportion. Ultimately, the feminist therapist wants to help a woman channel her rage and to make clear choices, but only if channeling does not mean repressing, diluting, or denying. There is an awareness, however, that therapy has limits, particularly in changing economic conditions. As Lerman (1974:10) explains, "All human pain is not directly accessible to psychological intervention. We cannot change the

world in our offices." Rather, the role of the feminist therapist is "to help a woman recognize the sources of her oppression and what power she actually does have to affect her situation" (Dejanikus and Pollner 1974:11). Often, this means that a feminist therapist acts as a referral source, telling clients or other women and/or organizations who are struggling with similar issues. Some discuss the importance of fee negotiation in this context. The panel members at a recent conference in Boston agreed that "any woman who calls herself a feminist therapist and doesn't charge on a sliding scale within her clients' means is not a feminist therapist" (Edwards, Cohen and Zarrow 1975).

Mander and Rush (1974) present a somewhat different perspective on feminist therapy and therefore it is presented apart from the others. They define therapy as healing, and explain that because feminism enables a woman to become integrated, to trust other women, and to be conscious of the social context and of the connections between her life and the outside world, between sex and society, work and play, body and mind, it is therapeutic.¹⁹ Feminism, then, is therapy--"We don't necessarily need 'therapists' to do 'therapy'" (p. 51).

Unearthing the true natures of ourselves as women today is healing in itself because we can then understand and function congruently with our energies. Seeking to correct the imbalance of women's position in society and in their personal lives is also a healing process which helps everyone get more in touch with themselves. (p. 55)

Although they speak of wishing to move beyond techniques, their book contains the only listing of identified feminist therapy "techniques"

¹⁹A speaker cited in Edwards, Cohen and Zarrow (1975) disagreed, saying that feminism is not therapy by itself and that no matter what--or how perfect--the social and economic structure, there will always be difficulties in human interaction.

or exercises in the literature. They explain that before incorporating any technique, they ask themselves:

Is this based on concepts of segmentation or integration?
Where did the philosophy behind it come from? What political
stance does it take and advocate? What relationship to power
does it encourage? Does it bear the stamp of a class value?
Does it integrate body and mind? Is it a process which will
leave room for opening and balancing of our female energies?
Does it emphasize the technique or the content? (p. 96)

Overall, they differ from the other literature describing feminist therapy in their emphasis on the spiritual and on the healing or therapeutic aspects of feminism itself and accordingly, on their de-emphasis of therapeutic skills and the therapeutic process.

In the literature on feminist therapy, a number of issues are raised on which there is no clear agreement. They include whether feminist therapy is really any different than other therapies, whether feminist therapists should be women, whether feminist therapists can (or should) work with men, whether the objective of feminist therapy is to make women into feminists and following that, whether therapy is merely a personal solution.

In response to the first issue, many feel that the most important thing is that the therapist be a sensitive, competent human being--in other words, a good therapist. However, others explain that a feminist therapist must have a clear political consciousness, a broader understanding of sexuality, the ability to share herself, and an awareness of alternatives. For some, the differences seem to be a question of the quality of one's conviction; others stress the presence (or absence) of certain beliefs. Dejanikus and Pollner (1974:11) state:

You ask what's a feminist therapist . . . To know we'd . . . ask certain questions: Will she try to keep somebody in a bad marriage? Will she push monogamy? Will she talk about penis envy or in any way inculcate those kind of fucked-up Freudian ideas? Obviously, she can't do any of those things and be a feminist therapist. There's an enormous danger when a therapist has no feminist consciousness, no political consciousness.

In response to the question about whether feminist therapists must be women, most women feel that because of the potential commonality of experience existing between women, the inherent institutionalized power a man has in relation to a woman, and the advantage of a strong female role model for women, feminist therapists who are women have more to offer women clients at this time. Some, however, explain that there is an important place for male therapists who are serious about feminism in working with men.²⁰

Most feminist therapists writing or interviewed in the literature seem to see few men, but do feel a feminist therapist can work with men, explaining that the goal of helping a person become himself or herself and assume personal power without the restriction of traditional sex-role stereotypes is a need of men as well as women, although men are enculturated differently and therefore bring different issues to therapy, in particular not being able to get in touch with feelings and an over-dependence on rationality.

In response to the issue of whether the goal of feminist therapy is to make women into feminists, Lerman (1974:10) responds that she both agrees and disagrees. She does want her clients to become feminists

²⁰The Lesbian Feminist Therapy Research project (cited in Edwards *et al.* 1975) refers to their statistics which show, for example, that women who had been in therapy came out to their families with much less frequency than those who had not, to argue that even a feminist therapist may not be appropriate for a lesbian if she is not also a lesbian.

if "feminist" means awareness of external oppression and the attempt for a woman to gain self-definition as a person and personal power to the degree possible given that existing external oppression. However, if becoming a feminist means a woman would have to accept totally all tenets of feminism, then that would not be her goal.

Women come to therapy with all degrees and types of commitments already established: to specific people, families, ideologies, jobs, life styles, and values. The goal is to help them become the best person they can be, within the limits of their personal circumstances and the patterns of society in general. If that means they need to become active feminists, fine; if not, fine too.

Webbink (1973) explains that feminist "shoulds" can be as destructive to women as the traditional "shoulds," and that her goal is to free a person from all "shoulds" so she can choose for herself, which she considers real liberation. Fashing (1974) seems to feel, however, that individuals when liberated through feminist therapy will want to change oppressive institutions and that is a goal for her.

In regard to the last issue, some radical feminists criticize feminist therapy, saying that it is counter-revolutionary because it leads women away from the political into the personal and defuses anger (Jacobson 1973). Most feminist therapists disagree. Some explain that some degree of personal actualization is necessary before anyone can be effective in any movement. Silveira (1972:22-23) feels that using the personal solution/political solution dichotomy to attack psychology is spurious. She explains that psychology's present emphasis on the personal solution "is a result of the institution's male, white, status quo reactionary bias. . . . Psychology properly defined is the study of intra-organism laws that limit and structure human behavior."

In January 1975, a Conference on Women's Mental Health was held in San Francisco, and in April 1975 a similar one was held in Boston. Papers presented highlight and refocus what seem to be additional issues in feminist therapy currently (Dubitzky 1975; Duxbury and Heaney 1975; Edwards, Cohen and Zarrow 1975; Hunter 1975; Perlstein 1975; Wolman 1975). The developers of the Boston conference (Edwards, Cohen and Zarrow 1975:18) explain that they organized the conference out of their dissatisfaction with the published material available on feminist therapy and their desire to answer questions about how to integrate feminism into the therapeutic process.

[We] wanted to know what other women think feminist therapy is--a philosophy, a practical theory, a definable skill? . . . Where does therapy stop and consciousness-raising begin? While there is no such thing as value-free therapy, and we believe in the value of feminism for women, at what point is a client making her own choices instead of merely reacting to her social condition--or her therapist's politics? Feminist therapists also have to decide which skills and theory from other schools of psychology are useful to us and which to throw out.

Some issues raised, such as structural questions of fees, times, availability, dealing with value orientations of therapist and client, men as clients of feminist therapists and as feminist therapists themselves, and straight women working with gay women, were incorporated into the interview used in this study. However, the most central issues debated at this conference had to do with how professionalism and fees related to feminist therapy and how therapy related (or doesn't relate) to the society (or the system) (Perry 1975).

Dubitzky argues very strongly that it is impossible to have a therapist-client relationship that even approaches any equality of power, which is a critical aspect of feminist therapy, when the therapist

is committed to the responsibilities and rewards of professionalism, particularly when that professionalism is composed of learning from male institutions. Following from this, Duxbury and Heaney, and Wolman, question the degree to which therapy, working on an individual level with individual problems, can even be relevant to the need to change the current sexist capitalist society. They are concerned that it is too easy for therapy--including feminist therapy--to become another "external addiction" of the privileged few. Duxbury and Heaney (1973:3-4) state:

The harsh reality of economic survival takes precedence over head-tripping. A white middle class therapist must recognize her limitations in dealing effectively with those women who are struggling every day for economic survival. . . . How relevant can Gestalt exercises in awareness be when the woman cannot buy tampax or toilet paper with her foodstamps? . . . A therapist who charges \$10 or more an hour to a typist who makes \$2.50 an hour cannot consider herself a feminist.

It is not enough, they argue, for a feminist therapist to be a feminist--she must also be working for radical personal and political change. Feminist therapy must assume a role of helping women become aware of internalized oppression and ways to reverse complicity with one's institutionalized powerlessness. Thus, Duxbury and Heaney (1975:1) state:

We believe feminist therapy can be a valuable tool in helping women to reclaim some of their power and become aware of some internalized blocks towards expression of that power. But those blocks were not created in a vacuum and to only work them out in a therapist's office is just another vacuum. Allowing a woman space to express her anger in a group of other women may be a positive first step but without that anger being allowed and encouraged to take place outside in the world where it belongs, her power is short-circuited. We feel that if a woman is to consider herself a feminist therapist, part of the process of therapy must include making clear the political connections between a woman's personal life experiences and her socially reinforced sense of powerlessness. Finding solely individual

solutions to personal problems is a symptomatic approach. We can no longer afford to supply band-aids to our wounds: we must look and see what is causing all this bleeding.

Similarly, a speaker at the Boston conference defines feminist therapy as helping "women transform their unconscious, covert slave rebellion to conscious, open warfare against the persons and institutions which work to enslave them" (Edwards, Cohen and Zarrow 1975:18).

In this literature on feminist therapy, several interviews with individual feminist therapists exist. Jacobson (1973) interviewed five feminist therapists, as did Boatman (1973) but both are brief syntheses of interviews with feminist therapists selected arbitrarily. To date, in none of the available literature has there been any attempt to systematically determine what feminist therapy is (and isn't), and to describe its theoretical bases and cite examples of its practice, based on information provided by those actually doing it. That is the goal of this study.

CHAPTER III

RESEARCH DESIGN

I. INTRODUCTION

The basic design utilized in this study is a qualitative methodology. Filstead (1970) and Glaser and Strauss (1970) argue that such research is not merely exploratory in function or prefatory to quantitative research but is a distinct research strategy particularly applicable to the construction of substantive theory. "In short, qualitative methodology advocates an approach to examining the empirical social world which requires the researcher to interpret the real world from the perspective of the subjects of his investigation" (Filstead 1970:6-7). Because it is based in the tradition of verstehen, or understanding, qualitative methodology assumes that knowledge (and hence, understanding) of any social phenomenon--such as feminist therapy--can only be attained by an approach which incorporates what Filstead (1970:4) calls "both an inner and an outer perspective." In this study, that was done by focusing on the feminist therapists' perspectives of feminist therapy, her own and that of others, both on a theoretical and on a clinical level. In turn, this methodology provided an approach in which the beginning formulation of substantive concepts preceded the development of formal theories, rather than vice versa, as Glaser and Strauss (1970:304) explain:

Ignoring the task of discovering substantive theory that is relevant to a given substantive area is the result, in most cases, of believing that formal theories can be directly applied to an area, and that these formal theories supply all the necessary concepts and hypotheses. The consequence is often a forcing of data and neglecting of the relevant concepts and hypotheses that may emerge. Allowing substantive concepts and hypotheses to emerge first on their own enables the analyst to ascertain which of diverse formal theories may be inclusive of his substantive theories, thus enabling him to be more faithful and less forcing of his data (or more objective and less theoretically biased).

In this study, an extensive literature review was itself the initial form of the field research, out of which tentative hypotheses about the theory and practice of feminist therapy began to emerge. This continual intermeshing of data collection and analysis with no clear-cut line between the two is cited by Glaser and Strauss as characteristic of this methodology, leading to the perusal of multiple hypotheses concurrently. Thus, hypotheses from the literature review became the questions raised in the interview, and in the interview process the second round of data collection and analysis commenced. The actual thematic analysis of the interviews themselves was the third round of the methodology, out of which came the summary and conclusions, the ordering of the findings into a discussion of some of the parameters and tenets of feminist therapy.

The specific design of the research was as follows: A sample frame of those who identified themselves as feminist therapists or counselors in three of the four major metropolitan areas on the West Coast--Portland, Seattle, and the Bay Area--was first generated and then surveyed via a questionnaire for characterizing data, with particular attention to differences among the three locations surveyed and among the varying degree levels represented. The primary information for

analysis was then collected by administering focused interviews to a random sample of those feminist therapists. The interviews were tape-recorded and transcribed, and the contents thematically analyzed to delineate issues, identify areas of consensus and areas of difference, and characterize clusterings of response and assumptive patterns within the population.

Initially, the interviews were planned to be purposive. However, a desire for increased generalizability led to the utilization of a more formalized process for locating potential members of the sample frame, development of a questionnaire to identify those actually in the sample frame, and application of a random number table to the sample frame to choose those to be interviewed.

The population was purposefully chosen to include residents of three metropolitan areas instead of just one because as a newly emerging form of therapy, it was felt that feminist therapy would perhaps be practiced, defined, or adhered to differently in different areas depending on their degree of exposure to it and their receptivity to therapeutic and cultural innovations in general. For example, in particular, it was felt that the Bay Area was an environment where there was a heightened awareness and an accelerated adaptation of cultural changes in general and an historical fostering of radical and feminist movements. Thus, no one area could give a complete picture of feminist therapy as it is currently being practiced on the West Coast. In the questionnaire analysis, attention is given to comparison of responses among the three areas to determine if in fact differences presumed to exist among them are reflected in the characteristics of

the population.

The criteria for inclusion in the population were that the person live within the chosen metropolitan areas, that the person be involved in therapy in a role other than or in addition to a student or residency capacity, and that the person identify themselves as a feminist therapist. Self-identification was decided upon as a means of discriminating feminist therapists from non-feminist therapists because a review of the literature indicated no clear definition of feminist therapy against which an otherwise-identified feminist therapist could be compared. This criteria for self-identification led to a certain amount of questioning among respondents. When asked to reply "yes" or "no" to the question, "Do you consider yourself to be a feminist therapist or counselor?" they could in turn respond that it depended on one's definition of a feminist therapist or counselor. It could be argued that many who excluded themselves on the basis of their "no" or "don't know" response to this question would, if surveyed, be no different than those who replied "yes." However, a basic assumption was that the decision to formally identify oneself as a feminist therapist was a crucial aspect of being a feminist therapist¹ and therefore that those who had made this identification for themselves, for whatever reasons, were likely to

¹Recently, a woman who identified herself as a feminist therapist on the questionnaire reported in another context, "I became a feminist therapist the day Susan Thomas asked me on her questionnaire if I was one." Feminist therapists interviewed themselves discuss and disagree on whether self-identification is a necessary criteria for feminist therapy (see Chapter IV, Section III, Qualifications About Feminist Therapy).

differ (although perhaps in very intangible ways) from those who had not.

The initial research dilemma was locating the sample frame. Contacts with what seemed to be obvious sources (such as the National Organization of Women) revealed no single organization in any one of the three areas with any potentially complete list of feminist therapists in their area. Therefore, the decision was made to utilize the "natural helping network" or "natural system of service delivery," described by Collins (1973:46) as "a network of relationships in which individuals seeking a specific service find it, without professional intervention." It was assumed that such a network exists within the feminist movement, an unformalized yet highly efficient system for referral, evaluations and listings of individuals and services adapted to, sympathetic to, or needed by women involved in and peripheral to the women's movement, including legal services, child care, gynecologists, rap groups, as well as therapists identifying themselves as feminist therapists or sympathetic to the feminist movement. A further assumption was that a systematic process of tapping into and moving through the network would ultimately result in the generation of a sample frame encompassing as much of the population of feminist therapists as it was possible to locate. This assumption is substantiated by the work of Milgram (1967; Travers and Milgram 1969) on the "small world problem" in which it was found that highly efficient linkages did exist between even randomly chosen individuals. Since in this study, individuals and organizations were not randomly chosen but were located in the same area and were involved in some way either with therapy or with women, it seems very

likely that feminist therapists would be known to feminist or women's organizations and/or to each other, producing, when contacted, the most complete and representative sample frame possible. Entry into the network involved two phases. The first phase was an attempt to replicate the process a woman seeking feminist therapy would go through in locating a feminist therapist. The second phase was asking all potential feminist therapists located to list the names and addresses of other feminist therapists they knew (the technique of snowballing). Because of time limitations, the second phase could not be followed through to completion. In addition, the actual size of the population is not constant because of the transience of its members, among other things. However, at the point in time at which the research was undertaken, 65 percent of the known population had been contacted, and it is assumed that the sample frame so generated is representative of the population of feminist therapists in Portland, Seattle, and the Bay Area.

Finally, two aspects of the research design deserve some discussion, the utilization of interviewing as a means of data collection and the question of researcher bias. Becker and Geer (1970) argue that interviewing has a basic shortcoming as a research technique when it is used as a source of information about events that have occurred elsewhere and are merely described by informants. In this study, then, there is the possibility of discrepancy between feminist therapists' descriptions of their practice and their practice itself, and between their theoretical orientations as they present them, perhaps influenced by how they think a feminist therapist "should" respond, and their actual beliefs. Deutscher (1970) raises the similar issue of

distinguishing between reliability and validity, arguing that although research data may be reliable (i.e., the interviewee says what she thinks), such reliability is not equatable with validity (i.e., that she does what she says she does). These are obvious limitations of such an exploratory study.

As a strategy, qualitative methodology demands that the researcher be on the inside of what is observed, for it is only through participation in an activity that interest, purpose, point of view, value, and meaning can be generated. Such participation, however, also creates bias, for the observer becomes part of the observed and in turn has a personal stake in what is studied (Filstead 1970). This issue of research bias is dealt with in Section V of this chapter.

II. DEVELOPING THE SAMPLE FRAME AND CHOOSING THE SAMPLE

A fairly similar process of sample frame development was followed in all three areas. In the fall of 1974, initial contacts were made with women's health clinics, National Organization of Women, women's bookstores and resource centers, Women's Studies Departments, and YWCAs in each metropolitan area. Published directories of area-wide resources for women were used when available, as well as posters listing workshops, advertisements in the alternative press, and information provided by friends living in each area. When contacted, these sources in turn suggested other organizations and persons to contact, until at a certain point no new contact sources surfaced, and old ones were repeatedly mentioned. In this manner, 147 names were gathered for the initial questionnaire mailing.

Differences between the three cities were observed during this process. In Portland, the smallest of the three metropolitan areas, information was the least widely known and referral the least specialized and centered. Three initial contacts (Women's Resource Center, Women's Health Clinic, and PSU Women's Studies) provided the majority of the initial names. These three places each had small lists of therapists to whom they referred (not necessarily feminist) and did not know of other more complete lists.

In Seattle, initial telephone contacts with such organizations as N.C.W. and Women's Studies led to other organizations and clinics. Four of those--University YWCA, Women's Resource Center, Seattle Center for Sexual Minorities, and Aradia Clinic--had compiled fairly extensive lists of feminist therapists in Seattle, and these names were the basis of the initial Seattle mailing.

In the Bay Area, the process was complicated by distance and sheer size of the population. Population size and a certain "cultural heightening" seemed accompanied by a higher level of specialization and organization. In the summer of 1974, a local alternative newspaper, the Bay Guardian, published a resource guide for women which included a counseling and mental health section. From the listings in this directory, contact was made with the Women's Switchboard, and the San Francisco and Berkeley Women's Centers. The former two were a source of the majority of the Bay Area names. The Berkeley Women's Center appears to be the most organized referral source in the three areas. The collective involved with referral discussed my request for a list of names and decided that to give out the names of therapists on file with them

"would be an unfair thing to do unless we were to call each woman up first and ask if it were OK to give out her name, and there just isn't time for us to do that."² The Resource Directory also listed names of collectives and centers doing feminist and radical therapy. Other sources contacted in the Bay Area, such as bookstores, generally suggested the three initial sources previously contacted. In the Bay Area, it seems referral has become a discrete and specialized process.

In order to ascertain whether or not a person fit the criteria for inclusion in the sample, a questionnaire and explanatory letter were developed (see Appendix A and B). The letter explained the goal of the study, the purpose of the questionnaire, the overall research design and the criteria for inclusion in the sample frame. A notation was made on the bottom of the letter indicating to the recipient from whom their name had been obtained. The first question was designed to provide the information on which to base inclusion in or exclusion from the sample frame, asking, "Do you consider yourself to be a feminist therapist or counselor?" and adding, parenthetically, "I have not defined this further, wanting your answer to reflect your own personal standards and criteria." A "yes" or "no" forced-choice followed. The remainder of the questionnaire dealt with theoretical orientation, length of time having done therapy, degree level and field of degree, focus of practice, mode of practice, practice setting and areas of

²After meeting with them while conducting the interviews several months later, they were very helpful and allowed a comparison of their list of names with the ones obtained by the researcher. This is discussed further later in this section.

specialization. Two final questions asked if a person were willing to be interviewed and for the names and addresses of other feminist therapists they knew of who could be contacted for the study.

The initial questionnaire (along with the explanatory letter and a stamped, self-addressed envelope) was mailed on December 5, 1974 to those 147 therapists whose names were located as possible feminist therapists or places where feminist therapists might be practicing. Although some replies were received by return mail, others were returned much more slowly. Names listed as other contacts on the returned questionnaires (if they had not already been sent a questionnaire, as was often the case) were sent a questionnaire packet as soon as they were received. Since it was possible for this process to happen several times (i.e., an initial contact would list several names, those names when contacted would list other names, etc.), locating the sample frame by this means was a lengthy process. Approximately three weeks after the first mailing, those who had received the first round of questionnaires and had not returned them were contacted by telephone when possible or by mail. Henceforth, a follow-up contact was made whenever three weeks had passed and a questionnaire had not been returned.

By January 15, 1975, 187 questionnaires had been mailed out, with 40 of those 187 names generated from returned questionnaires. After January 15, no new questionnaires were sent out although questionnaires were still being returned, often with listings of additional names to contact. Table I indicates by area the

questionnaires sent and the additional names generated, resulting in a potential population of 273.³

TABLE I
GENERATION OF POTENTIAL SAMPLE FRAME

	Original Mailing	Names generated by 1/15 and sent Questionnaires	Total Questionnaires Sent	Names generated after 1/15 by Questionnaires; no Questionnaire sent	Names otherwise generated after 1/15; no Questionnaire sent ⁴	Total
Portland	22	15	37	6	3	46
Seattle	50	6	56	22	-	78
Bay Area	75	19	94	26	29	149
Totals	147	40	187	54	32	273

It is interesting to compare the generation process in each of the three locations. The number of names generated by the questionnaire was proportionately much greater in Portland than in either of the other

³Interestingly, of these 273 names, only four were male, and only one of the four said he was a feminist therapist.

⁴These names were obtained during the interviews themselves (2), by the interviewer from bulletin boards and friends while traveling to conduct interviews (10), and from the Berkeley Women's Therapy Collective who granted the interviewer permission to compare their list of names with the researcher's list. Of the 35 names they had on file, 15 were already known and 20 were new.

two areas, almost doubling the original number of contacts. It appears that in Portland, information about who the feminist therapists are is known primarily by the feminist therapists themselves. Of the 22 additional names generated in Seattle after January 15, 18 of these were unnamed members of either a feminist therapy training group or a newly forming women's counseling collective; and it is unclear how many would if contacted be found to be duplications of names previously obtained. However, even if this aspect of the Seattle response is not considered, some pattern seems observable just in the sense that in Portland (and possibly in Seattle), the numbers of additional names obtained lessened as the process progressed while in the Bay Area, the new names received or otherwise located kept increasing. This could be an indication of size above all else: obtaining a finite list of feminist therapists in Portland utilizing the natural helping network seems possible in a finite amount of time. In the Bay Area, although a certain number of names were consistently duplicated, names listed were equally likely to be new names not previously contacted. However, it would be expected that if there had been no need to stop the snowballing process because of time constraints, duplications would ultimately have begun to outnumber new names.

After January 15, 1975, renewed efforts were made to obtain those questionnaires which had not yet been returned. Twelve questionnaires sent in the total mailing (of 187) were considered inapplicable because of unforeseen inaccuracies in the process of screening the mailing (i.e., one address sent three questionnaires replied they were a women's center but not a feminist therapy group; one woman said in response to a

reminder letter she had never received the questionnaire and was not a feminist therapist anyway, etc.). Thus, the actual mailing to potential therapists was 175, hereafter referred to as the adjusted mailing.

Of the 175 questionnaires in the adjusted mailing, 135 were returned. These questionnaires were divided on the basis of the response to the first question in which respondents were asked whether they did or did not consider themselves feminist therapists. A number of those who responded qualified their responses by defining feminist therapy and by that definition thereby including or excluding themselves, or saying that they didn't know what feminist therapy was and therefore could not respond. Criteria were established for categorizing their answers and thus determining inclusion in the sample frame, but this process would have perhaps been more accurate if in addition to the "yes-no" choice, categories of "don't know" and/or "non-sexist" had been included.⁵

Comments from those indicating a qualified "yes" (it must be noted that only a small percentage of the "yes" respondents--17 of 105--responded in this way; most did not qualify their affirmation) included comments qualifying their behavior ("but don't always behave as such" or,

⁵DuBois (1975) in a similar study currently in process at Harvard provided a continuum of six choices, including: "I am a radical feminist therapist," "I am a feminist therapist," "I am a feminist and a therapist," "I am especially concerned with women's issues in therapy," "My concern with women's issues does not change the way I actually approach therapy," and "Feminism is a political/social position, not really a part of therapy." However, her study had not begun when this questionnaire was developed.

"on a good day"), the meaning or narrowness of the term "feminist therapy," or the definition or implications of the term "therapy." One woman adding a question mark to her "yes" said, "Feminist 'yes'--therapist 'yes'," and another checking "yes" commented, "but humanist or 'non-sex-role stereotype'" might be closer. For purposes of categorization, however, if a person checked the "yes" category, she was included here and therefore in the sample frame, irregardless of how qualified her "yes" response.

Others did not check either "yes" or "no" or checked both, sometimes adding a question mark between the two or adding and checking a "maybe" or "don't know" category. Their explanations included:

I don't know. I haven't decided what "feminist therapy" means. I know I am a therapist, and I know I am a feminist. Does that help?

Yes in the sense that I am very aware of sexism and patterns in our culture which have kept women back and get in the way of their becoming fully human. No in the sense that men are completely equal in my groups--the aim is to recover our humanity. I guess it depends on how you define feminism.

For categorizing, any response which on the first question checked both categories or neither category, as well as those making their own categories of "don't know" and "maybe," was scored as "don't know."⁶

Some of those checking "no" explained their decision. A majority of those comments objected to the "anti-humanism" and politicization of a feminist therapy position:

⁶The two exceptions are one woman in the Bay Area, a member of an explicitly feminist therapy collective, who checked neither and was nonetheless counted as a "yes;" and one woman who checked "no" but added a big question mark and a qualifying comment about her uncertainty, who was scored as "don't know."

Feminist therapy implies "one" is political first--a therapist second. I see myself as having primary allegiance to my patients--and so their ethical/moral/political connections.

I am a feminist and a therapist. I feel this definition leaves me a lot more space than your term "feminist therapy." I work with both men and women, and the goal is to bring people to themselves. When feminist attitudes help this process, good--but I don't make a big deal of it.

One woman said that although she did some feminist counseling, she did not do it with all clients, and therefore responded negatively. Another wrote that she was a feminist in her own life but that was not the context of her work. One woman differentiated between utilizing feminism therapeutically, which she did, and being a feminist therapist.

I am not a therapist. I feel non-therapists are crucial . . . in ironing out the contradictions between therapy (male-developed) and feminism. [The particular focus or area of specialization in my work] is clarifying women's roles, options, conditioning--rectifying therapy-induced misconceptions.

Table II illustrates responses to the first question.

TABLE II
RESPONSES TO, "DO YOU CONSIDER YOURSELF TO BE A FEMINIST
THERAPIST OR COUNSELOR?" BY PERCENTAGES

	Number of Questionnaires Returned	Yes	Percent of Returned	No	Percent of Returned	Don't Know	Percent of Returned
Portland	36	25	69%	8	22%	3	8%
Seattle	40	30	75%	6	15%	4	10%
Bay Area	58	50	86%	7	10%	1	2%
Totals	135	105	78%	21	16%	8	6%

What seems most important about this data is its validation of the natural network focus used in this study for locating feminist therapists: 78 percent of those returning questionnaires were in fact feminist therapists (and had the criteria for identification been different or clearer, this figure may have been even higher). The degree of "accuracy" with which a person thought to be or referred to as a feminist therapist would in fact identify herself as such increased from Portland to Seattle to the Bay Area, where only 12 percent of those contacted were not included in the sample frame. Again, this may reflect the greater specialization and/or specification of referral in the Bay Area. However, as indicated by the 2 percent level of "don't know" in the Bay Area as compared to 8 percent and 10 percent in the other two cities, it may also reflect an increased general knowledge among those referring and among feminist therapists themselves of what a feminist therapist is. Although 86 potential feminist therapists were not sent questionnaires because of time limitations and therefore not included in the sample frame, there is no reason to doubt that their responses, proportionately, to the question of whether or not they considered themselves a feminist therapist would differ from those who were surveyed because their names were obtained utilizing the same process. In fact, therapists whose names were obtained (as these were) from other returned questionnaires were even more likely to be feminist therapists than those whose names were obtained through other means of entry into the natural helping network. In other words, feminist therapists were the most accurate source for locating other feminist therapists.

Of the 175 questionnaires in the adjusted mailing, 134 were returned, for a 77 percent return rate. Table III illustrates the questionnaires returned.

TABLE III
QUESTIONNAIRE RESPONSES BY PERCENTAGE

	Adjusted Mailing	Questionnaires Returned	Percent Returned	No Response	Non-responses as Percent of Adjusted Mailing
Portland	37	36	97%	1	3%
Seattle	51	40	78%	11	22%
Bay Area	87	59	68%	28	32%
Totals	175	135	77%	40	23%

All non-respondents were contacted either by telephone or by postcard. As in the problem with the inappropriate mailings, many questionnaires were sent to groups whose functions and/or existence was uncertain, and in which the individual members were not known, either by name or number. As Table IV indicates, 73 percent of the non-respondents were in groups or collectives. This trend is particularly evident in the Bay Area, whose 28 non-respondents composed 70 percent of the total non-respondents.

The non-respondents were sampled to ascertain their reasons for not returning the questionnaires and to determine whether there was a non-response bias. Sixteen of the 40 non-respondents were accounted for: the one in Portland, three in Seattle, and 12 in the Bay Area.

TABLE IV
NON-RESPONDENTS IN GROUPS BY PERCENTAGE

	Number of Non-Respondents	Number of Non-Respondents in groups	Percent of Non-Respondents in groups
Portland	1	-	-
Seattle	11	8	73%
Bay Area	28	21	75%
Totals	40	29	73%

Examples of their responses explain the non-responses. One woman said she had received the questionnaire and, not being sure what the term "feminist therapy" meant, had set it aside to think about it, and lost it. Another assumed it was an advertisement and threw it out. One said she was in a "spaced-out place" when it came and thus didn't respond. An example from the Bay Area illustrates some of the problems involved in mailings to unknown groups. Four questionnaires were sent to a Berkeley Feminist Counseling Collective listed by the San Francisco Women's Switchboard at one address and three questionnaires to a Berkeley Feminist Therapy Collective listed on a returned questionnaire at another address. There was no response to a postcard to each asking that the questionnaires be returned. While in the Bay Area, a representative of the group was finally located, and she said that the two groups were actually the same. When asked why the questionnaires had not been returned, she said she was too busy and besides she was skeptical of universities and people from universities. Parenthetically, she

added that the collective had broken up anyway. These 16 non-respondents were coded as to what their reply would have been to the first question on the questionnaire, as shown in Table V.

TABLE V
SAMPLING OF NON-RESPONDENTS

	Number of Unreturned Question- naires	Number of Unreturned Question- naires Sampled	Responses to Question 1			Question- naire not Applicable
			Yes	No	Don't Know	
Portland	1	1	-	-	1	-
Seattle	11	3	3	-	-	-
Bay Area	28	12	3	1	-	8
Totals	40	16	6	1	1	8

From this information, it does seem that the non-respondents were feminist therapists and that the non-responses were largely a factor of lost, discarded and non-applicable questionnaires and not because those not responding were not feminist therapists or were unsure. Therefore, it is concluded that the generalizability of the results are not influenced by any non-response bias.

Those therapists returning the questionnaire and indicating "yes" on question 1--that they considered themselves to be a feminist therapist--constituted the sample frame, the available part of the population.⁷

⁷One feminist therapist in the Bay Area who did not meet the criteria for inclusion in the sample frame because she was enrolled in school and functioned in no other practice setting except a field placement was eliminated at this point, leaving 104 feminist therapists in the sample frame.

Using a random number table, a 20 percent sample was drawn from the sample frame of five feminist therapists in Portland, six in Seattle, and nine in the Bay Area. All who returned questionnaires were notified by mail that their response had been received and was appreciated and were told whether they would or would not be contacted for an interview (see Appendix C). A list of feminist therapists in Portland and Seattle was compiled and sent to respondents in those two cities because of the lack of centralized referral processes there.

III. INSTRUMENT FOR DATA COLLECTION

The initial stages of instrument design involved familiarization with the literature in the field (summarized in Chapter II), with particular focus on: 1) possible instruments which could provide a means to discriminate feminists from each other on the basis, perhaps, of political views or positions on issues related to the feminist movement; and 2) areas of potential consensus and areas of potential disagreement raised in the literature, in particular as related to feminist therapy. All instruments encountered in the literature, however, were designed to separate feminists from non-feminists or supporters of women's liberation from opposers of women's liberation rather than any internal differentiations among feminists (Acker 1974; Dempewolff 1974a; Rosenkrantz, et al., 1968; Steinmann 1974; Tavris 1972). In addition, most of these studies were designed in 1970 and 1971, and were felt to reflect attitudes about what it meant to be a feminist four to five years ago (i.e., whether or not a woman shaves her legs; Acker 1974) rather than any reflection of contemporary

issues, concerns, and divisions within the women's movement.

For these reasons, the decision was made to develop open-ended questions based on issues raised by the literature review itself, and in the analysis, proceed from there to possible categorizations and correlations based on the data obtained from the interviews rather than attempting to include any one closed question or series of questions taken from previous studies. Six main topic questions were developed:

- 1) Who are the feminist therapists?
- 2) What is the range of techniques utilized in feminist therapy and what are the new techniques or variations on traditional techniques being developed?
- 3) How do feminist therapists describe their own feminist therapy?
- 4) What are the theoretical orientations and positions of feminist therapy?
- 5) What are the attitudes of feminist therapists toward feminism and toward therapy?
- 6) How do feminist therapists define feminism and feminist therapy?

All relevant issues raised by the literature review, consultations, and brain-storming were listed under the appropriate topic heading. Information for the first topic area was to come from both the questionnaire analysis and the interview, while information for the other topic areas was to be provided by the interview. Effort was concentrated on developing a series of broader, more carefully designed questions which would subsume the more specific questions. A schematic representation of the interview, illustrating the six broad topic areas, the interview format of general questions followed by probes in each category, and the information the questions were designed to elicit, is included in Appendix D. During the interview, certain probes generally required

more elaboration than is indicated, and where this was the case, the form of the elaboration is explained in Chapter IV.

Before the final interview form was arrived at, the interview was piloted with three Portland feminist therapists in the sample frame but not in the sample itself. Extensive feedback from the interviewees followed each interview. The primary information gained from the pilots was that the questions were answerable, that they elicited appropriate responses (i.e., they "made sense"), and that they did in fact generate the type of information desired for the study. Since this was the case, inputs from these women that the questions were at times vague and "hard to get handles on" did not lead to specific changes in the questions per se but were incorporated into an introduction given by the interviewer prior to each interview, as follows:

The feedback I've gotten from other women I've interviewed has been that some of the questions seem hard to get handles on or difficult to focus. I've kept them in the interview nonetheless because I've felt so good about the information I've gotten anyway. But it's OK with me if you don't have an answer all "figured out"--I don't myself. I feel real comfortable with your sharing your ambivalences and am as interested in the process you may go through in deciding how to answer as "an" answer.

As an additional part of the introduction, permission was requested (and received) for taping each interview. A final question asked for interviewee feedback on doing the interview was added at the end.

IV. DATA COLLECTION

Those 20 therapists identifying themselves as feminist therapists on the initial questionnaire and comprising the sample were notified by letter. Interviews were scheduled in Seattle on February 27 and 28,

in Portland March 3-7 and April 4, and in the Bay Area March 12-17, 1975. In addition to the interviews with the feminist therapists in the sample in the Bay Area, an interview was also done with two women involved with the Berkeley Women's Center's Feminist Counseling Collective, which functions as a feminist therapist screening and referral service. A summation of this interview is included as Appendix E because of a growing interest among women in finding feminist therapists and/or in setting up such a service.

In preparing the initial thesis prospectus, attempts had been made to obtain funding with which to compensate the therapists interviewed for their time, on the assumption that many of them were working on a subsistence level. Funding was never obtained, and its lack did not seem in any way to affect the willingness of those sent questionnaires (over 90 percent of whom indicated they were willing to be interviewed) or selected for the sample to be interviewed. Those interviewed were assured that they would receive a summation of the results of the study, and this seemed a "fair trade" for their time. Those interviewed seemed open and eager to participate in the study and to share what they were doing. This impression is further validated by the feedback received after each interview, presented at the end of this section.

All interviews were completed as scheduled. The original time estimate of an hour, based on the length of the pilot interviews, was too short. The actual interviews ranged in length from an hour and 15 minutes to close to two hours. All interviews were tape-recorded to free the interviewer for attention to the content of responses and the interview process.

One of the women in the Bay Area sample had decided, after returning the questionnaire indicating she identified herself as a feminist therapist, that she did not feel that the label applied to the way she currently functions in her position at a community mental health clinic. For her, feminist therapy was a type of therapy she could offer and would enjoy doing if someone she were seeing wanted that kind of consciousness. However, because she works in a public agency, she feels a responsibility to deal with "anybody who comes in the door whether or not their consciousness is sufficiently raised" for her to do feminist therapy, and therefore she will often "let it drop." Although this interview was completed, her responses have not been included in the analysis of the findings. A similar situation occurred when one of the women in the Portland sample was interviewed. She reiterated several times throughout the interview that although she had indicated on the questionnaire that she was a feminist therapist, she really wasn't sure that she was one. In response to the interview question asking for her definition of feminism and feminist therapy, she replied:

That's what I can't define for you. That's why I can't say to you, "Yes, "I'm a feminist therapist." I put a question mark there. . . . I need some more time to get it really clear.

A later telephone contact confirmed her somewhat ambivalent position. Because those who returned questionnaires indicating they were "not sure" if they were feminist therapists or not were not included in the sample frame, the information from this interview was also not

included in the data analysis.⁸

A research question raised by these two interviews is whether the responses and practice of these two women and others like them differ significantly from those who identify themselves as feminist therapists. However, this is a peripheral issue to the primary purpose of this study, which is an exploration of feminist therapy rather than a comparison of feminist and non-feminist therapists, and therefore the comparison has not been pursued.

Finally, one woman in the Bay Area sample invited a colleague who was also a feminist therapist (one whose name had been received after January 15 and therefore not sent a questionnaire) to join us for the interview. Her responses have been included in the data analysis. The final interview data analyzed, then, consists of interviews with 19 feminist therapists: four in Portland, six in Seattle, and nine in the Bay Area.

Vidich (1970:172) writes:

Data collection does not take place in a vacuum. Perspectives and perceptions of social reality are shaped by the social position and interests of both the observed and observer [or interviewer and interviewee] as they live through a passing present.

Given this position, it is important to consider here two aspects of the interview process which have potential impacts on the data received, in particular as they relate to the question of bias. The first

⁸Since both of these women responded on the questionnaire that they considered themselves feminist therapists, those figures reported previously in this chapter have not been changed, and their questionnaires are included in the questionnaire analysis in Chapter IV, Section I.

developed because of a minor change after the eighth interview in the process by which the interview was conducted. Previously, the researcher had asked the questions and the interviewee/feminist therapist had responded. Beginning with the interviews in the Bay Area, a duplicate copy of the questions and their probes as used by the interviewer were given to the therapist when the interview began. The actual idea of making this change occurred spontaneously, but it was continued because it seemed to incorporate into the interview process the interviewer's own feminist value of mitigating as much as possible structured power differentials. The concern that this change might bias the results was considered, particularly with regard to the validity of questions designed to generate responses (for example, "What do you do with your feminism in therapy?" and "What does a person get from you that she wouldn't get from someone who wasn't a feminist therapist?") when potential responses (at least from the point of view of the researcher) were listed as probes. However, a comparison of responses to these open-ended questions before the interview was shared and after does not validate this concern. In both cases, replies were often received which were not included as probes; and in those interviews in which the questions were shared, probes were at times considered aloud by the interviewee as possible responses and then disagreed with or dismissed.

The larger issue here, however, goes beyond specific responses on specific questions to the biases potentially inherent in the overall interview process itself. From the initial contact on, the bias of the researcher was clearly in the direction of supporting, being influenced by, and wanting to become more involved with feminist therapy. The

introductory letter accompanying the initial questionnaire, in explaining the rationale for the topic itself, said:

That choice [to do a thesis on feminist therapy] has grown out of my own experiences and needs. Being in therapy myself with a woman conscious of feminist concerns was very important for me. Currently, I see primarily women in the college's student counseling center, and am attempting to bring to that situation a similar consciousness. However, I feel a real need to know what other women are thinking, directions they are moving, and ways they are merging theory and practice.

Similarly, throughout the interview, the researcher, while attempting to focus the interview on the interviewee, did at times make comments and share experiences which indicated if not her position on an issue at least her concerns. To a certain extent, even the design of the interview itself could be seen in this light. Although based on a review of the literature and pretested to uncover omissions, nonetheless at some point processes such as choosing which issues to probe on cannot help but reflect one's theoretical position. This question of whether there is any shift of the data toward the researcher's position vis a vis feminism could be compounded by emphasis at times in recent social-political movements for people to be "more radical/militant/feminist than thou." In other words, there can be at times a pressure to appear more (or at least no less) radical (or feminist) than those around a person, and in fact to present oneself as more radical (feminist) than one actually is (Keniston 1968, 1971). In fact, one feminist therapist directly acknowledged this pressure and several alluded to its impacts on their clients (the feminist "parent" or "should," discussed in Chapter IV, Section III, Other Comments on Feminism).

Because of the researcher's clearly pro-feminist and pro-feminist therapy position, one could argue that the participants in the study responded to what they thought they "ought" to say and what they thought the researcher wanted to hear. This criticism, however, fails to look at the larger dynamics of interview process. In both instances above, what the interviewer did not do is as apt to distort or project bias as what she did do, and vice versa. In other words, while sharing the questions could be criticized for its possible influence on interviewee replies, a similar and equally strong argument could be made--although it is rarely done--about the impacts and value statements made by the interviewer not sharing with the interviewee.

Vidich (1970:169-170) argues that the problem of a researcher's conscious identification with the groups, causes, or issues being studied can be perceived similarly, again from the position that "complete and total neutrality is extremely difficult, if not impossible, to assume." He continues:

Neutrality even to the point of total silence is a form of reaction and not only will be considered as such by all parties . . . but also implies a specific attitude toward the issue--being above it, outside it, more important than it, not interested in it. Whatever meaning respondents attach to neutrality will, henceforth, be used as a further basis for response. This is true even when respondents demand an opinion or approval in structured interview situations. Failure to make a commitment can create resentment, hostility and antagonism just as easily as taking a stand. In both cases, but each in its own way, relationships will be altered and, hence, data will be affected.

Becker (1970) similarly states that research uncontaminated by personal and political sympathies is impossible and that there is no position from which sociological research can be done that is not biased in one way or another.

Although there is no control group with whom to compare the possible effects of the bias inherent in the research as it was designed and conducted or in the minds of those interviewed, the responses themselves can to some degree respond to these concerns. First, when it came to the specific questions as to what constituted feminist therapy, few if any of those interviewed agreed totally with all the informal hypotheses of the researcher: things she by her definition considered important aspects of feminist therapy the feminist therapists seemed just as likely to feel had nothing to do with feminist therapy, and vice versa. Secondly, it is the researcher's observation that women whose position was less "radical" seemed open and willing to present their own positions, often acknowledging their differences from those they perceived to be "more feminist" or at least "more radical" than they were, noting to which of their statements they thought others would take exception, and at times disagreeing with the focus, ideas or perspectives of other feminists. Personality characteristics of feminists cited in Chapter II (under The Rise of the Second Wave of Feminism) which found security about self-worth, independence of judgment, and the ability to resist group pressures, seem demonstrated here.

In general, the interviews followed fairly closely the order of the questions in Appendix D. If, while answering one question, another question generally raised later on in the interview seemed applicable, the interviewer brought it in at that point. The interviewer attempted to maintain a role of clarifying questions, re-focusing the interview, monitoring for clarity and congruency, and supporting the interviewee with the feedback that her responses were understandable, acceptable,

and helpful.

As the interviews progressed, it became more apparent that it was necessary to constantly probe for differentiations between what a person did because of her training or personality and what she did because of her feminism. For example, when asked if she self-disclosed, a feminist therapist might respond with a strongly affirmative comment. However, if then asked, "Does that have anything to do with your feminism (or being a feminist therapist)?" she might respond negatively, as one did saying, "That I think I would do whether I was a feminist or not." As soon as the interviewer became more aware that a therapist affirming she behaved in a certain way did not necessarily explain why she did it, more attention was paid in the interview to clarifying this.

The interview process also surfaced a number of questions which were not included in the interview and in retrospect might well have been. Some issues alluded to by feminist therapists in answering questions could have been asked more directly, specifically whether a feminist therapist had to label herself a feminist; whether they saw differences between feminist therapy, a therapist who was a feminist and feminism as therapy; and whether women clients should be seeing women (or feminist) therapists. The issue of therapeutic directiveness was discussed by almost all interviewees at some point, and could have been developed into a useful question. A series of questions could have been developed to further determine attitudes about how feminist therapists perceived American society and mental health, posing, for example, the assertion that no woman can be healthy in an unhealthy society and therefore that therapy runs the danger of supporting and encouraging adaption to that

unhealthy system. A related question could have raised the issue of what feminist therapists see as a change of focus--i.e., sexual inequalities vs. economic inequalities. The original question on professionalism might in retrospect have been refocused to include more current issues, which in the Bay Area were activated at a recent conference on Women and Mental Health when the idea of a union for all feminist mental health workers--professionals and nonprofessionals alike--was heatedly debated. Finally, the question on diagnosis could have been replaced by a question asking feminist therapists to compare various theoretical orientations (i.e., Freudian, Gestalt, etc.), particularly as they related to women.

Feedback received from interviewees was highly positive. They said they enjoyed the interview and moreover, that the interview process (or anticipation of the interview) provoked a reclarification in their own minds of what feminist therapy was or reactivated issues for them. As one woman said:

I enjoyed the questions. I liked the things they made me think about and liked even the tension I experienced a couple of times when I realized, "I don't have an opinion about that one. No . . . I can't think of anything." I thought, "My God. I must be missing something." It was sort of nice to feel, "Look, this may be an area I can look at." It's very easy to get very self-contained and do my own thing and not get stuff coming in. So this sort of thing feeds me. This is really nurturing for me.

V. DATA ANALYSIS

The material for data analysis is in two forms: the information from the questionnaires received from the entire sample frame, and information from the interviews with a random sample of the sample frame,

the latter providing the bulk of the research data. Data analysis itself proceeded in two stages. The first involved analysis of the questionnaire and of each interview question, and the second stage involved development of five main questions into which the questionnaire analysis and interview questions were re-grouped and at times synthesized.

The questionnaires provided information about the characteristics of all the feminist therapists in the sample frame, generalizable to the population as a whole. It provided information about the theoretical orientations, length of time doing therapy, highest degree attained and field of degree, focus of practice, mode of practice, practice setting, and area of specialization of the feminist therapists in the sample frame. Initial analysis of the information from the questionnaires involved tabulating the data received in each category to determine general population characteristics, with particular attention to differences, if any, among the three metropolitan areas. Perusal of this information revealed a wider range than had been expected of years of practice and degree levels, and so comparisons were made with these as the independent variables. Some possible comparisons between such characteristics as theoretical orientation or focus (especially women) and other characteristics could not be charted because of multiple responses on each heading. Also, because of the number of questions for which more than one reply was possible, traditional forms of analysis for significant relations were not utilized, and totals were instead expressed in percentages and compared visually.

Preparatory to actual data analysis of the information obtained from the interviews was the task of transcribing the 22 hours of cassette

tapes on which the interviews were recorded. This was a much more tedious and time-consuming process than had been anticipated, and yet it was felt that these verbatim transcriptions of the interviews themselves were necessary to provide the detailed information needed for the interview analysis.

Aside from omissions of clearly extraneous material and occasional inaudible phrases, the interviews were transcribed as completely and accurately as possible, culminating in 162 single-spaced pages of typewritten material. This document was copied and the original was cut apart into sections, with the complete responses to each interview question (with each probe viewed as a separate question) constituting a section. The sections were sorted into folders so that all responses to each question were grouped together.

This first stage of data analysis of information from the interviews involved the development of categories of responses by location of thematic response clusters among the replies to each question. Categories for some questions were mutually exclusive; on other questions responses overlapped categories (this overlap or inclusiveness of replies is indicated in the discussion of each question). Responses were sorted into the appropriate category or categories, and each category was summarized, focusing both on commonalities and, where indicated, differences within each category. If there were comments extraneous to the previously defined categories or question qualifications, these were also summarized and included in the analysis or refiled for analysis under a future question. In all, the 25 questions (as indicated

in Appendix D⁹) were analyzed in this fashion.

In general, each woman responded to each question except in several instances when the researcher inadvertantly omitted a probe and during the last third of the interview which involved the two therapists together when the tape recorder did not record. Some probes were spontaneously answered (or partially answered) in replies to earlier questions, and when this was the case, they were re-sorted as necessary. The findings indicate the total number of feminist therapists replying to each question as it is considered.

The questionnaire analysis and the 25 interview and probe questions, while originally designed to stand alone, were found to be difficult to understand or to synthesize in any context, even when arranged within the six original questions on which the interview was based. Therefore, five new questions, seen as more focused and yet more encompassing while less repetitive, were developed:

- 1) Who are the feminist therapists?
- 2) How do feminist therapists define feminism?
- 3) What is feminist therapy?
- 4) How does feminist therapy perceive and incorporate therapeutic issues?
- 5) How does feminist therapy perceive and incorporate feminist issues?

The 25 interview questions as well as the questionnaire analysis were then re-sorted into these five categories. Sometimes, two or more interview questions (or portions of questions) were synthesized and

⁹The numbers following each interview question and interview probe indicate the groupings used in the original data analysis. For example, while Question 2 was composed of only one probe, Question 23 was composed of one interview question and three probes.

retitled. For example, although designed to generate different information, the two interview questions, "What do you do with your feminism in therapy?" and "What does a person get from you that she wouldn't get from someone who wasn't a feminist therapist?" in fact elicited very similar information. Therefore, as part of the information explaining the third category above, "What is feminist therapy?" they were synthesized to produce a subsection of that category entitled Descriptions of Feminist Therapy. Other original interview questions, particularly, "Can you give an example of a time when it was hard for you to incorporate your feminism and your therapy?" and "Are there other questions, issues, or struggles for you right now in combining feminism and therapy?" were divided and incorporated into several categories. Some information, such as the criticisms of feminism discussed as part of the second category, were gathered from throughout the various interview questions rather than being responses to one question. Chapter IV presents synthesized responses to interview questions (and the questionnaire analysis) in each of the five categories. An introductory section preceding discussion of responses in each category explains which interview questions are incorporated into that category. All quotations cited are verbatim transcriptions from the tape-recorded interviews with minor modifications for flow (i.e., omission of "kind of" and "and"), and occasional sentence transpositions. The quotations are identified by fictitious names to provide confidentiality and yet enable one person's responses to be followed throughout the data analysis.

CHAPTER IV

FINDINGS

I. WHO ARE THE FEMINIST THERAPISTS

Information answering this question includes the analysis of the questionnaires returned by all members of the sample frame, and answers to the interview questions, "Did you become a feminist first and then a therapist or a therapist first and then a feminist?" (as Personal Histories of Feminism); and, "What percent of your time do you spend doing therapy?" (Time Allocation). Also included are several portraits of individual feminist therapists interviewed.

Questionnaire Analysis

This aspect of the data analysis includes the tabulated results from the 104 questionnaires composing the sample frame: 25 in Portland, 30 in Seattle, and 49 in the Bay Area. Since not all respondents answered all questions on the questionnaire, percentages are calculated in terms of the actual numbers of responses to that question.

Theoretical Orientation. This question asked the respondent to indicate her general theoretical orientation, apart from her feminism. The instructions indicated that one should check all categories which applied and add any not listed, with the result being that responses ranged from one item checked to as many as 14, the mean being four. This in itself indicates the diversity of theoretical orientations held

by any one feminist therapist. Table VI indicates the responses checked, ranked by the percentage of respondents indicating this orientation.

TABLE VI
THEORETICAL ORIENTATIONS OF FEMINIST THERAPISTS

	Respondents Indicating			Respondents Indicating	
	#	%		#	%
Eclectic	74	72%	Co-counseling	12	12%
Gestalt	63	61%	Jungian	12	12%
Humanistic	46	45%	Radical therapy	11	11%
Transactional analysis	36	35%	Adlerian	4	4%
Assertive training	33	32%	Mutual goal setting	4	4%
Psychodynamic	29	28%	Primal	3	3%
Behaviorism	23	22%	Learning theory	3	3%
Bioenergetics	20	19%	Family therapy	3	3%
Rogerian	18	17%	Social casework	1	1%
Freudian	17	17%	All others	16	16%
Reichian	14	14%			

The "others" included Assagioli's psychosynthesis, Wolpe's relaxation, Don Juan, psychodrama, reality therapy, massage, experiential, existential, self-healing, music therapy, body work, "my own developing theory re. women," and "a model our collective has developed."

Distribution of responses by areas shows a fairly similar ranking in each, with "eclectic" consistently the most frequently indicated, followed by "Gestalt." Certain orientations received different percentages of adherents in each city. For example, no one in Portland indicated radical therapy as a theoretical orientation, whereas 13 percent did in Seattle and 15 percent did in the Bay Area. Thirty-five percent of Bay Area respondents indicated a Freudian theoretical orientation, as

compared to only 7 percent in Seattle and 4 percent in Portland. Therefore, for further comparison, the theoretical orientations were grouped in three categories: Traditional (including Adlerian, Freudian, Jungian, psychodynamic, and social casework); Eclectic/Humanistic; and Avant-Garde (including assertive training, bioenergetics, co-counseling, family therapy, Gestalt, learning theory, mutual goal setting, primal therapy, radical therapy, Reichian, TA, and all others). Despite any area differences in particular orientations, feminist therapists in the three areas surveyed differed only minimally in their adherence to the three groupings of theoretical orientations. Traditional replies were, interestingly, somewhat greater in the Bay Area, with a corresponding decrease in Avant-Garde replies. This was contrary to expectations that the Bay Area would be more "in touch" with recent therapeutic innovations and consequently more Avant-Garde in theoretical orientation than Portland or Seattle. Of the theoretical orientations checked, 19 percent were Traditional, 27 percent were Eclectic/Humanistic, and 54 percent were Avant-Garde. Clearly, the overall propensity among feminist therapists in the three areas studied is for theoretical orientations which are newer and/or non-traditional.

Length of Time Doing Therapy. The next question asked, "How long have you been doing therapy (total time, whether feminist or not)?" The responses ranged from three months to 29 years, with the mean being 6.32 years and the median five years. An analysis of variance found the difference by areas not to be significant. When the responses were clustered, 29 percent had been doing therapy for two years or less, 44 percent for three to six years, 17 percent for seven to 14 years,

and 10 percent for 15 years or more. Although this seems to show that feminist therapy is done by those in practice six years or less, it is interesting that those with some experience (six years) are more representative than those with less, and that those with more experience, particularly those with 15 years or more, do comprise a portion of the population.

Degree Attained. Respondents indicated their degree level, as shown in Table VII. For coding purposes, only the highest degree was tabulated.

TABLE VII
DEGREE LEVELS OF FEMINIST THERAPISTS

Degree Level	Number Indicating	Within Clusters	
		#	%
None	1		
High school	1		
R.N. ¹	1	14	13%
B.A. in process	1		
B.A./B.S.	10		
M.A. in process	1		
M.A./M.S./M.Ed.	22	23	21%
M.S.W. in process	4		
M.S.W.	34	39	36%
D.S.W.	1		
Ph.D. in process	6		
Ph.D.	21	27	25%
M.D.	4	4	4%

¹There were five R.N.s in the sample frame, but four had B.S.s or M.S.s as well, and were tallied there.

Except for Portland, where there is one more person with a Ph.D. than with an M.S.W., the Master's degree in Social Work (including here one D.S.W. and four M.S.W.s in process) is the most common degree held by feminist therapists in the sample frame. At the B.A. level, major fields ranged from psychology to drama, and included math, nursing, English, and education as well. At the Master's level, major fields ranged from psychology (held by 12 respondents) to English, and included Gestalt processes, sociology, nursing, and music therapy as well. Ph.D.s were generally in psychology, with one in counseling and one in psychobiology. The M.D.s were in psychiatry. Of note is the wide range of degree fields among feminist therapists at the B.A. and M.A. levels.

Focus and Mode of Practice. This question was initially designed to differentiate among clientele focuses (i.e., women only, couples, etc.) and primary modalities for doing therapy (i.e., individually, groups, consultations). However, because the instructions again told respondents to check all applicable categories, some therefore checked all six focuses and all six modes listed. Thus, information about primary focus or mode is not as clear as would have been desired. In retrospect, instructions to indicate the focus and the mode or to indicate percentages for each (DuBois 1975) would have generated more useful information here. Tables VIII and IX illustrate responses to the question, "What is the focus of your practice?" "Women" are the most frequently listed focus, followed by "couples" and "women and men" both. There is little difference between those indicating they work with individuals and those who work with groups; many do both. The

TABLE VIII
FOCUSES OF PRACTICE AMONG FEMINIST THERAPISTS

Practice Focuses	Number	Percent
Children	17	6%
Adolescents	28	9%
Women	78	26%
Lesbian women	32	11%
Families	31	11%
Couples	53	18%
Women and men both	52	18%
Other (young adults, parents, prisoners, communes)	4	1%

TABLE IX
MODES OF PRACTICE AMONG FEMINIST THERAPISTS

Modes of Practice	Number	Percent
Individuals	84	30%
Groups	72	26%
Workshops	39	14%
Training	40	14%
Psychological testing	12	4%
Educational/vocational testing, counseling	16	6%
Teaching, writing, lecturing	7	3%
Community organizing	2	1%
Other (consultations, intakes, mediations)	4	4%

differences among areas are minimal, although, interestingly, the Bay Area is the only area where community organizing was mentioned as a mode of practice. The 13 women coded as "teaching, writing, lecturing," "community organizing," and "other" (including consultation, intake, and

commune mediation) give some overview of the range of modes considered by feminist therapists to be part of their therapy (discussed further in Section III, Qualifications About Feminist Therapy, of this chapter).

The problem with analyzing this data is that respondents did not generally indicate, in the cases of children, adolescents, couples and families, if there is a focus in terms of the sex of those seen, although several did indicate they saw only female adolescents or lesbian couples. Although "women" and "women and men" were intended to be mutually exclusive categories, some checked both. In an attempt to determine those feminist therapists who do focus on women only, a tally was made of those who checked "women" and/or "lesbian women," but not "women and men." This produced a figure of 45 percent of the sample frame who focus on or see only women, and is perhaps more meaningful as an indication of practice focus than the 26 percent who checked "women" as a focus above.

Practice Setting. This question listed five possible practice settings, asking the respondent to indicate which applied to her. Again, many checked more than one (but not more than three) practice settings. "Private agency" was inadvertently omitted as a possible choice. Although a number of feminist therapists indicated that this was the setting in which they worked, more might have had it been included. Settings such as Women's Center, Outside In (drop-in health and counseling center for transient youth), Counseling Center for Sexual Minorities, and Solo Center (resource center for single and divorced adults) were listed by five respondents and included under private agencies, although as "alternative institutions" they may be more like

private practice settings or collectives. Table X shows the practice settings in which feminist therapists indicated they worked.

TABLE X
PRACTICE SETTINGS OF FEMINIST THERAPISTS

Practice Setting	Number	Percent
Private practice	63	39%
Public agency	31	19%
College or university faculty or staff	24	15%
Collective	18	11%
Enrolled in school or psychiatric residency	10	6%
Private agency	13	8%
Other	3	2%
Unemployed	1	1%

Private practice is the most frequently indicated practice setting, utilized by over a third of the feminist therapists. In comparisons by area, Portland has a higher percentage of feminist therapists working for public and private agencies and enrolled in school and correspondingly less in private practice, while Seattle has more on the staffs or faculties of colleges or universities. The percentage of those indicating private practice is highest in the Bay Area, as is membership in a collective, which seems to be almost entirely a Bay Area phenomenon.

Area of Specialization. This question asked, "Do you specialize in a particular area(s) or problems?" Approximately half indicated they did, and those checking "yes" were asked to indicate their areas of specialization. The majority (28) listed a specialization particularly involving women, including career counseling for women, rape, women in

the middle years, women in the process of divorce, single women, women in conflict re. childbearing, and feminists with problems of integrating feminism, its values and heightened consciousness, into their lives. The next most frequently mentioned area of specialization was sexuality, indicated by 11 women and including sexual dysfunction, sexual identity, and groups for pre-orgasmic women. Eight therapists indicated a focus on particular techniques, such as assertive training, massage, art therapy, and feminist body work. Other areas of specialization listed included drug and alcohol abuse and addiction (listed by five), obesity, depression, low self-esteem, intimacy, large group relationship problems, alternative lifestyle and adjustment, women's therapy referral counseling, advising a lesbian resource center, teaching women's studies, and training paraprofessionals. Again, as in the responses to the question about theoretical orientations, in viewing these responses what is apparent is the diversity and lack of traditionality in the areas of specialization chosen by feminist therapists.

Comparisons. A series of grids were developed, enabling responses on one question to be compared to those on another. In comparing theoretical orientation to degree, those with the least formal education (B.A. or less) report the most Avant-Garde theoretical orientations. Looking at social workers as compared to feminist therapists at other degree levels, they seem to be somewhat more traditional in orientation than M.A.s and slightly less traditional and more Avant-Garde than Ph.D.s. In comparing theoretical orientation to years of practice, there is remarkably little difference between those in practice 0-2 years, 3-6 years, or more than 15 years. Despite what may be expected, those in

practice 15 years and longer are no more Traditional and no less Avant-Garde than those much more recently beginning to practice. Those with less academic training (i.e., B.A.s and less) tend to be in practice for less than the mean or median figures for all feminist therapists. Except for psychological testing, done as would be expected primarily by Ph.D. psychologists, other modes of feminist therapy differ little by the degree of the feminist therapist. Those feminist therapists with B.A.s or less are the most likely group to be in private practice and the most likely to be members of a collective. Social workers are the most likely to be employed by a public agency, more likely than M.A.s or Ph.D.s to be in private practice, and the least likely to be on a college or university faculty or staff and to be members of a collective.

In comparing length of time to focus, differences are small. Those in practice 15 years or more are least apt to indicate "women and men." Correspondingly, those in practice the least amount of time are most likely to indicate "women" as a focus and least likely to indicate families and couples. Length of time in practice seems to have minimal effect on mode. Private practice and positions as college or university faculty or staff increase as a feminist therapist's years of practice increase. On the other hand, those in practice the least number of years seem to be employed by public or private agencies or in school. Those in collectives are therapists practicing six years or less.

Personal Histories of Feminism

In response to the first interview question, "Did you become a feminist and then a therapist, or a therapist first and then a feminist?"

the largest group of feminist therapists identified themselves as feminists before they became therapists--eight of the sample of 19. Of the other 11 women, six said they were therapists before becoming feminists while for five, becoming a feminist was concurrent with becoming a therapist.

Several themes run throughout all these histories, regardless of whether they were feminists first or therapists first. Perhaps the primary one is the impact of the events of the late sixties and early seventies on the consciousness and the lives of these women. For some, there was a sense of a support system where there had been none before, a sense of connectedness, a name to feelings they had had but had felt alone in.

Throughout my life I've had, like so many women, the gnawing feeling that "this isn't enough; I don't fit into this role." But I didn't have a label and there weren't the words and there weren't the people to be supportive of that . . . before feminism came to the forefront.
(Sue)

Others speak of growing awarenesses and realizations of the oppression of women, themselves included, of their own similarities and commonalities with other women, and of the ways in which they were cooperating in their subjugation. This awareness was described by some as an intense and critical experience in their lives: "It fell on me like a ton of bricks when it happened" (Leslie). "It was the most compact growth experience that I've ever experienced" (Sue). "It was just like it happened almost overnight" (Marsha). For a large group of the women in the sample (13 of 19), this consciousness was accompanied by or supportive of major changes in life style, whether that was deciding to leave a marriage, to not get married, to go back to school in a field they had chosen, to become

involved in work that was meaningful to them, or to change a work setting or work form to one that was more supportive, congruent and often involved with women. At present, feminism is a profoundly important part of their lives. As one woman explained, "My feminism is totally integrated into the rest of my life. I do not separate myself out, one activity from another. I feel that I express my feminism 24 hours a day" (Teri).

Another theme is their perceptions of the impact of their developing feminism on their therapy, and vice versa. Obviously, the fact that a criterion for inclusion in the sample was that all of them identify themselves as feminist therapists means that some integration of feminism and therapy has occurred for all of them on one level.

None of the eight women who were feminists first and then therapists saw a direct connection between their feminism and their decision to become a therapist; if they did see any influence, they characterized it as "unconscious" or as of secondary rather than central importance. For two, their increased awareness of their minority position as women and the implications of that secondary status led them to learn to do therapy as an attempt to understand their own "wounds" as women.

I believe that people become therapists . . . out of their own sense of being wounded themselves, and trying to deal with that That certainly is connected to my experiences of myself as a feminist, but I don't think that is the central issue . . . --that's like an added thing. (Beth)

My choice to be a therapist didn't have lots to do with being a feminist, I don't believe, except maybe in the sense [that] if you're a member of some kind of minority, if you feel some kind of discomfort with the way the world is or the way people are [then] you try to figure that out. I'm sure my

status as a woman added [to what influenced me to become a therapist] but there were a lot of other influences . . . that were more important. (Alice)

Four of these women who were feminists first perceived feminism to be connected with their becoming therapists in that it supported their rejection of the traditional roles their families and the society expected them to play as women and their decision to do "what I wanted for my own self" (Ann).

People in my family go either into agriculture or secondary education. I was on the track to being an English teacher and so I sadly said goodbye to my longings [to be a therapist] . . . It wasn't until I was in the women's movement . . . [that] I started thinking about what I really wanted to do and something that kept coming up was being a therapist. . . . It wasn't until I started making decisions about what I wanted to do apart from the cultural and family scripting that I let myself go with what I really wanted. (Pat)

Within the group of those whose feminism developed concurrently with their becoming therapists, there were differences in the degree to which the two developments were intertwined and interrelated or were parallel and separate. For only one woman did the two seem totally integrated:

I have a feeling that they happened simultaneously. At the same time I was learning therapy skills, I was also defining feminist consciousness. (Teri)

This is also the one woman in the sample whose training in therapy skills came in large part from her work experience coupled with involvement in radical psychiatry/radical therapy collectives as opposed to more formal degree-oriented or graduate training. The others identified their feminism as developing "parallel" to their therapy, with the one at times seeming to have no impact on the other and then at one point or at points in time becoming more integrated.

I was a feminist in my own life, but I wasn't in the way that I did groups. . . . And then about three years ago . . . I thought, I want to start integrating my feminism with my therapy because I felt like I was a split person. . . . It came out of my own need to merge the two . . . [and] totally on my own. I didn't know anyone else who was doing it at the time.

(Karen)

Time Allocation

Feminist therapists were asked, "What percentage of your time, in terms of a 40-hour week, do you spend doing therapy?" Nine (of 19) women did therapy full-time. The others responded as follows: one at 60 percent time, one at 40 percent time, three at 25 percent time, two at 10-15 percent time, and one at under 10 percent of her time.

This question was the most close-ended one in the interview, and its demand for specificity produced several research problems. The question was initially designed to reflect a woman's level of involvement as a therapist. However, underlying the question were the assumptions that full-time work was equatable with full-time commitment and that full-time work is the same as a 40-hour week. However, some women reported working 60 and 70 hour weeks, holding full-time jobs during the day and involved in their private practice during the evenings and on weekends. In analyzing responses, those women were categorized as "full-time." For one woman, her decision to shift from a five-day week to a three-day week was in part a feminist-based decision, growing out of the permission she now felt to decrease the amount of time she spent earning money (and subsequently the amount she spent to live) and to commit more of herself to other parts of her life--including the women's movement and feminist therapy--that were important to her. Therefore, the

percentage of her time she spends doing therapy reflects neither her commitment to feminism or the percentage of her income she derives from doing therapy (which is 100 percent).²

Secondly, the question raised early on in the interviewing process was whether to include only direct therapy as time spent "doing therapy." Ultimately, "activities related to your therapy" were included in the time approximation, on the assumption that full-time therapists engage in reading and study, training and supervision, consultation and perhaps personal growth experiences in addition to the direct therapy they do in the course of a 40-hour week. Therefore, the percentages of time spent "doing therapy" include these therapy-related activities as well.

For several women in the Bay Area interviewed, "therapy-related activities" included what seems to be a newly developing form for training in feminist therapy--peer consultation or case study groups. The groups vary from one with a focus on specifically feminist issues as exemplified by particular cases presented, to one with a radical feminist-socialist perspective concerned with integrating feminism and socialism, to one which combines such issues as whether one can be a feminist and relate to men with personal therapy for the group members by others in the group. In all the groups, however, the basic format is similar, with

²Acker (1973:179) deals peripherally with this issue in discussing the oversights in sociological research with regard to sex roles. She writes that considering women "as persons rather than as appendages to males" still does not resolve the problem of how to define their social status, "particularly if they are not working for pay and cannot be categorized on the basis of their own occupation and income. Can value be assigned to productive work which is not paid labor?"

a focus on integrating feminism and therapy through meeting on a regular basis in a group of one's peers for study, consultation, input, support and, at times, personal growth.

Finally, an issue developed around what exactly "therapy" was. Many of the women interviewed were engaged in a wide variety of activities which could in the broadest sense be considered therapy: from teaching women's studies to assertive training workshops to boat building. If in the course of answering this question it appeared that a woman's range of activities included more than therapy in the traditional sense, she was asked which of those activities she considered to be "therapy" or what she was meaning when she talked about therapy. Her definition of therapy was henceforth accepted during the course of that interview both in terms of calculating a response to this particular question of time allocation, as well as included and probed for in future questions during the interview regarding the nature of her therapy. Therefore, within the sample, the distinctions while internally consistent are externally inconsistent, in that what one woman included as therapy another may have excluded. However, since the study was based initially on self-identification as a feminist therapist, it seemed congruent to go one step further and allow for self-definition of those activities labeled as "therapy."

Portraits of Feminist Therapists

In many ways, the data analysis, focused as it is on themes, on commonalities and differences, and despite the attempt to utilize quotations liberally, loses the flavor of the individuals involved.

Therefore, presented here are brief descriptions of two of the feminist therapists interviewed, followed by some impressions about the feminist therapists from the interviewing process.

Nancy. I went to Nancy's house for an early morning interview. Somehow I had expected her to be older than I am, but we are both in our late twenties. From her questionnaire, I knew she was an M.S.W. who had done therapy for three years, currently in private practice and working for a private community clinic, focusing on women, specializing in long-term psychotherapy, women's counseling, and women's sexuality training, and listing assertive training, behaviorism, eclectic, Freudian, Gestalt, humanistic and psychodynamics as theoretical orientations. The two things that impressed me first were that she wore her bathrobe for the interview and had coleus plants on her sunporch that were three feet tall. As the interview progressed, I was impressed by her concern and commitment to honesty. She spoke slowly, thoughtfully, and seriously, deliberating before she answered. My sense was that many of the questions I asked her were ones she had herself been thinking about for some time.

From the beginning, she described herself as a "very conservative breed" of feminist therapist, and often referred to the differences between herself and other feminist therapists she knows, which become particularly clear for her in combining her private consultation with a psychiatrist with the input of the peer consultation group of which she is a part.

This is one of the interesting things I'm trying to put together. . . . The structure that I work within is something that a lot of feminist therapists wouldn't go near, because it is a man that I consult with, and he's not only a man--he's an older man who's a Freudian. . . . [It is] very stimulating

and challenging for me to sort out. I'll go to him with a case that I might want to talk about a certain angle of, and I'll present a different angle of it to my peer group, and then what I'm left with no matter how I look at it is trying to integrate what happens with both groups. . . . A client of mine I've been seeing for some time has now come full-way around to defining herself as a lesbian. . . . In the peer group, we'll talk more about whether we can help somebody at that point or not, and what all the issues might be that there are to be dealt with. Those are the same things that I'll talk to my Freudian shrink about, but the peer group will be much more sensitive to the issues behind the lesbianism, of what I as her therapist now mean to her, and . . . giving more credit to the social influence. My Freudian consultation will get right into the heavies, the transference, and stuff like that. When I go into the next session [with her], I'll be trying to integrate this and coming up with what I really do. It's really challenging, and I love it, and I wouldn't have it any other way.

On most issues, she does take a more conservative position. In terms of making connections for a woman between her personal and social experience, she describes herself as "fairly low-key with interpretations" generally and wonders if that has to do with her style as a therapist, as a feminist therapist, or as a feminist.

I personally . . . feel it's real important to help people get to their own conclusions, and to know the right time to put [out] interpretations, so that I do go easier on that than this other woman [I know] that I think puts out a lot of interpretations to a woman that she's behaving that way because she's a woman, and why. There's a definite extreme of that I don't go near.

She explained that she herself came to feminism very gradually. She was a therapist first, and thinks this may explain some of the differences between herself and other feminist therapists who were feminists first and then decided they wanted to be therapists. When asked what influenced her in becoming a feminist, she said that it was partly her own life experiences, particularly the combination of influence of one woman in 1967 who was a feminist, her divorce, and her decision to go to

graduate school; and partly it was her exposure to the political activities of other women and women's groups around her in the last few years.

At the end of the interview, she wondered whether the questions I had asked seemed to be the ones that most feminist therapists were asking themselves and struggling with, and then she explained why she had asked:

What I mean by that in personal terms is that it might not sound like it, and then on the other hand it may, [but] I think that I've thought about just about all of the things that you've asked about. So my personal translation of what I was putting out was, I'm eager to know if there are more issues and more questions that haven't come to my attention yet, and I'm anxious for those.

My sense is that it did show that she'd thought about these things. In doing the data analysis, I was struck repeatedly by the awareness she conveys of the issues involved in each position she takes and the integrity with which she maintains a consistency in therapy with her beliefs and values.

Diane. Diane described herself on her questionnaire as having an M.A. in Educational Cognition, having done therapy two years, currently employed by a public agency, focusing on women, and listing eclectic, Gestalt, and Don Juan as theoretical orientations. I interviewed her on the small boat in which she lives, moored in Seattle's ship canal. In keeping with her philosophy of Death and Dying (or, as she changed it, Death and Living), which says that you could die tomorrow so you must live as though there is no tomorrow, she decided she wanted to live on a boat, bought one, learned to drive it, and sailed it to the moorage where it is now docked.

I get most of my philosophy now from Don Juan and this little book a friend gave me called Lazy Man's Guide to Enlightenment--it's by living as if there is no tomorrow. For example, if I wanted to buy a boat and I had to wait until I had the money for the down payment or until I had a job--it was a very insecure place to move out and buy a boat and yet because I did it, things happened, things took over for me.

Although she said, yes, she considered herself a feminist therapist, at first I had a hard time understanding what she did as a feminist therapist--certainly it was like no one else I had interviewed. She said people called her when they needed her and they would come to the boat, but that she didn't charge them. Mostly, she spends her time helping a neighbor rebuild his boat. As she talked, it became clearer that she would be called a natural helper, someone who functions in a helping capacity, without pay, without any organization behind them, but to whom people in their network know they can turn. I shared this with her, and she said:

Sometimes I feel like I'm a walking philosopher. I think I'll probably be a guru in my next life. I feel like I'm always expounding on how I feel about things [whether I'm building the boat or helping somebody in a more "therapy-like" way]. I'm living feminism . . . and I'm sharing it as I'm living it, not at certain hours, certain days. . . . It's going to be a person-to-person thing that happens through my friends or when somebody needs me in a moment. I'm not going to take money for it. And a lot of my teaching of my feelings and my philosophy about feminism is by example. . . . I'm a hell of an example to all these people down here [as the first woman] This place has changed, I've heard, since I moved down here. Because I'm very much a woman, and yet they see me rebuild my Volkswagen engine, they see me take care of my boat. I manage things and I'm still a woman . . . I feel like I'm also a teacher to my other women friends or women who meet me, because of that example, because I do live my life very much for me

[When I do do "therapy"] the things I talk about are very much related to me and how I'm living my life. If somebody sees me, they see me down here, so there's congruency. I'm not spilling out a philosophy that I've learned in order to fit their situation. I'm coming from me, and what I feel the strongest. I get

emotionally involved. I don't stay aloof. I'm not afraid to care about someone and let them know that. I left [behind] all those rigidly defined structures, philosophies. . . . I'm going to be doing [my therapy]--street therapy--while I'm building boats. . . . [But] who knows how long I'll do boat building. Who knows how long I'll live.

When I asked her if she were a feminist first or a therapist first, she said that she thought she was probably always a feminist.

I've always lived my life according to how I needed to live it and how I saw what was important to me. I never got married, went through a marriage and subjugated myself to my husband or my children. Somehow I managed to stay away from relationships that were really degrading to me. Inside my head, even though I wasn't conscious of it, I was taking care of myself all those years.

However, she became more identified with the feminist movement five years ago when she was working as a legal secretary and began noticing that her boss was very threatened by her intelligence and the fact that she was going to leave the office because being a secretary wasn't satisfying enough for her. She also sat next to an older woman in the office who was active in the women's movement thirty years ago, and out of those two influences she started feeling a rapport with the women in the office, encouraging them to wear pants and to call the attorneys by their first names. After going back to school and getting her Master's in educational psychology ("I thought[at first] I'd go into special ed., and as soon as I got into the department I knew I wasn't supposed to be there because they were passing out M&M's . . . which just abhorred me"), she did therapy for a year, followed by a death and dying workshop, after which she increasingly came to reject the traditional forms of therapy.

I think what made it change is I realized I don't grow by going and talking to somebody else about when I'm down. I work it out on myself by doing things. Doing things makes me feel better, particularly if I'm doing them for myself. . . . [It's] not growing by complaining to somebody else.

Overall Descriptions of Feminist Therapists. When I let images of the feminist therapists I interviewed move through my mind, what I see are 19 individual women in the midst of our interviews. All were women; most of them were in their late twenties, although six were in their middle years. I interviewed them in their homes and offices (although sometimes the two were the same). I felt their commitment to what they were doing and the people they worked with, and observed, parenthetically, that all but one woman spoke of "clients" rather than "patients." Overall, the thing I was struck by was the integrations each woman had made for herself. They disagreed with each other in many areas, but each woman was consistent throughout in terms of her own position. They took the interview seriously, struggling to answer the questions, to explain what they did and moreover to be helpful to me.

II. HOW DO FEMINIST THERAPISTS DEFINE FEMINISM?

Information comprising this section includes part of the answer to the question, "What do you do with your feminism in therapy" (as Feminist Values), and answers to the interview questions, "How do you define feminism?" (as Definitions of Feminism) and "How much of a feminist does a person have to be to do feminist therapy?" (as Feminist Criteria). In addition, included (as Other Comments on Feminism) are comments made at various points during the interview about the directive pressures exerted on women by feminism, the relevance of feminism only in this social context, and the relation of feminism to economic and political analyses.

Feminist Values

In answering the question, "What do you do with your feminism in therapy," a number of women began their responses by stating, in essence, "What I do with my feminism in therapy is be a feminist." Often, clients come to them because they are identified as feminists, expecting them therefore to have certain values and orientations.

I think . . . 90 percent of the people that I see come to me because . . . in their own minds . . . they define . . . me as a feminist or a "woman's libber" or identify me in some sense with a person who believes in women, who believes in women's potential, who believes in non-stereotypic kinds of roles for women or at least the opportunity to choose from among a vast variety of roles and lifestyles.
(Sue)

Feminism is integrated into their own lives, their feelings, their value systems and their way of looking at the world--"it's part of my make-up" (Ann).

I feel like my whole life is feminist in some sense. Just the fact that I am a woman. I feel like I confront prejudices against women on all kinds of levels all the time, including in myself.
(Beth)

To be a feminist "means that you have a certain kind of knowledge" (Alice). With the integration of feminism into their lives is the integration of feminist values into their value system. "It's hard for me . . . to separate my values [from what I do]. My values are feminist-related, very much so--that's who I am" (Sue). As they do therapy, that feminism may be "triggered" or felt more strongly at some times than others, but it is always present.

They speak of themselves as having "feminist" values, which seem to go beyond a narrower definition of values as ethics or morals to encompass a belief system or world-view which a person "buys into,"

acknowledging from the beginning that at a certain point a moral judgment of reality is made (Stevens 1971). On the most basic level, for them feminist values include:

--the belief that women differ from men because of social conditioning on the basis of sex-role stereotypes.

--the belief that that socialization has been destructive and oppressive for women, further institutionalizing them into certain restricting and conflictual roles, behaviors, and careers which have hindered their self-actualization, perpetuated their secondary status, and produced emotional distress.

Being a feminist, then, for these women means a belief in women and in their potential. They stress the positiveness of their orientation--they value women and being a woman.

I try and focus the basic feelings that go on with anyone--insecurity, anger, sexuality . . . --with their consciousness of their additional status, additional burden. And I try then, a little at a time, to turn it into their additional asset, the sense that to be a woman, to be in touch with all those things, to have had that experience, as debilitating as it was and can be, they can turn to strength. They can turn their anger into power; they can turn their sensitivity into an awareness not only about themselves but about other people. (Alice)

Almost all the women interviewed talked about feminism as embodying a belief that each woman is--or can be--responsible for herself and for her own life, that she does know what she wants and what is best for her. If she is supported and given the permission to do so, the decisions and choices she makes will come--and need to come--from that knowledge rather than, as perhaps previously, responses based on stereotyped role models of how a woman "ought" to be.

I seem to run into a lot of women who feel like they have to have a man in their lives As a feminist I'm asking continually, what are they doing to make themselves happy, what does their life consist of I emphasize more, "What is your life beyond . . . does he love me or does he not love me?" So in a sense I'm defusing that. (Ellen)

I just basically view [feminism] as respect for other people, . . . not putting people in a 'not OK' position. . . . Feminism means right now [to me] to just be yourself, [to] decide you're OK whether you fit the role model or not. (Holly)

To a certain extent, they are restating basic humanistic values. However, there is the additional focus on the ways sexual stereotypes have kept people, and especially women, from self-actualization, an awareness of and sensitivity to the particular needs, problems and concerns of women as different from those of men. There is also a valuing among these women of the questioning of traditional stereotypes and of moving toward non-stereotypic role models or freedom from all sexual roles. As an example, one woman described a contract group she ran for women.

A lot of the women came in with a contract that they wanted to feel better about themselves . . . or to be able to express their anger more. In a way all these things are really related to how we feel about ourselves as women and how we're scripted to not be ourselves and to take care of everybody else [Although] the contracts were not specifically, "I want to know more about myself as a woman," in the process of working on those things, they've become more liberated. One woman I can think of started out in a very submissive, docile [place], and was in a marriage that she didn't want but wasn't ready to do anything about. . . . She's now separated from her husband, has a lover (which she's gotten lots of strokes for, lots of permission to have) and is just like a completely different person. (Peg)

Definitions of Feminism

Definitions of feminism were arranged within a four-square grid and sorted 1) according to whether the definition (or component of a definition³) focused on human commonalities and human potentials,

³A number of definitions contained several components. In order to preserve the complexity of the response, definitions were separated into component units and each component was listed separately. Thus, it is possible for one respondent to have more than one response in a category, and/or responses scattered among several categories.

classified as egalitarian, or on women and/or differences between people based on sex roles and sexual oppression, classified as sexual differentiation; and 2) according to whether the definition (or component of a definition) dealt with beliefs (values, attitudes, consciousnesses, awarenesses, perspectives) or processes (actions, struggles, movements).

Whether the definitions are counted as single units or combined within squares by respondent, the order of frequency of categories listed remains the same. Definitions involving beliefs in sexual differentiation are listed most frequently, followed by processes of sexual differentiation, egalitarian beliefs, and egalitarian processes, in that order. Because this was part of the final question of the interview, most responses are short, terse and unexplicated, and Figure I shows the definitions of feminism sorted according to the above system in their totality. Table XI shows the number of responses in each category.

TABLE XI
CATEGORIES OF DEFINITIONS OF FEMINIST THERAPY

Category	Total number of definitions in category	Total number of individuals listing one or more definitions in category
Sexually differentiated beliefs	17	9
Sexually differentiated processes	12	7
Egalitarian beliefs	7	5
Egalitarian processes	4	4

Eight more definitions based on beliefs are listed than definitions based on processes, seeming to indicate an emphasis on feminism as a belief

FIGURE 1
DEFINITIONS OF FEMINISM

	EGALITARIAN	SEXUAL DIFFERENTIATION
BELIEFS	<p>Belief in the equality and potential of all people</p> <p>Being aware of yourself as a person</p> <p>Being aware of people as people rather than by power or sexual categories</p> <p>Attitude that men and women are equal, have the same potential, the same rights to exist</p> <p>Ways of looking at people that acknowledge women as equal to and in a unique balance with men</p> <p>Belief in peoples' freedom to choose as individuals</p>	<p>Being aware of yourself as a woman (2)</p> <p>Sense that being female is very powerful and ultimately freeing</p> <p>Recognition of impacts of living in a patriarchal society</p> <p>Sense of the impossibility of women depending on male support</p> <p>Believing that women need not be alone in their personal problems, that personal problems are reactions to a sexist oppressive society</p> <p>Awareness of the way women have been put down</p> <p>Belief that it is OK--and good--to be a woman</p> <p>Position that says women are as good as men</p> <p>Position of countering notions of male dominance and male superiority</p> <p>Appreciation and understanding of the historical devaluation of the feminine principles, and of women</p> <p>Understanding of the value of the feminine principles and the need to bring it into the world and into peoples' lives</p> <p>Understanding of women's place in our current society and what that means to individual women</p> <p>Consciousness of sexual roles and cultural conditioning</p> <p>Position in favor of liberation from sexual roles</p> <p>Worship of the female deity, of the intuitive power women have</p> <p>Sense that this society doesn't have anything to do with women</p>
PROCESSES	<p>Movement enabling people to become what they want to become and allow others to become what they want to become</p> <p>Developing one's own potential and setting one's own goals without cultural or sexual bias</p> <p>Enabling people to recognize and realize all their potential and make choices based upon their own needs, values, and interests</p> <p>Means of helping the person develop his or her own potential and achieve goals chosen by him or her while recognizing there's a real world as well</p>	<p>Great masses of women getting together in the service of their own liberation</p> <p>24-hour-a-day self-conscious struggle against sexism, both in yourself and in your intimate relationships</p> <p>Advocating the wholeness and quality of women, with each other and with men</p> <p>Process of humanizing the female, incorporation of any and all human potentialities (legal, social, sexual, etc.)</p> <p>Active involvement in confronting sexism</p> <p>Real care, concern and commitment to women</p> <p>Total radical change in the way we live and deal with our children</p> <p>Action directed toward changing the secondary citizenship of American women</p> <p>A woman struggling to live her life as fully as possible and develop herself as fully as possible</p> <p>Women struggling with their sisters to help each other grow and build unity to combat the negative impacts of sexism</p> <p>Struggling with one's own oppression as well as not oppressing others</p> <p>Enabling women to have the freedom to recognize and realize their potential</p>

system. Twenty-nine definitions involving sexual differentiations are listed, as compared to 11 definitions involving egalitarian sexual commonalities, a strong indication of feminism's focus on women as a separate group and on differences between people based on sexual roles and sex role oppression.

Feminist Criteria

Interviewees were asked, "How much of a feminist does a person have to be to do feminist therapy?" In essence, they were asked to indicate what criteria they would use in deciding if a person who said she or he was a feminist therapist were one or, in other words, whether there were certain behaviors or degrees of feminism they felt would necessarily have to be present for a person to be a feminist therapist (or a feminist) and whether there were certain behaviors which would exclude a person. The question intentionally spoke of a "person" rather than "a woman" so that men could be included or excluded in an interviewee's response (probed for specifically in Section III, Men as Feminist Therapists).

There was great diversity and variation among what these feminist therapists thought were the basic criteria necessary to be a feminist therapist. For purposes of presentation and discussion, a four-square grid was developed which enabled the sorting of responses as follows:

- 1) low-demand/high-demand: to what degree incorporating the behavior demanded risk, sacrifice, life-style modification, or basic and significant changes in feelings and attitudes; and
- 2) inclusive/exclusive: whether the behavior as described in response to this question had to do

specifically with feminism or sexism as differentiated from therapy per se. In each case, the response presented is the behavior (or one of the behaviors) one or more feminist therapists said they thought had to be present in order for them to consider a person to be a feminist therapist. Figure II shows the behaviors indicated differentiated by categories, with numbers following each behavior showing how many feminist therapists listed this behavior as a criteria for being a feminist therapist. As Figure II illustrates, the greatest number of therapists listed responses which were high-demand exclusive.

This would seem to indicate that most feminist therapists see the criteria for being a feminist therapist as 1) placing high demands on the person, and 2) having to do with feminism. However, the number of high-demand exclusive responses are closely followed by the low-demand inclusive responses. Since there were no respondents with replies in both of these two categories, this may indicate a division between those who see the criteria for being a feminist therapist as those any good therapist would be expected to have and those who see the criteria for being a feminist therapist as those only feminists would have and moreover those which place high demands on the feminists themselves. It is interesting to compare the number of responses under each heading. Nineteen behaviors listed (seven inclusive and 12 exclusive) were labeled high-demand as compared to 13 behaviors (nine inclusive and four exclusive) listed as low-demand, seeming to indicate that feminist therapists see being a feminist therapist as highly demanding of the person herself, implying risk, sacrifice, life-style modification and/or basic and significant changes in feelings and attitudes. Interestingly,

FIGURE II
CRITERIA FOR DOING FEMINIST THERAPY

	Low Demand		High Demand	
Inclusive	Be self-actualized, feel good about yourself	3	Acknowledge issue of power in therapy, not perpetuate or abuse power relation- ships	3
	Be comfortable with all kinds of people and life-styles	3	Self-Disclose	1
	Believe in the poten- tial of other people	2	Maintain low or negotiable fees	1
	Have (and use) those skills necessary to do good therapy	<u>1</u>	See health as a struggle	1
	Total	9	Be true to one's conscious- ness and values and be explicit about them	<u>1</u>
			Total	7
Exclusive	Be non-sexist	2	Feel feminism at a "gut" level	3
	Be aware of feminist issues	1	Engage in self-conscious struggle against sexism in one's own life	2
	Use non-sexist language	<u>1</u>	Lead lives congruent with feminism	2
	Total	4	Have a certain anger at the system that oppresses women	2
			Really believe in and appreciate the message of the women's movement	1
			Emphasize role society plays in woman's problems and development	1
			Be a "strong" feminist	<u>1</u>
			Total	12

16 responses were inclusive and 16 were exclusive, seeming to indicate that of those behaviors deemed necessary to be a feminist therapist, those which do not have specifically to do with feminism are as important as those which demand a feminist consciousness per se. This may indicate either the belief that the criteria for being a feminist therapist goes beyond what is typically considered a "feminist consciousness" to include changes in other therapeutic behaviors as well or that feminist therapy is not something only a feminist can do. Both positions are represented among respondents.

Some feminist therapists are concerned because they feel that being a feminist does not mean a woman necessarily does good therapy, while some feel that a number of women are calling themselves feminist therapists who are not really "feminist enough." In other words, some see feminist therapists who have jumped on the "therapy bandwagon," thinking they can do therapy just because they're feminists, while others see therapists who have jumped on the "feminism bandwagon," thinking they are feminist therapists just because they're women. Seventy-five percent of those who talked about a "therapy bandwagon" had replies in the low-demand category, while all of those who talked about a "feminist bandwagon" listed criteria for being a feminist therapist that were high demand.

The low-demand inclusive response of feeling good about yourself or "having your own head together," and having the necessary skills to do good therapy were listed by three feminist therapists prefatory to an explanation that some feminists could not do good feminist therapy because of their anger, the need to "put down" others not in agreement

with themselves, and an inability to be open to and accepting of all people.

I think that there are probably a lot of feminists who can't do feminist therapy very well . . . for one reason or another, because of aggressiveness, because of lack of patience, because of an inability to relate to somebody else's experiences in a way that enables them to grow and not utilize [the therapy] for one's own personal needs to be on a bandwagon. . . . Too much lecturing is not therapy. (Sue)

These feminist therapists were critical of other feminist therapists who they perceive to be imposing their values on their clients, telling them what they must believe.

One of the problems with a lot of feminists is that they feel they know better than a lot of women about what's best for the woman. And that's [just] pushing another party line. . . . It's not Freud, but it's Marx, or Mao Tse Tung or . . . feminism. And the woman doesn't have a choice. She's put down if she doesn't stand up for herself or get a job or . . . if she waits for her man. She may want to wait for her man. All I'm interested in is that she knows that she's doing that and that she feels OK about that. (Leslie and Carol)

They are saying that no matter how much of a feminist a woman may be, if she has not done her own personal work, resolved her own personal conflicts, she cannot be a good therapist and a good feminist therapist.

A lot of women are involved in the movement who feel dissatisfied in themselves and so they've put a lot of negative energy out by putting other people and things down in order to make themselves right. It's like, if you want to move from point A to B, if A was, "I was married and I have three kids and I cooked for my husband all my life" and all of a sudden I decided to change [to move to point B], so I called him a schmuck and the kids a burden to me and anybody who is [still] in that role a creep, just for me to move. There was so much negative energy in the women's movement that I had to get away from it because I find it sickening. . . . In order to help somebody, in any sense, you have to feel good about where you're at, [and not be] struggling to get to a certain place and therefore . . . have to put a lot of other places down in order to get there. . . . They're a lot of feminists that I would say could not give very good therapy. . . . Their focus is so limited and so angry--they miss the whole rest of the world. (Diane)

On the other hand, some feminist therapists criticized women who had not had any "gut experiences" with feminism or did not live in accordance with feminist values but had read a few articles and were sympathetic with the women's movement and thought therefore that they were feminist therapists while still continuing to do things--like charge high fees--that were in contradiction with feminism.

There are some people who call themselves feminist therapists, who say they do feminist therapy, who I feel are being deceptive. . . . Part of me feels that at least if you call yourself a traditional therapist, then [clients] know what [they're] getting in for. But I think a lot of people who say they're feminist therapists and who I know are not are kind of getting on the bandwagon. It makes me furious. (Karen)

This theme was repeated through most of the high-demand exclusive responses. Three therapists said that for a woman to be a feminist therapist, she would have to have had a "gut" experience with feminism.

For me, feminist consciousness is like picking my head up and turning it all the way around and setting it back down again. People who haven't gone through that experience can miss a whole lot and end up looking at the world in what I consider now a very outdated way, coming onto men in the groups in an old female stereotyped pattern, missing issues that women are dealing with because they don't yet exist with emphasis [for them]. I don't like rote therapy, people doing a number because they've seen it done . . . or read about it in a book, and it doesn't come from the gut. For anyone to deal with feminist issues who hasn't had a gut experience with it seems like rote therapy to me. (Pat)

These women stressed the importance of a very deep, almost shocking experience in coming to awareness of feminism, and felt that those who had not experienced this could not really be feminist therapists. One woman said, "It takes some kind of 'leap' experience with it yourself, some kind of shock experience, when suddenly I see what I haven't been aware of before." She went on to explain that she felt many women

therapists who had read an article or two and subscribed to Ms. Magazine called themselves feminist therapists but were not really that at all and were merely

. . . leaning on the fact that they're women and . . . think that gives them a certain amount of feminism simply because they are women. But I think it takes more than being a woman. It takes more than having read a few articles. It takes more than having some sympathy or identification with the movement.

(Leslie)

As contrasted with those three therapists who under low-demand inclusive said a feminist therapist needed to be self-actualized, two therapists in this category focused on the process of struggle towards that, believing that the important thing was not to achieve "mental health" which was impossible, but to be self-consciously struggling toward it in one's own life. Two therapists said that it was critical for a feminist therapist to lead her life in congruence with feminism.

I would imagine to really see feminism as part of your life, something that you think about and is part of you, to have gotten that so much inside you that it's just part of you, that you would have to be pretty feminist. . . . If it weren't part of your life, I think it would be impossible for you to be any kind of feminist therapist.

(Ann)

Two other therapists felt a feminist therapist needed to have "a certain anger at the system" (Ellen) that oppresses women. They disagreed with those who, in TA terms, viewed anger as a contamination of the adult ego state and therefore always saw feminism as in part pathological.

The oppression is real. It's out there. The anger is important. Anger has a definite place in the world and I don't think it should all be spent in therapy, worked through. I think it's a healthy reaction that women especially feel. What's important is what they do with the anger.

(Holly)

One woman said that a feminist therapist needed to be "a very strong feminist." She continued:

As Ti-Grace Atkinson said, "In the ultimate sense, it's who you die with." And I would die with women. That's where my loyalties are. If you spend two-thirds of your energy with men and call yourself a feminist, I find that questionable. . . . She used to say, "It's like fighting the Germans from 9 to 5 and going to bed with them at night." That does not make sense to me, and the analogy holds [for men]. So it's a struggle a lot of women are going through, and a lot of women have to make some choices about that. (Marsha)

As would be expected, there were a certain number of qualifications to the question itself. One therapist said that it was a question she just couldn't answer because her definition of what a feminist therapist was had "room for all kinds, all gradations on a scale." If a woman called herself a feminist therapist, then this therapist would not have any reason to question that. In fact, "If she said that, I think I'd be prejudiced in her favor, frankly" (Alice). She and another therapist both indicated that "how much of a feminist" a therapist needed to be depended on what the individual client wanted, "and there are all kinds of clients."

There are people for whom I would be too much [of a feminist]. There are others for whom I'm not enough, 'cause I don't march, because I do my thing in a relatively small-scale private way, and they believe that larger, more vocal action, more observable action is what it takes to be a feminist. Their definition varies with mine. And they call one "more" than the other. I don't see it that way. I don't know how to quantify it. (Alice)

Another therapist also commented on this difficulty in quantifying feminist therapists, saying, "How much--is that like being part pregnant?" (Sue). Four women expressed a concern that the question fed into establishing a judgmental hierarchy of feminism, that it was "a set-up to play 'more feminist than thou'" (Teri). They wanted to focus on the commonalities, not the differences, among women.

I don't want to get into the thing of putting women down. A lot of people do call themselves feminist therapists and they're not as political as others. We just have to struggle. They're doing a thousand times better, I think, than any male, in dealing with women.
(Marsha)

One said that in order to answer the question, she would have to determine the context in which it might even be relevant.

I know that there are women and men who call themselves feminists and practice feminist therapy who I don't agree with about some stuff, who I think are not doing the self-conscious struggle in their own lives, perhaps. I think there are some professional women therapists who are Queen Bees. So they're still called feminists, but it seems like they're a lot of contradictions in their own personal practice. My tendency is not be a "leftier than thou player," though, a "more feminist than thou" player. It depends [again] on why that question would be necessary. When it came to a direct referral, would I refer someone to somebody who I think isn't doing good? No. If I have a sense that somebody is not going to be as good for someone as someone else, then I'm not going to send them. Would I work with somebody who calls themselves feminist but I feel is very individualistic and bourgeois? Yeah, I work with women whose political goals I don't agree with.
(Teri)

She concluded by saying that even though there are some feminist therapists she knows whose political positions she disagrees with, they are still going to be better than most male therapists, "no matter how radical his politics and no matter how much he avows his feminist position" (Teri).

Finally, four feminist therapists discussed in their answers criteria they could imagine for what a feminist therapist had to do which would exclude them; and for all four, that criteria had to do with active (or "heavy") political involvement since they described their own involvement as tangential or minimal. In answering, one therapist struggled to decide if she would consider herself a feminist therapist, and ultimately decided that being true to one's politics--whether they

be personal or social--was for her the crucial criteria for being a feminist therapist and therefore that she was a feminist therapist.

I have in my head . . . a couple continuums along which it's possible to define feminist therapy. I can see how it's possible to say . . . that unless someone is politically active (that is, involved in some group, some kinds of educative efforts or some kind of political setting up of alternative structures or fighting against existing structures . . .) and then carrying that politics directly and explicitly into their therapy, then one would not be defined as a feminist therapist.

Well, I fit into that category with some people I work with, so I could say I'm a feminist therapist with some people . . . who . . . want that. But . . . one could be a purist and say if I don't [do so] all the time then I'm not and [then I would be] on the further [outside] end of that continuum.

On the other hand, I could say that where I'm at is trying to be true to my consciousness and my values and beliefs with whomever I'm working whether or not political issues . . . become explicit. Maybe I'm hiding and pretending [in saying that] because then I'm not assuming a political position really--but yes I am. I'm assuming a position in terms of personal politics [although] I may not be assuming a position in terms of social politics So if you get way down to that end of the continuum you could say . . . I continue to be a feminist therapist in the sense that I'm true to my consciousness and I operate . . . in a way that's compatible with that. (Joyce)

Other Comments on Feminism

In the context of other responses, 11 women at various points in their interviews discussed the directive pressures exerted on women by other feminists (and by feminist therapists, discussed above). They speak of their sense of the judgmental aspects of feminism--"putting people in a 'not OK' position" (Holly).

One thing I feel really strongly about is I don't want to be a part of a movement that creates another stereotype in the process of wiping out one stereotype. I don't think there should be a stereotype of the "liberated woman," the feminist. [I don't think there should be] a right way to be for women which says the right way to be is to have a career. I think there are too many people who perceive that, but it really is OK to be a mother, a wife . . . if it's a choice. (Sue)

Sometimes, these therapists say, they see clients who have incorporated the feminist value system into themselves, and use it as a standard to measure themselves against. One woman explains that feminism has been so demanding in its insistence on conformity to an ideal that it leaves women unable to acknowledge publicly when they do not "measure up" to that ideal. Another therapist described how women "top dog" themselves, being highly critical of those things they do which may be "unfeminist." This is an issue for her as well as for her clients. She explains that her tendency is to be judgmental, set arbitrary criteria, and take the most radical position, and that she is struggling to feel more compassion for herself.

One of the things that I'm coming to accept is that we're all struggling, that it's not perfect, that there are a lot of contradictions I think it's important to struggle with it but I've been more easy on myself. . . . Having to be the most radical is what I'm struggling with now. A lot of tyranny that a lot of women have experienced, including myself, is being afraid to open our mouths because we won't be saying the most radical thing. . . . I've used dogma on myself, saying, "You're not really a feminist therapist." One of the things that I've been seeing in getting together with other women is that it's a new area, that things aren't set hard and fast--it's something that's being tested and developed. (Karen)

Another therapist reported asking a married woman, in an intentionally non-expressive, non-judgmental way, if she were still doing the cooking, an issue the client had discussed with her previously. The client "bristled," hearing the therapist's question as coming from a feminist perspective, according to which, by cooking, she was "not OK" (Nancy).

Several therapists said that while the women's movement has been important in their own lives, they see it as demanding that women be always hard and strong. One therapist feels that at times feminism is

. . . counterproductive for some women when its focus is really anti-feminine. . . . The women's movement has focused on getting women in and being aggressive rather than on bringing our historically present gentleness and tenderness into the social process. A lot of people who call themselves feminists I think are . . . female chauvinists. I think they're sexists, or racists, or whatever you call that--hating men and also supporting male values, or what are male values to me. (Beth)

In a similar vein, one therapist felt that the women's movement uncritically claimed that "anything that is female is superior or wonderful, and I don't agree with that" (Teri). A therapist who had been very active previously in the women's movement explained that she has rejected the idea of the movement that "what you do is get your consciousness raised and then you go around help, help, helping other women." She does not see women as the "helpless, hopeless cases" that some feminists portray them as, "a disaster area" to which those who have been "enlightened" need to spread the word (Pat).

Two therapists said that for them, feminism was a position that they hoped would ultimately be unnecessary. They explained that while feminism was certainly necessary and relevant in the current social context, their goal was to make it irrelevant.

I think it's an antithesis position. We started with masculinism. Feminism is a position taken to counter masculinism. It's not yet synthesis. It's better than non-feminism but it isn't yet where I want us all to be. I see it as a position of countering notions of male dominance, male superiority. It's for me sometimes an assertion of bringing women up to the norm; sometimes it's an assertion that women are higher than the norm; sometimes it's just a stand off--"We're equal, dammit!" All of which is a lot of energy involved in the countering. It's an annoyance . . . that part of what has to happen in these times right now is that in order to respect myself I take this position called feminism which I hope someday is going to be outdated. (Pat)

Five women discussed the relation of political and economic change to feminism. Three felt that feminism needed to be combined with

socialism or anti-capitalism, a perspective they see often lacking among feminists.

One of the tendencies of the women's movement is to "trench off" and [say] anti-capitalism [is not the issue]. A lot of women think that all the trouble is with men. . . . I think that while there still might be sexism in a socialist context, it will be easier to combat sexism in a socialist context . . . I think capitalism needs sexism in order to survive. Capitalism needs men to breed, to perform like robots on assembly lines, to go home and rip off their ladies for nurturing and keep producing with their ladies more workers for the assembly lines.
(Teri)

However, they did not feel that if a woman did not deal with these issues, she was not a feminist. One therapist, however, disagreed. She believed that feminism can come out of any political structure.

I'm not crazy about ours, or anything, but I'm not as strong a socialist as some of the people I know. . . . [It's like] saying that you can't be a feminist unless you're a lesbian. I really can't agree with that; and I can't agree that you can't be a feminist without being a socialist, or any other kind of restriction.
(Nancy)

A fifth therapist said she "went around in circles" with this issue, trying to decide whether the particular oppression women face which leads to their emotional breakdowns, disturbances, depressions, masochism and self-destructiveness comes from men as the oppressors or from "the fact that this is a destructive world" (Marsha).

Finally, in response to the question about what the issues were for them in combining feminism and therapy, one woman said that she felt a real lack of alternative models of how to be a woman (Holly). Another woman has been struggling with the issue of whether she as a feminist can be in a relationship with a man. "It's a question I think all of us feel at some point or another--can you still call yourself a feminist and be struggling with a man?" (Karen).

III. WHAT IS FEMINIST THERAPY?

This area for data collection was the broadest, most open-ended, and consequently, most difficult to synthesize. Questions asked required descriptions of relatively amorphous concepts and behaviors difficult for any therapist to specify (Burton 1972). This difficulty is reflected in the qualifications given to many of the questions (as Qualifications About Feminist Therapy). The interview questions asking, "What do you do with your feminism in therapy?" and "What do you think a person gets from you that she wouldn't get from someone who wasn't a feminist therapist?" as well as examples of using feminism in therapy and "feminist techniques"⁴ are combined here as Descriptions of Feminist Therapy. Responses to the presentation of two polarized definitions of feminist therapy are included as Continuums of Feminist Therapy, followed by a summation of the definitions given in answering the question, "How do you define feminist therapy?" A final section summarizes the question, "Can a man be a feminist therapist?"

Qualifications About Feminist Therapy

Qualifications About the Role of Feminism in Therapy. For most feminist therapists, their developing feminist consciousness has had

⁴Generally in response to these questions, the probes for a "good example" of using feminism in therapy and for "feminist techniques" were spontaneously answered. When asked as probes, they were framed as follows: "Can you give me an example of a time when you felt good about how you used your feminism in therapy?" and "Are there any techniques or modifications on techniques (i.e., Gestalt techniques) that you've made to better incorporate your feminism into your therapy or techniques that you find you use more frequently because of your feminism?"

more than an inconsequential impact on their therapy, and in turn their therapy has increased their awareness. Two women spoke specifically of their feminism as developing as their therapy skills develop and as their practice brings them more into contact with women and the problems they face.

As I am a therapist, I am more of a feminist. I was a feminist first, but my inclinations in that direction seem to be more so, the longer I have done the work. I'm just much more tuned into what's going on in terms of the problems [women face], so none of it sounds like words to me, where a lot of it did [before].
(Ellen)

However, at various points in the interview, nine feminist therapists qualified the impact feminism has on their therapy. One therapist said that her therapy has not changed significantly since she has become a feminist. "My sense of it is that I would probably do essentially the same therapy regardless of whether there was a current feminist consciousness" (Betsy). One woman questioned whether feminist therapy really exists, since there is not even a psychology of women yet, let alone a whole approach to dealing with women. She explains that a feminist therapist could be a person who counsels feminists, a feminist who does therapy, or a person who does a special kind of therapy called feminist therapy. In her own work, feminism has become less central in her therapy as she has received more training as a therapist, so that now she finds herself doing "feminist therapy" less for any political reasons than because she likes working with women.

I became a feminist first, and I thought that I would be able to do good therapy because I was a feminist. I have my Ph.D. in Clinical Psychology, but I didn't really have much training in therapy. When I started doing therapy as a feminist therapist, I discovered that a lot of the things that I was doing facilitated Victim positions. We would sit around playing

"Ain't It Awful." It is awful, patriarchy is fucked; but to sit around and feel powerless and blame it on men and male structures was something that was going on a lot. . . . It wasn't until I started learning more about TA and Gestalt and found a framework that I felt comfortable in that I developed my good skills. (Holly)

Several qualified their remarks by saying that they weren't sure that the things they did differently than other therapists had to do with themselves as feminists, as women therapists, or because "I'm me and not somebody else" (Pat). Several thought that what someone would get from them was very similar to what they would get from any good (woman, one said) therapist. They did not consider self-identification as a feminist a necessary criteria for being a feminist therapist.

I have a feeling there are some women who do feminist therapy who don't call themselves feminists. . . . There's one person [I know] whose whole life-style and everything she does . . . is feminist, but all she connects with the liberation movement is bra-burning. (Sally)

On the other hand, other feminist therapists felt very strongly that "Feminist therapy cannot be done by someone who is not a feminist" (Teri). At the same time, this therapist also questioned whether to label things that she did--like self-sharing and fostering cooperation in her groups--feminist or not. She wonders, for example, whether she fosters a spirit of cooperation between people because women generally behave more cooperatively than men for feminist reasons or because as victims of master-slave relationships, they have learned to cooperate with their masters in order to survive (Teri). One woman said that while feminism was always present for her when she did therapy and that its absence in a therapist would be a terrible lack, feminism was not by itself an adequate approach to psychology as a whole, and did not by any means "sum up the whole of me at all" (Beth). Two women found it hard to

answer these questions because, as one said, "I don't think about feminist therapy every day of my life. It's like I do it because I do it, because I believe in that" (Sue).

Four therapists said that the degree to which they utilized feminism in their therapy depended on where their clients were at in terms of feminism. One woman who saw mostly women "heading in a feminist direction anyway" didn't see any need for her therapy to "put them on the track" (Betsy). Those who worked in a public agency felt a primary responsibility to respond to what their clients wanted and not to respond out of their political position if that were not wanted.

[What I do with my feminism in therapy] is very much determined by the kind of person I am working with. I identify myself immediately as a feminist, . . . [but] there are people who come to me who really don't understand the label, who couldn't care less--it's not an issue in their lives. Survival matters to them. Their awareness isn't in a place where they need or want to hear from me on that issue. It wouldn't be appropriate. It would simply be intruding into their space, which oftentimes is very fragile. But those who have found me through directories or by referral from other women generally know that I am a feminist [and want me to be a feminist]. (Alice)

In response to the question about techniques, most of the feminist therapists did describe one or two specific techniques they used to incorporate feminism into their therapy. Ten also qualified their responses to the question by saying, in essence, that they did not see changes in technique as being as central to feminist therapy as changes in values. Basically, they are saying that any technique changes they may make come out of a larger shift in the whole point of view from which they now do therapy. One woman differentiated between developing techniques which incorporate feminism into therapy and developing a whole new orientation toward therapy. Her collective has done the

latter, calling it a "socio-therapy" (Marsha).

Qualifications About the Nature of Therapy. In describing the percentage of time they spend doing therapy, a number of differing distinctions were made about what constituted therapy. Some definitions were broad, including not merely structured therapist-client situations but other situations which feminist therapists feel have therapeutic impacts. For a Dean of Women Students, this includes career counseling with older women returning to school, teaching, advising and training. She includes the career counseling because "we always get into the whole area and issue of stereotypic kinds of roles and how their lives progressed and how they are now at the point of looking at themselves and their lives very differently." The classes she teaches are only open to women, and again, the issues of how women have been socialized reoccur continually.

I consider in . . . those classes the focus being furthering one's own personal potential, and dealing with what you have to deal with right now, as a woman. . . . And I consider that therapy, in terms of facilitating what happens in a group of women who are discovering some new things about themselves and their lives. (Sue)

Similarly, the advising and training of women leaders of Associated Women Students she labels "educational growth-producing experiences" and considers therapy as well because as she works with them, she is also talking to them about their lives, feelings, and goals. Another therapist explained that her therapy was not merely limited to the act of therapy, but included as well situations (such as her participation in two radical therapy collectives) in which she expects of herself the same performance as when she does therapy, and her personal life, in which she consciously utilizes her problem-solving and

therapeutic skills in her personal relationships and is willing to be called on by her friends for "therapy" (Teri).

Other women defined therapy for themselves more narrowly. Although they saw themselves doing other things in their work which were feminist and/or therapy-related, they did not consider them therapy. One woman, for example, distinguished between the assertiveness training she does and the therapy she does, referring to the former as one of many possible therapeutic/educational experiences a person might have, but which are still distinct from therapy. In part, the difference for her rests on the degree to which professional standards and ethics, such as not advertising for doing therapy, are adhered to (Alice). Another woman distinguished between what she does as a feminist and what she does as a psychotherapist. Since she considers her primary identification to be feminist, she functions as a feminist "really 100 percent of the time." However, she defines psychotherapy itself as "dealing more directly . . ., dealing more with the casualties [of the system]" (Marsha); and she is not always in that role. A woman who is the director of a drop-in center says that one of the things she does is model a new consciousness about women, "a new way for women to be in the world," which is an extension of--but not directly--feminist therapy. However, while she does not include her administrative functions as part of the therapy she did in calculating the percentage of her time she spends doing therapy, she did include the time she spends training the staff,

. . . because one of the things that we talk about [in staff training] is self-assertion for the women who work here, and

gentleness and compassion for the men who work here--how to break out of cultural patterns in relating to people.
(Pat)

Descriptions of Feminist Therapy

Highly similar responses were received to the two questions, "What do you do with your feminism in therapy?" and "What do you think a person gets from you that she wouldn't from someone who wasn't a feminist therapist?"⁵ although the former was designed to elicit behavioral descriptions of feminist therapy and the latter broader generalizations about the differences between feminist therapy and other therapists (i.e., the critical aspects of feminist therapy).

Basically, they seem to be saying, "I am a feminist. Out of my feminism comes for me certain values, beliefs, ideas and ways of perceiving and acting which I integrate into, build on, and utilize in the therapy I do." As discussed in Section II, the essence of the feminist value system as described by feminist therapists is two-fold: a belief in the potential of women (called Feminist Humanism) and an awareness of how women's potential has been thwarted by sex roles (called Feminist Consciousness). Out of their Feminist Humanism and their Feminist Consciousness come those things which make up feminist therapy, and differentiate it from other therapies. For purposes of discussion, the components of feminist therapy as described by feminist therapists were synthesized, and are described below. The number following each item indicates how many of those 19 feminist therapists

⁵Other question responses in which comparisons were made between themselves and non-feminist therapists are included in this latter question as well.

interviewed described behaviors falling into each category. Some replies overlapped categories, and are included in more than one.

Feminist Humanism 16

- Believing in freedom from any models or roles--
particularly sexual--of how a person (and
especially a woman) ought to be
- Giving women permission and support to act in ways
prohibited by traditional sex role stereotypes
- Modeling a positive image of a woman and of
feminism

Feminist Consciousness 16

- Having a greater awareness and understanding of
women and women's problems due to sex roles and
sexual oppression
- Analyzing problems people bring to therapy from a
world-view which has incorporated a feminist
consciousness
- Having an awareness of societal influences on women
as well as the individual dynamics of their
problems

Changes in the Traditional Therapy Relationship 16

- Making changes in the role of the therapist
- Being concerned with power issues and attempting
to move toward equality or mutuality
- Allowing oneself to become more involved, more
of an ally (more contact, less distance)
- Sharing one's values and experiences (self-
disclosure, attempting to demystify oneself)
- Stressing action as well as introspection
- Discouraging lengthy therapy and dependency on
therapy
- Maintaining reasonable fees

Raising Consciousness 10

- Bringing to a woman's awareness the existence of
sex-role stereotypes and sexual oppression
- Bringing into the therapy the societal influences
on individual women
- Confronting sexism in clients, peers, and other
professionals

Emphasis on the Commonality of Women 9

- Giving a woman a sense of her unity and
commonality with other women
- Supporting women sharing with each other, learning
from each other
- Breaking down the isolation women feel toward each
other and the mistrust they feel for each other

Responses in each section and methods of implementation are discussed below.

Feminist Humanism. Out of Feminist Humanism, the belief in the potential of women and in the knowledge of each woman of what she wants and what is best for her, comes a desire to free women of roles which have prohibited the actualization of that potential. Feminist therapists feel a major difference between themselves and non-feminist therapists has to do with their way of looking at women and men and at their potentials. Feminist therapists see this difference in perspective centering around their depth and degree of commitment to freedom from sex-role stereotypes, equality between the sexes, and a person's (often, especially a woman's) self-actualization without restrictions from or the determinism of sexual (or any other) roles. They feel that non-feminist therapists still carry with them certain stereotypes and values--often based on sexual differences--about what are appropriate behaviors, life-styles, interests, directions for growth and change, and roles, and that their acceptance of a wide range of options in these areas from life style to politics to role choices is what differentiates them.

For example, a feminist therapist trained in Transactional Analysis does not accept it when others ascribe the injunction, "Don't Be a Woman," to someone.

I get confused and angry when I hear that . . . because I don't know if the corollary is that what they really have is a "Don't Be," a "Don't Be Normal," a "Be a Man, a Neuter, a Little Girl." I've heard that as a blanket label put on, . . . and what I think is going on is that the women . . . have been somehow not fitting the feminine stereotype. . . . It may be helpful to know if someone's got a "Don't Be Sexual" or a "Don't Exist at All" . . . or just a "Be generally weird," . . . but the labeling that someone has a "Don't Be a Woman" injunction is scary to me because I see that as a subtle way of getting her back into a role.

(Pat)

She goes on to say that part of her feminist perspective means that she has a broader definition of what it means to be a woman than some other therapists might.

I think that maybe more than most people, I'm willing to let women that I see . . . be a woman however they want to be a woman. I think I'm more willing to let the definition of "what is a woman" be wider. So that if someone comes in always wearing Army boots, that doesn't signal to me that she's got a "Don't Be a Woman." It signals to me that she wants to wear Army boots. It may be because it's cold. It may be because she wants something heavy on her feet to stay grounded. It may be because her father always wore Army boots--but I don't think it matters.

(Pat)

They see themselves as giving women permission and support to act in ways that traditional sex roles have prohibited--to be assertive, make non-stereotypic life decisions, develop equality of task-divisions in relationships, question her life and her relationships, get in touch with and take the necessary action to meet her needs, feel her own strength and power, and become her own person. A therapist described this process in Transactional Analysis terms as "decontaminating the adult around messages they've gotten about what women's and men's roles are supposed to be and not supposed to be" (Peg).

Six women spoke of using their Feminist Humanism in therapy by presenting a positive model of ways of behaving women are generally

conditioned against: being assertive, sexual, independent, a feminist and a woman.

One thing [I do with my feminism in therapy] is what the traditional folks would call role-modeling. A lot of my work is a function of who I am and how I act. I think I'm pretty gentle but I also think I'm pretty potent. I'm not afraid to be assertive. In my own personal life, I struggle against taking shit from people, and so that gets transmitted into my therapy.
(Teri)

One woman feels that modeling is perhaps the most important thing she does with her feminism--"I'm living feminism and sharing it as I'm living it."

A lot of my teaching of my feeling and my philosophy about feminism is by example. . . . I'm a hell of an example to all these people down here . . . because I'm very much a woman and yet they see me rebuild my Volkswagen engine; they see me take care of my boat. . . . I feel like I'm also a teacher to my other women friends or women who meet me, because of that example, because I do live my life very much for me.
(Diane)

Feminist Consciousness. Coupled with this Feminist Humanism is the added component of their feminist consciousness and feminist framework for analysis, that particular sensitivity to and understanding of the experience of being a woman, the particular problems or prohibitions women bring to therapy, and the limitations sex roles (or any models of how a person "ought" to be, however covert, and including feminism) place on a woman's self-actualization and have historically placed on the self-actualization of women. Said one, "To be a feminist means you have to have a certain kind of knowledge" (Alice). They are saying that because of their feminism, they have a different--or more encompassing--perspective or knowledge-base from which to approach understanding of what a client is saying and how she came to be where

she is. This knowledge-base encompasses not only the traditional forms of therapeutic assessment but an awareness of the psychological effects on women of social conditioning, of sex roles, and of a secondary status.

Feminist therapists feel that because they have more understanding and awareness of the problems a woman may be experiencing, they are less likely to discount her problems or perceptions as not real, inconsequential or less important than her husband's and more likely to "hear" what she is saying, question certain initially-stated goals, and take seriously the pressures of the society on her.

Based on watching some of the men in the training group work and from what I've heard from some of my female friends who have gone to [non-feminist] therapists . . . , I think [a woman] would get [from them] . . . a "pat-on-the-head and go-back-and-be-the-good-little-wife and everything-will-be-OK" [message, the sense of] "Don't really look at those areas 'cause they're too threatening somehow." (Peg)

From their own experiences as women they offer validation of a woman's experiences and from their feminist consciousness and perspective a social context and a reality-base from which a woman can check out and understand her own perceptions and experiences.

I think they get [from me] someone who has a clearer, more whole, complete picture of what our social structure is like. Anybody who isn't a feminist and doesn't have that kind of awareness, regardless of how they've labeled themselves, . . . doesn't have as complete a picture of our culture and what it does to women and how outside pressures, situational things and historical things have contributed to that person's psychodynamics [as I do]. So [the client] gets, I think, a better clinician in me. (Alice)

They explain that because of their feminist consciousness, a woman is much less likely to get in therapy the kind of oppression she will get from a therapist whose consciousness is not raised and who therefore

will respond to her like the culture as a whole responds to women, "fuck[ing her] over in a lot of subtle ways just like the culture's fucked women over" (Leslie).

It's absolutely crucial for either sex to work with somebody who is real aware of the sexual pressures of society and who really appreciates, not in an intellectual way but really inside themselves, the equal potentials of the sexes. There's just no way that that isn't going to be communicated to whoever you're seeing. . . . If you basically have any kind of prejudice, it gets communicated. . . . At the most subtle level you just don't pick up things that someone else would pick up who wasn't prejudiced.

One of the issues that therapists see all the time is the issue of people trying to decide whether or not to stay in their marriage. It seems to me that the traditional view is very committed to marriage, at the expense of the woman's identity. It's never at the expense of the man's identity. With the best of intentions and the best of theories, if somebody has that kind of bias, on an unconscious level, it gets communicated. That's something we all have to struggle with. You're taught not to value women as much as men, and the more caught you are in that, the less you can help your patients to get through it. (Beth)

They are saying that unless a therapist is particularly sensitive to feminist issues or committed to feminism, a certain amount of bias will exist in their therapy no matter how humanistic they feel they are. One woman shared what she thought a client got from her as a feminist therapist and then explained how she differed from non-feminist therapists in what she did.

Support for her humanity. Support to come from herself as a whole human being. Support to change. Support to struggle for freedom. I don't think that non-feminist therapists do that. I think that they might say they do [but they really don't]. I think that there are folks who come out of the human potential movement, some Gestaltists and some Reichians, who actually don't like women. Even though they espouse human liberation vis a vis the development of human potential, they still have fixed in their heads some models of how women and men are supposed to be. (Teri)

Changes in the Traditional Therapy Relationship. Feminist therapists indicated that an important thing they did with their feminism in therapy (and thus that a person would get from them) was to make changes in the traditional therapy relationship. One woman said that a thing she does in this context is to give women "a fair break in therapy" by charging them only what they can pay. However, generally the changes mentioned were changes in their role as a therapist, in the focus of their work toward action rather than introspection, and in their negative orientation toward long-term therapy.

Of those changes in the traditional therapy relationship indicated, changes in the role of the therapist were mentioned most frequently, by 15 (of 19) feminist therapists. For 11, changes in the role of the therapist included ways they dealt with or perceived the power imbalance in the therapy relationship. As feminist therapists, the relationship they have with their clients is one in which they try to foster, as much as possible, an equality or mutuality and break down the power hierarchy found in traditional therapy. They see themselves as sensitive to and wanting to deal with how they use their power as therapists, and whether they use it to stay distant in the security of their therapist role, to diagnose, to make decisions or interpret for clients, or to discount the importance of power itself as a dynamic of their relationship. They presented a number of ways of lessening the power imbalance.

Some feel this can be done by maintaining equality as a basic therapeutic attitude, based either on a sense of common identity as women whether client or therapist, or on humanistic values.

Given that framework--that we're unequal to begin with--I try to keep my attitude one of, "I don't know better for you. I do have some skills at helping you come in touch with what's inside of you that you don't have because if you did you wouldn't be coming to me." (Leslie)

Two women speak of negotiated fees or of asking for fees themselves rather than sending bills as ways to foster this equality.

Others discuss limiting the oppression of the client by the therapist's power by focusing on the power the client does have in the relationship. Women in particular are seen as out of touch with their personal (and collective) power, thus turning their frustration into "whining and tears and eating too much and pills that dull out awareness" (Cheryl) rather than action. If in the therapeutic relationship the client is given responsibility for herself, encouraged to get in touch with and take charge of herself, and to be aware of when she gives away her power, allowing others to be powerful over her, to influence her, then she can begin to reclaim her own power and the therapist becomes less a leader/director and more a "vehicle."

I see my whole job . . . [as making] women take responsibility [for themselves], so that they say "yes" and "no," learn how to go ask for what they want, learn how to get in touch with themselves. [So] if they say, no, they don't want to get into something, I'll honor that. If I have some feelings about that or some hunches about that, I'll say it; but I'm not going to say, "Hey, you're avoiding." Like I know best, or better than you. . . . [I'm also] non-interpretative. No way would I say . . . that I know what this means and you don't. (Carol)

Part of this is also refusing to accept power that the clients "give away" or project onto the therapist--"When the client gives me power I give it back" (Karen). Similarly, another therapist explained that increasingly she is turning the responsibility for problem-solving

away from herself and back to the women in her groups (Holly).

Feminist therapists also give examples of more direct means they use to make themselves more equal. One therapist who utilizes videotape feedback finds this technique also limits her power as the presenter of "reality" and enables clients to perceive themselves directly. "It is critical . . . for women . . . not to continue always relying on authority figures . . . [and to] become their own authority, their own best judge of who they are and what they want to be" (Alice). Contracts were also mentioned here as a way to limit the therapist's power to realms negotiated between therapist and client. Insisting on a contract means both that agendas of therapist and client are overt rather than covert, and purposively limits the therapist's power to lead the therapy in accordance with unstated ideas about what the client needs. By so doing, the client is in an increased position of power, in that she is the one who is clearly deciding what's going to happen, what she wants for herself, and what the therapist's role will be. Two women spoke of lessening the power differential between themselves and their clients by demystifying their therapy skills. They let their clients "in on what's going on" (Joyce) by sharing with them directions they see the therapy going, possible effects of a technique and their rationale for suggesting it, and then respecting their client's decision (the Feminist Humanism above) about which way she wants to proceed. When the women in one therapy group wanted training in Gestalt, the therapist began explaining step-by-step what she had done after working with each person "to demystify the process, so it wasn't so super-special only I could do it" (Karen). Four

discussed utilizing less "heavy" therapy and increased personal contact on their part with their clients, self-disclosure to demystify themselves, and attempts to enter the relationship as more of a person and less of a therapist.

[A client] said something to me that I could have dealt with as a "therapist" but I didn't. . . . I didn't just want to label it transference, even though it seemed like it was that. So I checked . . . out where I was . . . to see where I stood and [if] I was doing what she accused me of. . . . I think that a feminist therapist would . . . be much more willing to take responsibility for her part in something, not just to chalk it up to something else. [So] I don't approach everything therapeutically . . . , [but] more as me, just as a person to a person rather than as a therapist to a person. (Karen)

The second major change feminist therapists discussed making in their role as therapists, mentioned by nine, was purposively using themselves--their values and experiences--in the therapy they do. They may do this to raise consciousness by enabling the client to identify with examples of the therapist's experiences in discrimination or to lessen the power differential by demystifying themselves as therapists.

One of the things which I feel is very important (which other feminist therapists would disagree with) as a feminist therapist is to share yourself. I feel it's important to not put myself up or to come off as somebody who's better than, more together than [my clients]. That's not where I am. So I'm very much into sharing where I am, sharing what's going on with me, as well as having the person I'm working with feel more in power. It's very important to not project a lot of power onto the therapist, [onto] the role of the therapist. (Karen)

In addition to sharing examples of the discrimination she has experienced, one feminist therapist also shared her positive experiences as a feminist with the women she works with and in the classes she teaches, as a conscious form of role modeling.

[I share] what it means for me to be a feminist and how I consider that to be a growing dynamic thing in terms of my

ever-changing life . . . [I share how] my feminism enables me to see myself as a dynamic, growing person and not a static person, and how that affects my emotional life, my professional life, my personal life, even my physical life in terms of going out into what several years ago I would have considered risk to play handball . . . or to develop myself in a wide variety of ways which weren't previously open to me because of my blocking or because of what society told me was right or wrong.

(Sue)

Four of the six women who spoke here of stating their feminist values during therapy did so in the context of explaining its usefulness in the therapeutic encounter. In explaining their values, a process of negotiation, interchange, or contracting between them and their clients occurs. One woman identifies herself immediately to her clients as a feminist, and is listed in resource directories as a feminist therapist. Out of that identification an interchange occurs between her and her clients because

. . . ordinarily one of the things [clients] want to know is what do I mean by that. So I define what my value system is and how I believe that is important for me and for my work with women--and men. That [explaining] almost always happens. It's rare that it doesn't happen.

(Alice)

Another woman uses the statement of her bias as a forum for contract negotiation around whether or not her clients are willing for her to work with them to raise their awareness in these areas. Such negotiations are designed to change the power balance in the therapy relationship, as discussed above.

A second group of changes in the traditional therapy relationship discussed by six therapists had to do with focusing on action more than awareness or introspection (or a coupling of the two), particularly action in developing alternatives to therapy in the women's movement. One woman spoke of awareness and action as needing "to go hand in hand"

(Alice). Another said, "For me, [therapy] is cognition, it is feeling and it is action together" (Marsha). By "action," they mean that at a certain point they expect their clients to go beyond even awareness of the role of societal conditioning and oppression and to make real behavioral changes in their lives, to begin acting differently and to begin finding new ways to get their needs met.

A form of action mentioned by five of the feminist therapists is encouraging their clients to find alternatives in the women's movement for the needs which are presently being met by therapy. They encourage women to set up women's support groups for themselves outside of therapy. They make it a point to learn about and then give their clients information about various women's groups in the community, to a much greater degree than they feel non-feminist therapists would, with end goals of getting the women out of therapy or certainly less dependent on it. One woman said that clients come to her to get a great number of needs met, and if she does meet those needs, she is actually encouraging dependency and their remaining in therapy which is the opposite of what she wants to be doing. "So lately I have been very firm about saying, 'I'm not here to be ma. Let's look at how you can get . . . those needs met out there. I don't want to see you in here for the next year'" (Holly). Another woman's ultimate goal as a feminist therapist is for the women she works with to become feminists themselves and work for societal changes.

If they become feminist themselves, they will love to be with other women, and will support other women, and will be involved in women's groups, and will try to further the women's cause, which is my goal--not an individual solution but a total change of the system.
(Marsha)

Raising Consciousness. Over half the women (10 of 19) described as part of feminist therapy behaviors that are basically consciousness-raising, bringing to a woman's awareness the existence of sex-role stereotyping and sex-role oppression and the effects of the social experience on her personal experience. It is the idea that re-learning precedes behavioral change. Some do this by asking questions of their clients phrased to "get at" entrenched stereotypic assumptions which women have unquestioningly accepted.

I think there are a whole lot of questions that can be raised When women come in and talk about their lives (I'm thinking of mature women now) and they talk about where they have been, I'll say something to them to the effect of, "Did you feel like you were doing what was expected of you at that point?" They'll say, "Well, of course," and I'll say, "Was that your decision or somebody else's decision? And how do you feel about that?" I consider those feminist things [that I do] which lead into [me saying], "OK. Who are you? What do you want to do?" and, "It sounds to me like you've been spending your life trying to meet other people's needs. Have you ever sat down and thought about what your own needs are?" That leads into being a woman and what women are expected to do--to make sure to meet [other] people's needs.
(Sue)

As they ask questions, they are at the same time modeling questioning behavior and giving women permission to question as well.

A therapist trained in Gestalt described a technique she has used to enable a woman to "get in touch with the . . . implicit and explicit rules in her family about how she was raised to be a woman, how she was treated differently than her brothers." With a client whose two sisters, aunt and grandmother were very important to her, she placed pillows about in the room to represent all the women in the client's family, and had her experience through fantasy the messages she got from them about how to be a woman. This therapist explained that she can have a client similarly experience the messages from the men in her

family as well, and then "link that up culturally through seeing what's passed down through family lines." In presenting this exercise, she intentionally speaks of "the men in your family" rather than, for instance, "your father," because "He's a man and by his example he's going to teach and to show to the children what he feels about women versus men" (Leslie). "Reality bombardment" with video-tape feedback of therapy sessions is used by another feminist therapist to raise a woman's consciousness.

Women are conditioned to . . . be aware of how they look on the outside, to do all this adorning . . . and to spend [so much] time in front of the mirror, and they still don't know what they look like Using video-tape, . . . they can see their passivity; they can see how they sound like children sometimes; [they can see] how their voice gets . . . when they're angry and . . . when they're relaxed.
(Alice)

Other women more directly bring into the therapy they do the societal influences they perceive as impacting on the women they are working with. One woman described how she incorporates her own growing awareness of "societal influences" on women into her therapy.

I've become much more aware of the societal influences on women, and I bring that into what I do, . . . not only working with individual women's intrapsychic processes but with the effect of the culture on women If the woman is talking about having trouble picking a career, or knowing she wants to move out of the house but not knowing what she wants to do, it's one thing to work only on her own individual indecisiveness and her own passivity, her fearfulness. It's another thing to point out that of course she feels this way because as a woman in this culture she was trained to behave like that . . . [or] women will say they're afraid of men. I always used to interpret that as a totally individual thing, that the woman's own personal history alone had contributed to making her afraid--her father was punitive, and so on. But if you look at the larger societal envelope that goes around that, every woman is afraid of men and they have a lot of societal reasons to be afraid of men. So that [perspective] gets pointed out at the same time that the individual [perspective] does.
(Leslie)

Sometimes consciousness-raising means they confront sexist remarks made by men in their groups, colleagues or peers.

One Bay Area collective has developed a model of "socio-therapy" which focuses on this relabeling and reframing, taking things which are said on a personal level and integrating them with the cultural training women have had. For example, if a woman were to come in and talk about not being able to get along with other women and hating her sister, the therapist might reframe what she said, saying, "We are taught in this society not to trust our sisters How could you not feel hatred for your sister--that's what you've been taught" (Marsha).

Emphasis on the Unity of Women. For nine women, part of feminist therapy is giving a woman a sense of her unity and commonality with other women. Some do this in conjunction with raising consciousness, discussed above. By presenting the broader cultural perspective of how a woman's personal experience is often a conditioned social experience, their goal is to break down the isolation many women feel about the problems they individually bring to therapy and to promote a sense of unity with other women in the commonness of their cultural experience. One woman described how she incorporates this presentation of the cultural into her therapy:

First I believe it's really important for people to come to the awareness themselves, so [I do] a lot of reflecting back initially, to see if I'm hearing them right, to check and see where their awareness is. Are they really aware that what they're saying is that in fact some of these psychological problems have come about because of their additional status as a woman and the fact that they've been discriminated against, not just because of the sadness of human experiences and the existential situation, but as a woman they have experienced some real hardship and discrimination.

As they become aware of that, I give them support. One of the things I've heard myself saying on my tapes is, "I want you to

know, even though this may not be useful for you now, I want you to know that you have a lot of company in that boat." . . . I tell this to women over and over again: "I see women in therapy; I work with women's groups; I talk to women's organizations; and I want you to know that's one of the most common complaints I hear. You have women sisters all over saying the same thing you're saying and they all thought they were alone too." I bring in my experience with other women to let these women know that even if they are isolated because they have no social skills, because they feel they're only housewives, or whatever, I let them know they're not alone. (Alice)

Another woman purposively self-discloses as the means by which she breaks down the sense among women she talks with that they haven't experienced oppression or discrimination as women. By sharing her experiences as a woman, a kind of "clicking" goes on as other women realize that what she has been describing has been true for them as well. Of particular concern for one feminist therapist is her client's relationship and sense of contact with her mother. She focuses on this by having her clients imagine that they are their mothers at a certain age.

"Imagine what you're wearing, what you're doing, and then after a certain amount of time with that, get in touch with what are the disappointments in your life, what have you wanted it to be like and what is it like for you." (Cheryl)

Other feminist therapists promote this sense of commonness by things they do in their therapy to encourage the women in their groups to share with, feel a unity with, and support and nurture each other and to break down the traditional mistrust and hatred women feel for each other. Sometimes, just being in a group with other women with similar problems, particularly sexual problems, removes stigma and isolation. One woman related how she "discovered" a new way of enabling women to relate to each other when one of the clients in a group began to describe "what would have been potentially a real heavy Gestalt fantasy." Because the woman was "real good" at getting into past issues, this therapist

decided to try something different.

So I asked her to choose two or three people in the group to be her friends. [Then I told her,] "Now get down on the floor and surround yourself with these friends. And just tell them, friend to friend, about this." . . . I was sitting there--I didn't do anything. I was amazed at the brilliant ideas and answers they came up with, in response to her. The suggestions . . . I was amazed at the wisdom of these women. I didn't do it [initially] for feminist reasons, [but] now as I'm filtering it through my feminism, I'm saying, "Yeah, women are . . . not just nurturing and good and sweet and wonderful, but they're wise."

(Holly)

We talked of the power of this technique for giving women permission to "use their heads," to think. This therapist has felt that many of the Gestalt exercises she had been doing facilitated her clients getting in touch with their feelings, which women already have permission to do. Since her initial experiment, she has done more of this. She has also begun to tell women to "pick somebody else to talk it over with" when she feels that everyone is turning to her as the therapist to meet their needs. This again facilitates women learning from and supporting each other, as well as removing her from the more traditional therapist role, discussed above.

Continuum of Feminist Therapy

Interviewees were asked to read two quotes, each of which defined feminist therapy from a particular perspective, and to respond. The quotes were chosen to represent two end-points on a continuum of definition of feminist therapy. The first quote was chosen to represent the humanist approach (as differentiated from Feminist Humanism above). The interviewer explained that the statement was written as a comment on a returned questionnaire, and that she would like the interviewee

to read the quote and then respond to the question the writer asked:

I have been trained to believe that good therapy means helping the person develop his or her potential and achieve goals chosen by him or her. How does feminist therapy differ from that?

The second quote was chosen to represent the radical end of the continuum.

It was taken from a speech (Duxbury and Heaney 1975) given at a Bay Area Conference on Women's Mental Health. After responding to the first quote, interviewees were asked to read the second one and respond:

Feminist therapy must include making clear the political connections between a woman's personal life experiences and her socially reinforced sense of powerlessness.

As illustrated in Figure III, reactions to the two quotes, when taken together and placed on a continuum, were clustered into five main positions, with the left end being more "humanistic" and the right more "radical." Responses to the first quotation are indicated above the line and responses to the second quotation below the line. Numbers below indicate how many feminist therapists interviewed were philosophically in agreement with each position.⁶ As shown, most feminist therapists agreed with the first quotation wholly or partially and disagreed with the absolutism of the second. The following discussion summarizes responses at each point on the continuum, moving from left to right.

Position I. The largest group of feminist therapists were in Position I. They said that they didn't think feminist therapy differed

⁶One feminist therapist agreed with both positions, seeing them as integrated rather than ends of any continuum. "I believe a lot of things and they're all OK for different people in different situations and OK for me in different situations . . . I think everything exists and should exist" (Diane). Therefore, she is not included along the continuum.

FIGURE III

CONTINUUM OF RESPONSES TO PRESENTATION OF TWO
DEFINITIONS OF FEMINIST THERAPY

(7)	Disagreed that this <u>must</u> always be done; included men	Position I Agreed with first quotation
(5)	Disagreed that this <u>must</u> always be done; stressed importance of timing, of client making own connections	Position II Agreed with first quotation but added understanding that goals are influenced by social and cultural conditioning
(2)	Agreed with second quotation if "political" is defined as social or cultural	Position III Agreed with first quotation but added understanding that goals are influenced by social and cultural conditioning
(3)	Agreed with second quotation	Position IV Goals are influenced by social and cultural conditioning; will not accept any goal a person wants
(1)	Definition needs to go beyond "connections" to action	Position V Strongly disagreed with first quotation; all therapy is political

from the definition given in the first quotation, and disagreed with the mandating aspects of the second one. With regard to the first quotation, one responded:

I would say that that's a pretty good definition of feminist therapy. I think the key issue in terms of feminism is . . . equality and that naturally implies an equal opportunity

to make choices and an opportunity to move in whatever direction is congruent with [me], feels good for me and not necessarily [responding out of] those values or those opportunities or those goals that somebody [else] says are all right for me because I'm in therapy or [believing] that I can only develop this kind of potential because that's [what's] appropriate. (Sue)

After reading the first quotation, one therapist said that there was little difference in her mind between being a feminist and being a humanist (Peg). This group of feminist therapists felt that the second quotation implied certain absolutes of behavior by stating, "feminist therapy must include" While they generally agreed that it could be important for connections to be made between the personal and political realms and said that they often did so, they do not feel that they always "must" do so. Several therapists said they felt that when she was ready, a woman would make connections herself and therefore didn't feel that making the connections for her was necessarily appropriate or very useful.

In the process of talking about a woman's life experiences, . . . that comes up very frequently. But I don't think I as a feminist therapist need to "bang" that out. I think that maybe I need to ask the kinds of questions that enable that woman to say, "Yeah, that's what happened," and if she doesn't say, "Yeah, that's what happened," then she's not ready to see that [yet]. (Sue)

Some questioned the assumptions of the second quotation. One said that she wasn't sure that the statement that women were socially reinforced for powerlessness was always true, giving as examples women who had had social reinforcement for being powerless and did not end up feeling powerless at all. Several also felt that this definition excluded men, who are also scripted into sex roles and also need liberation.

Position II. Five feminist therapists qualified both quotations, the first for its lack of awareness of the role of the socio-cultural focus on women and, like the women in the previous group, the second quotation for its absolutism. They felt that the first quotation was a "starting point," but did not feel that it encompassed all of feminist therapy, omitting any awareness that the potentials and goals a person feels may well be what she has been taught to feel by socio-cultural conditioning. Women in particular, they believe, have been taught to see their potential as limited and to set only certain goals for themselves. They see being a feminist therapist as not merely accepting the goals presented by a client but helping a woman sort out the goals she has chosen, looking at the degree to which she has chosen them because of social conditioning, and then giving her permission to really choose for herself and do what she wants to do.

In these responses to the second quotation, these five feminist therapists said some things that were fairly similar to what those in the first position said. They objected to the idea that to do feminist therapy, they must make political connections, particularly if the client is not asking for that or if doing so would seem to run counter to the therapy process. "There are times when [doing] that fits and times when it doesn't" (Nancy). One woman said that she doesn't "do politicizing on the client's time." If the client wants that, she will. If the client denies that the culture has impacted on her as a woman, conditioned her as a woman, then she will also state that she sees such awareness as an important part of self-actualization but not demand that the client deal with it if she is not ready to do so. Two

women questioned whether it was true that women (or only women) really have a "socially reinforced sense of powerlessness."

Position III. The two therapists in Position III, like the women in Position II, saw the first quotation as omitting the sociological and cultural aspects of a woman's experiences, and therefore possibly accepting without question goals that may be very conditioned. However, they hesitated in a total agreement with the second quotation, redefining "political" to mean societal and cultural and perhaps not including in their definition ideas of power structures, institutionalized oppression, political gain, or economics.

Position IV. Three women disagreed with the first quotation and agreed with the second. They saw the first quotation as assuming that goals were chosen outside of any larger contexts. More strongly than most of the women at the positions above, they stated that there are goals they will not accept. For example, one therapist finds that clients who say they want to get along better with people often mean that they actually want to "find better ways of submerging their general anger so that they're more acceptable as they weave through the world." She also explained that sometimes, when women say they want to change their image of themselves, what they mean is "to weigh 110 pounds and be loved by all" (Ellen). Those client goals, they are saying, are never their goals as feminist therapists.

I will not help anyone fuck over another person. I will not help anyone let herself or himself be fucked over. . . . One example is a man I had in therapy. He was 50 years old and had a job that was making him miserable. Not only that, he had a drinking problem. I helped him stop drinking, helped him get it on with his wife. Their previously uptight non-communicative relationship took a turn toward being an open,

more fun relationship. . . . The next thing he wanted to work on was to adjust to his job. After a lot of probing it became clear that he would be adjusting to the most awful oppression, and I said I could not help him do that. I could help him change the situation. I could give him psychological support to get another job or organize in the situation to make the job more comfortable, but I wouldn't help him adjust to that job. I would never help women adjust to becoming better housewives or a better secretary. I might help a woman take power in a job such as a secretarial job so that she's not as oppressed, but I'll never help her become a slave. If that's what people's goals are, they'll have to see another shrink. But I'll probably get in as many licks as I can about how I think it would be bad for them to do it. (Teri)

These three women agreed fully with the second quotation, saying that making these connections (or making sure a client makes these connections) is an important part of their therapy.

I don't do a lot of lecturing to connect things but I would say certainly making connections. I would say that more often than not I go for the cultural scripting as opposed to the individual scripting. . . . If I see a woman responding to a situation that seems very universal or very generally much like a whole lot of other women, I'm likely to say, "You know, the problem you have is the problem a lot of women have." That has two functions. One is that it raises the awareness of female oppression. The other thing is that it makes a woman feel less isolated and less alone. In that sense I'm always making political connections. (Teri)

Position V. Finally, the woman in the fifth position disagreed with both quotes, going in her definition of feminist therapy beyond the radical end of the original continuum. She disagreed with the first quotation because it did not include any understanding of the political aspects of all therapy, the ways in which therapy is a means of social control and used to maintain an oppressive society. She disagreed with the second quotation because to her, feminist therapy is "more than 'making clear.' That's just insight." For her, feminist therapy is "cognition, it is feeling, and it is action together--some

kind of action and some kind of commitment to a revolutionary movement" (Marsha).

Men as Feminist Therapists

Feminist therapists were asked if they thought a man could be a feminist therapist. Responses clustered into six categories, ranging from an unqualified "yes" to an unqualified "no." The continuum in Figure IV shows the range of responses, with the number of women in each category listed below the line.

FIGURE IV
CONTINUUM OF RESPONSES TO QUESTION OF
MEN AS FEMINIST THERAPISTS

As the continuum illustrates, the greatest number of feminist therapists believed that some men could be feminist therapists, and the responses on the "yes" side of the continuum outweigh those on the "no" side (10 to 6).⁷ Discussion of responses at some positions on the continuum follow.

⁷It is interesting to compare this belief with the results from the sample frame development. In the process of developing the sample frame for this research, of the 273 names generated through the natural system as potential feminist therapists, only four male names were elicited, three in Seattle and one in Portland. Of those four, only the one in Portland said he considered himself a feminist therapist, leaving one male feminist therapist in the population and 103 women feminist therapists.

Yes, some. This was the most frequently given response, indicated by seven of the 19 feminist therapists interviewed. They felt that there were some few men who, if they had certain critical characteristics, could be feminist therapists. Critical characteristics listed included being sensitive to and concerned with feminist issues, having a feminist analysis of sex role oppression, being aware of the impacts of sex roles on his own growth, struggling with his own sexism, living a feminist consciousness in his life and in his therapy, and developing his nurturing and intuitive capacities. One therapist pointed out that possessing any of the qualities above did not necessarily make a man a feminist therapist, but that they were qualities necessary in order for a man to be a feminist therapist. These seven women seemed to feel that men had the potential to be feminist therapists, although they often had not developed that potential in actuality. Three therapists said that there were certain limitations for any man in being a feminist therapist.

I think men can do it . . . A man can't be a woman. A man can't know what a woman feels to the extent that a woman feels what she feels. . . . A man is more likely to have cultural conditioning as a man that is different than a woman's, so therefore may not have as much insight into that, but I think a man can have a consciousness of those things and try to work in accord with that consciousness and work in the same kinds of ways that a woman attempts to, in overcoming those things. (Joyce)

One said here that a good feminist therapist, no matter what her politics, "is going to be a lot better for most [women] than any male therapist, no matter how radical his politics and no matter how much he avows his feminist position" (Teri).

Ideally but not at this point in time. Two women felt that ideally, a man could be a feminist therapist, but given the situation at this point in the development of the society, he could not.

Not now. Though I know some men that consider themselves so enlightened, [who feel] that they're enough in touch with women's problems to deal with women. And I simply don't believe that. There's no way that a man can jump outside the culture. He was raised in it; he is sexist by definition. I don't think there is a man yet enlightened enough to step outside of that or on top of it no matter how important it is for him and how hard he tries. . . . There's so much mitigating against a man working with a woman. The whole thrust and the weight of the culture is behind his attitudes towards women, and it's exacerbated by his being in the position of a doctor and she in the position of a patient. So what happens is not only what happens between a man and a woman--it's doubled between a male therapist and a woman patient. So . . . I would say all women, at this time, if they want therapy, must go to women therapists. I really believe it.
(Leslie)

No, but he could help women in some areas. The feminist therapist in this position said that while she felt that any man labeling himself a feminist was an "unfair appropriation" that "set wrong" with her, she did feel that there were some areas, such as helping a woman get in touch with her own power if he had gone through that himself, in which a male therapist could be helpful to a woman. She went on to say that similarly, a woman therapist could not necessarily help another woman around feminist issues unless she had had "The Feminist Experience" (Pat).

No. Finally, three therapists responded to the question with unqualified "no's." One woman said she thought a man could perhaps be sympathetic, but that he could not be a feminist therapist. One therapist said that a man couldn't be a feminist therapist because he had inherently too much power with women. She feels that with a male therapist, there is so much culturally conditioned "seduction" going on between him and

the woman client that his words carry a dangerous amount of weight. She feels that with a woman therapist, the therapy "doesn't have the same stickiness, the glue, that happens between men and women and that I think even the best male therapists use, whether they know it or not" (Ellen). Lastly, one therapist said that a man could not be a feminist therapist because

. . . men are in some ways the people who are oppressing me. I mean, there are only two sexes in this world . . . It makes sense to me that if I am the oppressed, somebody else is doing the oppressing. . . . So they can't do [therapy with women].
(Marsha)

Definitions of Feminist Therapy

Definitions of feminist therapy were analyzed within a six-square grid and sorted as follows: 1) according to whether the definition (or component of a definition⁸) focused on human commonalities and human potentials, classified as egalitarian, or on women and/or the differences in people and perspectives brought about by or necessary due to sex roles and sexual oppression, classified as sexual differentiation; and 2) according to whether the definition (or component of a definition) dealt with client self-actualization (potentials, goals, personal power), changes in therapy process and/or in the role of the therapist, or social awareness and social action on the part of the therapist and/or as directly communicated to the client in an educative (consciousness-

⁸A number of definitions contained several components. In order to preserve the complexity of the response, definitions were separated into component units and each component was listed separately. Thus, it is possible for one respondent to have more than one response in a chapter, and/or responses scattered among several categories.

FIGURE V

DEFINITIONS OF FEMINIST THERAPY

	EGALITARIAN	SEXUAL DIFFERENTIATION
CLIENT SELF-ACTUALIZATION	<p>Helping people bring about their goals for themselves, as people</p> <p>Therapy that strives to bring both the feminine and masculine sides of a person out and actualize them</p> <p>A means of helping the person develop his or her own potentials and achieve goals chosen by him or her</p> <p>Seeing your clients as actually able to achieve their potential and their goals, whatever they are</p> <p>Any therapy that really respects the integrity of the client</p>	<p>Helping women break free of self-imposed oppression</p> <p>One of the processes of helping a woman incorporate any and all human potentialities</p> <p>Anything that helps a woman feel good about herself, be in touch with the power she has</p> <p>A belief in the dignity and worth and value of an individual woman</p> <p>Helping women in particular get in touch with their personal power</p> <p>Helping women to delight in their own physical being</p> <p>Without imposing my value system, helping women become aware of themselves, their power as women, their options and potentials</p> <p>A way of dealing with a woman that frees her to identify her own potentials and interests and make free conscious choices</p>
CHANGES IN THERAPY PROCESSES OR ROLES	<p>Seeing your clients as more equal to you in the therapy situation</p>	<p>Anything (meaning more than therapy in the traditional sense) that helps a woman feel good about herself, be in touch with the power she has. I don't want it to happen in this room; I want it to happen out there</p> <p>Doing therapy is a way that expresses my feminism</p> <p>Therapy done by a feminist</p>
SOCIAL AWARENESS AND SOCIAL ACTION	<p>An educational process to teach people new perspectives on the world</p> <p>Recognizing the role of the external world in a person's developing his or her own potentials and choosing and achieving his or her own goals</p> <p>Sharing steps in a grievance procedure, when appropriate</p>	<p>Seeing all issues through a feminist perspective</p> <p>Getting the message of how women have been put down to as many women as possible</p> <p>A revolutionary tool to get women angry and get them into fighting</p> <p>Helping women break free of externally imposed oppression</p> <p>Enlightening women to the possibility of struggling together to fight oppression--the idea that we are not helpless and that we can have power and control over our lives</p> <p>Seeing women's problems not individually but as reactions to a sexist oppressive society; seeing women's problems in a social context</p> <p>Therapy that recognizes women's place in our current society and what that means to individual women in therapy</p> <p>A recognition of the kinds of socialization and conditioning that may create some particular and special problems for women relative to appropriate roles, interest, behaviors</p> <p>Helping women see how they have internalized some of the debilitating concepts of a patriarchal society by helping them become aware, integrating their understanding, and determining what kind of action to take and how to take it</p> <p>An insistence that women aren't dependent on men but are dependent on each other</p> <p>Doing therapy in ways that are compatible with a consciousness of sexual roles and sexual conditioning and a position in favor of liberation from such roles</p>

raising) process. Figure V shows the definitions of feminist therapy given by feminist therapists sorted according to this system.

In this case, only three women listed definition components twice in the same category and therefore, for purposes of comparison, the absolute number of definitions (or definition components) will be utilized. Most frequently listed were definitions incorporating sexually differentiated social awareness and social action, followed by sexually differentiated client self-actualization. The other four categories were listed less frequently, and with fairly equal frequency, as Table XII indicates. Definitions incorporating social awareness and

TABLE XII
CATEGORIES OF DEFINITIONS OF FEMINIST THERAPY

Category	Total number of Definitions in Category
Sexually differentiated social awareness and social action	11
Sexually differentiated self-actualization	7
Egalitarian self-actualization	4
Egalitarian social awareness and social action	3
Sexually differentiated changes in therapy processes and/or changes in therapy relationship	3
Egalitarian changes in therapy processes and/or changes in therapy relationship	2

social action are listed most frequently (14 times), followed fairly closely by definitions incorporating client self-actualization (11) and much less frequently by definitions incorporating changes in the therapy process and/or role of the therapist. This would seem to indicate that

feminist therapists see feminist therapy as concerned with client self-actualization and consciousness-raising rather than changes in the therapy itself. Definitions based on sexual differentiations greatly outnumber egalitarian definitions (21 to nine), indicating a clear focus in these definitions of feminist therapy on the particular role of women, the results of sex roles and sexual oppression, and the perspectives designed to incorporate that.

As in the definitions of feminism, most definitions were terse and included in Figure V in full. Two therapists specifically differentiated between feminist therapy (or, for one, feminism as therapy) and therapy done by a feminist, saying they did the latter and were aware other feminist therapists did the former, wondering if what they did would really be considered feminist therapy in the strict sense.

IV. HOW DOES FEMINIST THERAPY PERCEIVE AND INCORPORATE THERAPEUTIC ISSUES?

During the interview, feminist therapists were asked in a number of questions how they perceived and/or incorporated therapeutic issues--in particular values and directiveness, structural issues, diagnosis, working with lesbian clients, power issues, self-disclosure and answering client questions, therapy as political or apolitical, and the possibility of losing potency by incorporating feminism. Their responses compose the first seven subsections of this section. In addition, two more general questions in the interview asked feminist therapists to list any issues or struggles for them currently in combining their feminism

and their therapy and to give an example of a time when it has been hard for them to incorporate their feminism into their therapy. In response to the question about current issues (and at other points in the interview when something was specifically mentioned as an issue or a current struggle), 34 issues were raised (some several times), of which 20 had to do with the therapeutic issues (most frequently with self-disclosure [5] and with values and directiveness [6]), and five with relationships with other professionals. The former are included in the discussion of each issue as it is presented, and the latter are discussed as Other Therapeutic Issues. When giving an example of a time when incorporating feminism into therapy was hard, eight (of 16) feminist therapists discussed their difficulty in working with women involved in a "traditional relationship" who weren't interested in or were threatened by feminism, and five of those 16 feminist therapists discussed their difficulty in working with women who found in their feminism or lesbianism reasons to be critical of or remove themselves from the therapy process. The first of these responses is included in the discussion of values and directiveness, and the second in the discussion of working with lesbian clients. At various points in the interview, feminist therapists spontaneously voiced their opinions about different theoretical orientations. Those comments are also included as Other Therapeutic Issues.

If it is possible to make the distinction, this section deals with issues that arise (or could arise) for a feminist therapist (or between feminist therapists) as a therapist trying to incorporate feminism into therapy and in the next section with issues that arise

(or could arise) for a feminist therapist (or between feminist therapists) trying to incorporate therapy into feminism.

Values and Directiveness

Since the issue of values was discussed in the literature, the following probe was utilized to provide information about what feminist therapists believe and do with their values (particularly feminist values):

Some therapists have told me that although their values are feminist, they don't feel they have a "right" to bring those values into therapy and attempt therefore to be as value-free as they can. Others feel it is important to be "up-front" with their values. Where are you at with this?

In addition to the replies to this particular probe, the whole area of values (their role in feminist therapy, questions of directiveness) was repeatedly mentioned in responses to other questions. The narrower issue raised by the probe, although not asked directly, was whether feminist therapists believe therapy can--and should be--value-free. In their responses to the question, nine feminist therapists said in answering that therapy could not be value-free. In response to the larger issues of therapeutic directiveness versus client self-determination around feminist values, six feminist therapists saw their values coming through indirectly, two felt their value of client self-determination mitigated the need to state other values, eight were "up-front" but attempted not to be directive, and three were clearly directive.

Therapy as Value-Laden. Although the question of whether they thought value-free therapy was possible was not asked directly, nine feminist therapists began their answers to this probe by asserting

that they believed all therapists have values and that it was impossible to be value-free.

I think it's impossible to be value-free. It's like leaving yourself out the back door. You can't do it. Unless you are completely analytic, . . . and I don't see how a feminist could also be analytic at the same time--they're just mutually excluding in so many ways.
(Betsy)

They believe that whether a therapist overtly states her biases or attempts to hide them, they nonetheless will come through in one way or another. "With the best of intentions and the best of theories, if somebody has . . . bias, on an unconscious level, it gets communicated" (Beth).

In response to the question about whether they thought they had a right "to be up-front" about their values or should remain value-free, three positions with regard to values and directiveness emerged, as listed below, with the numbers following indicating how many of the 19 feminist therapists interviewed were in each category.

Position 1: My values do come through indirectly in the questions I ask but I have no right to impose them on clients 6

or I am very "up-front" about my strong value of client self-determination and it mitigates my need to state any other values I may have unless I am asked 2

Position 2: It is important to me to be "up-front" with my values but I don't want to push someone who is not in my "space" or not ready to hear me 8

Position 3: I have values I want to put out to my clients 3

The following discussion will elaborate on each position.

Position 1. Six feminist therapists said that while they believe their values did come through in the ways they asked questions and led

the therapy, they did not feel that they had any right to impose their values on their clients. In contrast with those in the other two positions, they seemed to indicate that the evidence of their values in their therapy was more inevitable than intentional and in their responses focused on the dangers of value imposition. As one said, "I don't think you have a right to impose [your values] on somebody else but it seems almost impossible to me not to have your own values come through." This therapist gave as an example a client she was seeing whose 14-year-old daughter got pregnant. This woman had decided to cut herself off from all her friends because she was ashamed to mention this and afraid to see them and not mention it. Through the process of helping this client "decontaminate her adult" around her values (coupled with the very fact that the therapist identified those ideas as contaminations), this client knew that the therapist thought that what had happened was not a terrible thing and that it would be not just all right but helpful for her to talk about this with her friends (Peg). Similarly, one therapist explained:

Mostly I think [my values are expressed] by the way I set up the exercise. The things that are picked out to dialogue with are in essence saying, "These are things that can be looked at." By even saying that, I'm saying that this doesn't worry me or shock me--my belief is that these are all parts of my womanness or your womanness. (Cheryl)

Another feminist therapist said that she was aware that more often than she would wish to, she negatively reinforces traditional roles rather than allowing people freedom to have those roles.

To a much greater degree than the feminist therapists in the other positions, those therapists holding Position 1 stress women coming to awareness when they are ready to do so and their desire as therapists

not to impinge on that process by more overt value statements which may convey to the client any sense that this is what she "should" do or believe. They don't feel as therapists that they have a "right" to "lay their trip on somebody" (Ann). Instead, they see their role as at times being a catalyst for awareness but often find that women choose not to explore these issues further. "People who come [to see me] who are not feminist can leave without having one bit of change in that area" (Ellen). In accepting this, they are the least directive of the three groups. "I'm not pushy about the feminism . . . I'm not out there waving the flag" (Peg).

I see my own feelings and my own biases strike a chord a lot when I'm working with women, to the point where I almost have to temper myself, because there's a point where my own biases cannot take over therapeutic designs. I have to be careful sometimes to just not say, "You have a right to do that!" and [instead work to] help the person see that in themselves.
(Ann)

I don't think I as a feminist therapist need to bang [that feminist consciousness] out. I think that maybe I need to ask the kinds of questions that enable that woman to say, "yeah, that's what happened." And if she doesn't say, "Yeah, that's what happened," then she's not ready to see that. (Sue)

With regard to goals and directiveness, several stress the client's right to accept traditional roles "if that's what they want and that's what they enjoy" (Sally), and to "say no" to any of the values the therapist may be presenting. Only one of the therapists holding Position 1 gave any examples of being overtly directive, and this was in an instance in which the therapist became very frightened by the client's behavior and therefore insisted that a woman contact Alcoholics Anonymous.

Two therapists, included as a variant of Position 1, indicated that because their foremost value is client self-determination or

freedom of choice, they find themselves being overt about that and finding that value overriding any other values they may have.

The value that I always try to go with . . . is [a concern with] what's important for that other person to do for themselves and to totally support that. I can't say [I'm] value-free 'cause that's another illusion. I think that [this belief in the importance of] a woman going whatever route she really is needing to go is a possible value that I really do have . . . I try to be very aware of when a personal value of mine is getting in the way [of that]. . . . [Above all] I assert the value of freedom of choice. (Nancy)

These two therapists said that they thought they differed in their responses to this question from other feminist therapists. One wondered whether she was even a feminist therapist, feeling that most feminist therapists would not support a woman choosing not to be a feminist, whereas she would.

One thing I wonder is whether a feminist therapist would support a woman's desire not to be a feminist. For me, I think it's important that I not decide that other women have to be like me. [I think that] it's really unethical for a therapist . . . to have a creed, whether that be getting people back into the church somehow or [believing that] the only way that people can really be OK is in a heterosexual marriage. (Pat)

The second therapist described herself as "going easier" on the presentation of cultural influences on a woman's experience than other feminist therapists she knows because she feels it is most important for a therapist to help people come to their own conclusions. However, she also described her work with pre- and occasionally orgasmic women as an example of an exception to her focus on a less directive, less didactic therapeutic role. When she does these groups, she is intentionally different from the non-directive humanistic way she is in her individual therapy. Here she is clearly the leader, working for pragmatic changes in sexual and assertive behavior.

Position 2. The largest group of feminist therapists interviewed (eight of 19) held to the second position, that it was important to be "up-front" with values and yet not to push someone who was in a different place than they were, perhaps not ready to hear what they had to say. They seem to differ from those holding the third viewpoint in that they are "up-front" with their values less because they believe those values are always right for their clients but more because they value being "up-front" itself, particularly because it weakens the power the therapist has whose values are hidden or who denies she has any values. (Under Other Therapeutic Issues, this is discussed in relation to Freudianism.)

It's part of being clear with people and not laying a trip on them and respecting them in the sense of giving them the information to make their own choices and make their own decisions and for us to have an explicit equal kind of agreement rather than my manipulating them . . . in the context of traditional psychiatry. (Joyce)

Unlike those in Position 1, several stress here the importance of separating out and clearly labeling value statements for what they are.

As far as I am concerned, that idea about valueless therapy . . . is empty, because good therapists have values. I think to set a rule for yourself that you will not share those human values . . . does your clients a disservice. [I believe you should] separate your values and say to a client, "Those are my values. That's how I believe. I want you to know where I'm coming from so you won't think I'm trying to make you into something different--but I believe this to be good." That's respectful of other people. Otherwise those hidden values are back there working all the time anyhow, and the client thinks, "There's something going on back there. Why can't they tell me what it is." (Alice)

They are saying that those value statements which the therapist clearly labels as her own views are in turn values which the client can knowingly accept or reject, can allow herself to be influenced by or refuse to be

influenced by. Values which are denied or hidden are still influencing the client, but it is without the client's knowledge or consent. One therapist explained that she is working toward being clearer with her clients when she sees a conflict between her "bias towards freedom from sexual roles or roles of all sorts" and her client's position.

Sometimes I state that I have a bias in a certain direction that's different from theirs and then we need to make an agreement to agree to disagree or let me influence them or raise their consciousness or not. . . . I'm evolving towards being clearer [about that], and more open and explicit about agreements with people rather than assuming we have an agreement, [rather than] my working in my direction and they're working in theirs and not really being very explicit about checking those things out.

I more frequently state what my biases are rather than show them by the things that I comment on over time. I more explicitly state them when I become aware that they're very essential to the subject or the issues we're dealing with or the problems that the person has. [For example,] someone's talking about their relationship with their husband, and they're having some conflict about their roles. Then I feel it becomes necessary for me to say something about what my biases are in terms of gaining freedom from such roles. Sometimes there's a conflict with the person and then we have to figure out a way to work that out.

(Joyce)

More than those feminist therapists with the third viewpoint, these women are concerned with the impacts of their values on their clients and with tempering their potential directiveness.

Some therapists in this group indicated that the degree to which they overtly state their values depends on the degree to which a woman has enough of a feminist or radical consciousness of her own. These clients aren't expecting a therapist to assume a traditional role, but approach the relationship as one of equality and mutual respect and want certain kinds of teaching and consciousness raising from the therapist. Other clients, however, while recognizing the roles they are playing, are afraid to upset the balances in their families or find feminism

threatening. "Bopping [them] too hard with the idea of some of the cultural implications of some of [their] statements" (Leslie) or demanding they make certain changes may mean they will never return. One therapist talked about ways she has devised to deal with this that are non-threatening.

Usually the way I go about it is talking about women in terms of their power, what they've done with their power or haven't done with their power. If a woman comes in and says, "My role is to be there for my man, to be available, to . . . put myself second," I will talk about that in reference to the effect [on her] of doing that. I'll do a lot of stuff with her about her body. [I'll have her] make herself in a waiting place, and [help her see] what that does to her body, get her in touch with how she holds, how she tenses, how she denies and how she tucks feelings away . . . I just get her to pay attention to what it's doing to her, and then say, "Now you have a choice. You have a choice of whether or not you want to learn how to use your power in a more assertive way so that you're not cutting into yourself. If that's too threatening to your relationship, I want you to know what you're doing and that you're choosing not to do anything about this." It's her choice. I'm not into trying to push her to change her lifestyle if she doesn't want to, but I'm going to let her know how I see what's happening. (Carol)

One therapist in this group said she sees many clients for whom sheer physical survival, not feminism, is the concern. She feels that bringing up feminist issues to them is an inappropriate intrusion into their often fragile lifespace. Generally the degree to which these therapists are directive or highly overt with their values at any point in therapy depends on their assessment of the client and the therapeutic relationship.

[Before I state my values directly,] I need to have a relationship with somebody and I need to have some sense that they're not just going to react defensively and run away if I question [something]. I will not accept something that I disagree with, but I might not respond. When I confront somebody depends on when I feel like it's going to be productive. [An example is] a patient [I have] whose stated goal was to find a husband. . . . I know [at some point] I started to ask her [questions]. I think the initial question I asked her was how she felt about the fact that I wasn't married. At first her response was, "Well, you're divorced, so it's different. You used to be married."

That proves that you're OK." . . . Some of the other questions were, "Would you want a marriage like your parents' marriage? Is that your goal?" . . . Recently, we've gotten a lot into what she might want to do for herself professionally. . . . [And] she's real clear at this point that I do not see marriage as the live-happily-ever-after kind of thing. (Beth)

Therapists holding Position 2 seem to differentiate between stating their values, which they do clearly and purposively, and attempting to use those value statements, designed to reduce the power differential and promote a "straight" relationship, to explicitly influence or direct clients towards their values.

I tell people where I am. But [I tell them] where I am not [to say] that they should have to change, but that they should know what they're dealing with, . . . my position. I don't have a "should" that you should be more alive. If you want to be dead, if you want to be crazy, and if you want to be living the way you're living, that's your choice. But I want you to know what you're doing. (Carol)

While one therapist does not attempt to influence people explicitly, she does attempt to be very explicit about when she is being directive in therapy. When she feels that what would be most effective at a certain point in the therapy is a certain technique, she tries to explain to her clients what it is and why she is suggesting it, to acknowledge her directiveness and negotiate with them how to proceed.

What I try to do . . . is just explain to them what I'm seeing and at the same time I'm doing that try to give them every opportunity to agree or disagree or say what they want. [For example,] I could say, "We've gotten to the point of using this technique. This is my idea of something we can work with. Are you in agreement with using that?" If they say yes then I try to explain, "Well, I think that putting your mother over in this other chair and having this conversation with her is a way that will do this. I know that . . . I'm choosing to be directive when I do this and these are some of the things that might come out of it. Do you want to try it?" If they say no, then we don't do it. I'm naturally hesitant (not from my political consciousness but just from my own hesitancy) to push anything on anybody. I give people lots of permission to say no, even more than I should, than would be effective. (Joyce)

One therapist who always initially identifies herself as a feminist because of the opportunity doing so provides for value-sharing and value-openness explained that if a client is totally denying the socio-cultural implications impinging on her, then this therapist will state that a value of hers is that women-need to look at those things in order to be fully self-actualized.

What I would do is say, "I believe this. I think it's important. When it becomes important for you, or when you have some time and space in your life, I think it might be a useful thing for you to explore. . . ." But I don't do politicizing on the client's time, so to speak, unless that's what she wants. (Alice)

Similarly, one therapist in this group said that, although she generally doesn't believe in telling people what to do or feel she has "a right to push someone who's not in my space toward feminist thinking" and may talk about her thoughts and feelings but tries not to get emotionally involved in what a client does, there are times when she finds herself feeling very strongly about a feminist issue. In this case, she will label what she says as her value, her position. An example was a client whose housemate (male) told her that she would have to end her individual therapy before he would consider beginning the co-therapy she wanted, and then it would be with his (male) psychiatrist.

I came down really heavily--would she essentially abandon someone she had no complaints about in order to pacify him . . . That's one of the few times that I can remember taking a feminist issue and bouncing up and down on it. [I said to her,] "I'm taking full responsibility [for what I'm saying]. I'm coming off the walls, I'm so furious. How come you're not angry?" . . . But that was [clearly] my value. (Betsy)

One therapist in this group said she does inform her clients of certain rallies and marches she feels are politically important; another refers women to books and consciousness raising groups. However, while

stating their values, their emphasis and their focus again remains on client self-determination above therapeutic directiveness.

With regard to congruence between the values and their client's goals, one therapist said that while there are certain goals she will not believe, she would probably not be as directive as to state that initially but would question the goal, attempting to "be straight but also not put her down."

If somebody made a goal that was, "I want to live a nice middle class married life and be subservient to my husband," I wouldn't believe [that]. I can't believe that if a person started feeling her sense of power and her sense of strength, started feeling good about herself, that she would ultimately choose . . . something that oppresses her so much. In other words, if they're choosing it, they're choosing it out of not seeing another side. . . . But I don't know if I'd just say, "I don't accept that." . . . I'd find out more about it. I wouldn't put her down. A person who would say that probably feels bad enough about themselves as it is. I would talk about it. I'd say, "What makes you want that goal? How do you feel when you're in that position?" I'd ask them some questions about it, and would ultimately state that that wouldn't be a goal that I would want her to choose.

(Karen)

Another may take a stronger position, depending on the degree of incongruity between her values and her client's goals. If a client's goal differed radically from her values and belief system (for example, a woman wanting breast implants to be popular with men), then she would have to say, "Look, I cannot help you with those goals. They differ so radically from my values and my belief system that there is no way I could work with you on that" (Alice).

Position 3. Those three women in the third grouping felt that presenting their values was a critical aspect of their therapy. Many of those values had to do with feminism, and in those instances, presenting their values was a critical aspect of their feminist therapy.

I don't see how you can be a feminist and not assert your feminism to people you're in relationships with, or work with, or work for. One of the reasons I'm a feminist is because I think it's good for people to be feminists. It's better for people to take an advocacy for women's liberation than not to do it.

(Teri)

For example, one of these women at some point in therapy states her belief in the importance of women making the decision to change oppressive aspects of their lives and ultimately become feminists, saying, "I would like everyone to be a very strong feminist."

A lot of people (and especially women) come to therapy in general wanting permission to be miserable but lifted somehow. You know, [saying,] "You do it for me. I'm never going to make any changes in my life. I'm going to remain married and waxing floors and not having a life of my own, but I want to feel better." I immediately break that myth, and I say, "That's not possible. I can't deliver." I'm very honest about where I am . . . with people.

(Marsha)

Other values may have to do with anti-capitalism or existentialism, but in any case they believe strongly in clearly stating to their clients their beliefs and value systems because they do want their clients to adopt them, because they think it would be better for them to adopt them.

These women holding Position 3 seem to be the most willing to be directive with their clients. One describes herself as "very directive," and explained her rationale:

A great portion of people's psychiatric difficulties are based on sex-role oppression, meaning the way they were trained to fit into some preconceived ideas about what men and women are supposed to be . . . as well as other forms of oppression in the society. Then it falls on me to illuminate when I see it emerge the areas in which I feel my individual clients are affected in that way.

(Teri)

With a Native American gay woman who felt "like a very 'not OK' person," this therapist began in the first session to present her understanding

of how cultural and sex-role oppression led to their woman's unhappiness and to counter the cultural messages with the positiveness in her own ideas and values.

The first thing I said to her was, "Your unhappiness has to do with the fact that [you are] a woman, and a gay woman, and a Native American woman." [I said] that I thought it was important for her to find out what was good about all those things . . . So that's what she started to work on. I was very directive in that sense. The message I gave her was, "Who you are is fine." And, "Be who you are." (Teri)

When another of her clients wanted to use therapy to adjust to an oppressive job, she explained that she would support him in getting another job or in organizing in that situation; but she wouldn't help him adjust to an oppressive situation. One of the other therapists in Position 1 said that if a woman told her she was married, had a good relationship with her husband and two kids and didn't understand why she was depressed, she would immediately begin questioning those statements, at least to herself and over time begin giving her client permission to question them as well. This therapist stressed that with clients such as this one who are beginning therapy and have no feminist consciousness, she is much less directive. As they get permission to question and to make connections, she states her values more clearly and more strongly (Marsha).

Difficulties with Women in Traditional Relationships. In giving an example of a situation when it was difficult for them to combine feminism and therapy, eight (of 17--none of whom, interestingly, in Position 3) spoke of wondering what to do with those clients whose biases or whose oppression are apparent to them as therapists, when in the first instance the clients are not wanting to change those biases

and in the latter, the therapist fears promoting awareness of oppression runs the risk of radically changing a person's life. As one therapist wondered, "What do you do if people are going along in ways you don't accept?" (Ellen). The issue for them was to what degree they felt comfortable "pushing" their feminist consciousness.

I struggle with . . . wanting to educate people more than I do because that runs into conflict with both my belief and the expectations of the setting . . . that I not push my thing onto people that I'm working with, that I respect what they want and where they are--and I'm wanting to influence them more . . . There's a conflict there [for me]. (Joyce)

In all cases, the example they gave had to do with a woman who, in one way or another, chose her relationship with a man over what the therapist saw as the client's own needs for personal growth.

One example given involved a group of women who had been in a no-charge therapy group during the day. When the group was changed to an evening time and a fee was asked, many of the women were afraid to express to their husbands their desire for therapy and to ask assertively for the money and the evening away from home. In addition, these women had begun to see that they could "start waves" in their marriages if they remained in therapy, continued to realize the degree to which their needs were not being met and to make the kinds of changes they had been making to meet those needs. At this point, many chose not to continue (Sally). As one woman said to another therapist, "If I keep seeing you, I'll have to leave my husband, and I can't do that" (Karen). Another woman gave an example of a couple she was seeing for sex therapy. They were in their mid-fifties, and highly religious. She described their relationship as very stereotypic, with the woman taking a second-place position in the marriage, martyring herself and remaining

firmly in the role of mother to her husband and children. This woman was not ready or wanting to recognize what the therapist saw as her oppression in the marriage and as a woman, and the therapist felt it would be unethical for her to push this woman towards feminism even though she would have liked her to have those awarenesses. She felt that if the woman were to become aware it would probably destroy the relationship and she wasn't willing or wanting to accept responsibility for that (Betsy).

Some women come into therapy clearly opposed to feminism and "women's liberation," and the therapist knows her values are very different from theirs. Often stating her values and her awareness of how they differ from those of her clients has raised consciousness and avoided game-playing between them; but one therapist gave an example of a situation where this had not worked. When the client "came in saying she believed in God and husband and her role in obeying and living for and living out the values of her chosen man," the therapist tried clearly stating how her values were different from her client's but that she would try not to influence the client beyond her wishes. The therapist's perception is that the client was influenced by her nonetheless, "and then resented me for influencing her because it precipitated some intense conflicts she wasn't able to handle" (Joyce). Two therapists reported feeling very impatient with women in destructive relationships with men. One explained that when she sees verbal or physical destruction of a woman by her husband and yet the woman still wants to stay in the marriage, she finds it hard to moderate her own desire to tell the woman she should get out. She is aware of not

understanding "the glue of marriage" and questioning whether marriage is even desirable for people.

I think maybe my feminism, my personal sense of things, does get in the way of my therapy. It's real hard for me to support a woman who wants a marriage that doesn't make any sense in my terms.
(Ellen)

When that happens, she refers the client elsewhere.

One of these therapists also said that she is struggling currently to integrate her socialism as well as her feminism into her therapy. She gave an example of a dilemma she faced when a client who had been working in therapy on speaking her mind and disagreeing with people joined a food cooperative and objected to distributing the group's fliers which said, "Down with Capitalism." As a socialist, this therapist felt in a bind.

I felt like as a socialist, I didn't want to just let that go. I wanted to talk about where I'm at. Yet in the work I'm doing with her, for herself, it's important for her to disagree. I felt like in her own therapy, she should disagree, and for me to try to brainwash her to what I think in some ways might run against her own therapy.
(Karen)

Structure

Feminist therapists were next asked whether they had made changes in the structural aspects of their therapy that had to do with their feminism. Particular aspects probed for were ways of handling fees, structure of the first session, attitude toward clients shopping for a therapist, and contracts around goals and duration of therapy. This was an area where in retrospect probing to determine if changes had to do with feminism or with something else was particularly crucial, and was at times bypassed. Therefore, the analysis of responses to this question is more descriptive of what feminist therapists actually do

around structural issues than why they do it. Most negotiate fees and some encourage client "shopping" for a therapist and identify themselves during the first contact. In general, however, it seems that they do not see changes in the structural aspects of therapy as an important part of feminist therapy.

Fees. Of those women who handled fees and indicated how they did so, all spoke of incorporating some form of fee negotiation or exchange of labor except one woman who does her therapy as a "natural helper" and doesn't charge at all. They speak of not wanting to charge anyone any more than she can pay, and yet of their own need to establish some minimum fee. Some are fairly structured in how they scale their fees; others seem to let the client determine her own fee. One therapist makes it a practice to see one or two women in crisis situations for free or an exchange of labor. Several women indicated that this commitment to negotiate or income-adjust fees has more to do with their politics than with their feminism.

I don't know if it's feminist, [but] I have a political commitment to having a very large sliding scale, anywhere from \$10 to \$35. But that's not something I do just for women--[the fee] always depends on people's income. I saw one patient who was referred by the Women's Center and she got very very angry with me for charging her \$30 . . . She felt that as a woman, I should understand where women are coming from. I felt absolutely no sympathy for that at all. I felt that she had money and I didn't see why I should charge her a very low fee, just because she was female. (Beth)

One therapist's feminist reasons for negotiating fees are connected with her anti-psychiatric and anti-capitalistic orientations.

For sure, women have been less able to afford paying psychiatrist's fees than men. One of the things women need to become separated from their dependency on men is some economic power, and if I can give them support from a feminist position it would be a terrible contradiction to keep that

support away from them because they can't afford to pay me.
 . . . It's a combination of the anti-capitalism and therefore
 the anti-traditional-psychiatry bias, as well as a pro-feminist
 bias. (Teri)

Seven women talked about the issues involved in fees for them. Three reported that because of their socialism they don't believe that anyone should be charged for therapy and yet their agency demands they charge or they need to do so in order to survive. On the other hand, one therapist feels that "you have to put your money where your mouth is" and has found that "people who don't put in something also don't invest their energy" (Cheryl). Another reports that she used to feel that women therapists should work with their sisters for free or for very low fees because women clients so often have less money. Other women therapists in her group insisted that women ought to take therapy as seriously as men do and pay for it in the same way that men do. At the same time, the group grappled with how to charge women receiving alimony without maintaining their dependency on their ex-husbands. Over time, she has come to feel that "working for free is really counting yourself as less valuable" and so doesn't do that anymore, although she does negotiate fees (Betsy). One therapist was concerned that fees might be reinforcing in her clients the very powerlessness that she's trying through therapy to get them to overcome. "That's called insanity. I don't want to create an insane system when I do psychotherapy" (Marsha). Finally, one woman said that she is undecided about whether she should negotiate fees because on the one hand "people play such games around money" and yet she believes that for women who really need and want help and don't have the money to pay, holding to a rigid fee would be unfair (Peg).

First Session. Interviewees were asked if they did anything the first time they saw someone that they felt was feminist, probing at times for whether or not they made it a point to introduce themselves, explaining their values and biases, the way they did therapy, or their expectations of a client. Generally, things these feminist therapists may do during the first session is find out what has brought the client in and about past experiences in therapy, establish a contract for the length and perhaps goals of the therapy, specify their expectations of the client, describe or demonstrate the kind of therapy they do, and provide an opportunity for the client to ask any questions of them she may have. Different therapists, of course, do some of these and not others. Asking a woman for a "herstory" of her experiences in therapy has a feminist rationale for one therapist because she is particularly interested in knowing if her clients have had any negative experiences (including sexual) with other therapists, especially males, as well as finding out the client's expectations for therapy (Holly). Three begin to establish goal-oriented contracts at this time as well, but this seems to have more to do with their training than with their feminism.

Only three feminist therapists make it a point to say during the first contact that they are feminists and that that's important to them. As one woman explained when answering what she did with her feminism in therapy, identifying herself immediately as a feminist means that her clients often then ask what she means by that, and the actual process of defining her value system is an important part of her feminist therapy (Alice). One therapist explained her goals for the first session as incorporating this introduction of herself, her expectations, and

her method of doing therapy.

When I first meet someone, I try to say something about who I am, what I believe or expect. I say to them that I'm interested in whatever they can tell me about what they want or expect. I'm interested in answering whatever questions they have or telling them something of my philosophy to whatever extent they want that. [I tell them] that I expect to explain what I'm doing, expect not to be laying something on them that they don't want. I go over those kinds of things pretty carefully I try to communicate in the beginning that I'm going to respect their choices and their decisions, in whatever area.

(Joyce)

Four feminist therapists said that they don't announce themselves immediately as feminists. Sometimes this is because they work in an agency setting in which they feel it is not relevant, because people who come to them already know they are feminists, or because it's not how they primarily define themselves.

Shopping. Six women indicated that they encourage their clients to "shop around" for a therapist or that they at least encourage them to ask any questions they may need or want to know about the therapist or the therapy process. One therapist who supports clients in shopping around for a therapist doesn't charge for the first session, which she describes as much more like a mutual interview than her regular therapy. They explain that they believe in client shopping even though it is sometimes difficult or threatening to them. For one therapist, accepting this idea has come out of her realization that she isn't going to be the "right" therapist for all people, and she encourages prospective clients to trust their own feelings in choosing a therapist.

I used to think I should really be appropriate for anybody. Now I'm at the point where I don't need any reasons why that isn't so, but I just am willing to go along with the feeling that the two people have about whether they're comfortable with each other or not. As much as I can try to let somebody get a feeling of me the first time, I really encourage them to rely

on their own feelings about that. [If] somebody who's shopping around . . . is supported [to do that], . . . to go on their own hunches, . . . that is a very important thing that happens [out of the shopping], . . . something that women have not been encouraged to do. That's a feminist element to the shopping around that is different than the approach of traditional therapy.

(Nancy)

Giving people who ask her questions about how her groups operate "strokes for being inquisitive" is something another therapist does to support shopping. If people seem to need more encouragement, she explains to them:

"I think it's fine that you ask these questions. There are a lot of bad shrinks around here and it's good that you're asking me. I'm glad to answer any questions you have, and I think probably the best way to find out how I work is to come to a group and see what it feels like."

(Teri)

Encouraging shopping has to do with feminism for her because she sees it as a way for people, and particularly women who have been most oppressed by traditional psychiatry, to find therapists who will not oppress them. Finally, one therapist so strongly encourages client shopping because of the "horror stories" she's heard that if clients say they want to see her at the end of the first session without questioning her, she demands that they do so and trains them in how to do it.

[If] toward the end of the [first] session [clients] say, "Look, I want to see you in therapy," I stop them. I won't let them do that. I say, "What questions do you want to ask me. What do you want to know about me?" . . . I've gotten some heavy-duty questions. I also get women who say, "Nothing." And I won't let them get away with it. I make them hang in there. I say, "No. That's not good enough for me. You want to give me 20, 25, 30 dollars an hour and you don't have anything you want to know?! You're willing just to give that money away to somebody you don't know . . . anything [about] except that I'm a good listener and make a few pertinent observations."

For women who have decided not to come into therapy with me, . . . I give them instructions about interviewing the [next] therapist, and I tell them, "I want you to do it better with the next one than you did with me. You ask her some of these things. You find out. Some therapists will be willing to tell

you on the phone. Some won't. And take into consideration not all therapists operate alike. You could get a real good one who [for example] doesn't want to talk about sexual orientation. So you have to decide ahead of time how much that matters to you to know." . . . I say things that are geared to help them take what they want into consideration and assertively go after it. (Alice)

Diagnosis

Feminist therapists were asked, "How do you see diagnosis?" If they utilized any form of diagnosis, they were asked if they shared their diagnosis or not.⁹ Twelve of the 17 feminist therapists responding did not like diagnosis (or traditional labeling), but some found it helpful very occasionally or used another model (i.e., Transactional Analysis). Two thought it could be helpful, and three felt diagnosis was useless and/or irrelevant. Of the eight feminist therapists asked if they shared their diagnoses (from whatever theoretical orientation), four said that they did, explaining that it was a way of respecting the client, three that they did so carefully or partially, and one that she didn't share. The two feminist therapists with a positive attitude toward diagnosis felt that it was helpful in that it provided some sort of "handle" for them in working with a client that they would not otherwise have. "It gives you a little bit of a shorthand or a quicker way of knowing some of the things that might be true for them. You test it out somewhat, but it gives you a quicker

⁹However, the real objective of this question was to elicit indirectly attitudes toward differing therapeutic theoretical orientations. Although some feminist therapists discussed this issue at various points in the interview (see Other Therapeutic Issues), perhaps asking feminist therapists to compare their own and other theoretical orientations, particularly in relation to feminism, would have been more direct and relevant.

direction of where to go" (Nancy).

Twelve therapists were generally critical of diagnosis, at least in the traditional sense, calling it "jargony," "a bummer," "a 'should' in my life," but still utilized it in some way or some form. Seven described themselves as generally opposed to diagnosis and labeling but indicated very occasional instances in which they thought diagnosis could be useful to them, such as in consultations with a psychiatrist, in working with very severely disturbed people, or in making referrals for welfare. Three used a Transactional Analysis model of diagnosis instead. One therapist explained that while her basic position is against diagnosis, she worries at times that because she doesn't have formal diagnostic training, she may be missing some things. On the other hand, she wonders if those things others say they find by labeling she is already aware of, just by utilizing her intuition.

I also feel you can work from . . . intuition. This woman in my case study group said, "If I had been able to know she was a borderline, I would have been gentler with her." My thought is, "Well, perhaps I would have had the intuition to be gentler without knowing she was a borderline." Maybe I wouldn't have but it's a possibility. (Karen)

Three therapists took strong anti-diagnostic positions. One said that her diagnosis could only be based on her reality, on "one person's head and how they see the world. . . . But somebody else could see things completely differently" (Diane). One described diagnoses as "totally useless. They don't mean anything. They're lies" (Teri). A third said she saw diagnosis as "totally irrelevant . . . I think it's a bunch of crap, a waste of my time." She said, however, that when people come to her she does make an "intuitive evaluation" of "how

strong they are, how weak they are . . . , how together they are," at that point in time (Marsha).

Working with Lesbian and Radical Feminist Clients

Feminist therapists were asked either, "Can a woman (therapist) who's straight work with women (clients) who are gay?" or "Can you work with gay women if you're not gay?" This question was designed to elicit attitudes about feminist therapy with lesbian clients, in particular to determine if they saw a difference in sexual orientation between therapist and client to be an issue in feminist therapy. Of the 17 respondents, four said they thought a straight therapist could work with a gay client, ten said she could on certain issues or for certain clients, two said they were unsure at this point, and two felt that a lesbian therapist would be better for a lesbian client.¹⁰ In giving an example of a time when it was hard for them to incorporate their feminism into their therapy, five feminist therapists discussed their difficulty in working with women who found in their feminism or lesbianism reasons to be critical of or remove themselves from the therapy process.

Of the four women who said they thought a straight therapist could work with gay clients, one, a lesbian herself, said that in her experience, the question was more whether the gay woman would be willing to work with the straight therapist, explaining that it is gay women who are often "prejudiced" against therapy done by any therapist who is not a lesbian herself.

¹⁰Analysis of the data from the questionnaires indicates that 11 percent of the feminist therapists in the population focus on lesbian women in their therapy.

Ten feminist therapists said they thought a straight therapist could work with gay women, depending on certain things. Five said that it depended on whether or not the therapist had worked through her own feelings about sexuality and whether she saw lesbianism as a viable positive alternative that was truly acceptable to her on all levels. The idea of whether or not a straight therapist could work with a gay woman depended for five therapists on the client's reasons for coming to therapy or whether the client's homosexuality was still at issue for her. Several said that around certain issues, such as assertive training, communication skills, or determining what she wants for herself, they thought a difference in sexual orientation between therapist and client didn't make any difference. However, around certain issues, particularly when a client is dealing with her homosexuality itself (i.e., around "coming out"), they expressed more hesitation or felt that a gay client seeing a gay therapist would be more helpful. One therapist explained that she had been seeing one gay client who came to her initially as a straight therapist because this client had accepted the idea that straight women were better than gay women. Through this therapist's work with her as a feminist therapist, through the emphasis on minimizing the power differential between them, this client began to see straight women as not so perfect after all and ultimately left to work with a gay therapist, which this therapist saw as a positive step. She concluded:

I feel like I can work with gay women. I don't think it is the same, and I think it depends on what the person wants, what the struggles are. Like some mothers might want to see a therapist who's a mother, and for some it might not be that relevant at that point. So for this woman it was very important for her to make that move.
(Karen)

Three therapists said they felt that they could work with gay clients as straight therapists, but it depended on what the client felt about it and if she did not feel she could work with a therapist who was not gay, they would respect that. Two therapists in this group said they were aware that there was a position among some gay women that a straight woman shouldn't do therapy with a gay woman. One said she had recently read an article which argued that a therapist saying, "Whatever your sexuality is all right with me," was liberalism and that a therapist needed to take a stance. This therapist disagreed, saying, "I don't buy that. That's carrying it too far. . . . Nobody's had identical experiences with everybody else, so if that's the criteria for working with someone, then we're all in trouble" (Betsy).

Two therapists said they were unsure if a straight therapist could work with a gay client. For one, a straight therapist, this had to do with her lack of enough exposure to gay women to know if there would be any problems (Peg). The second therapist who was unsure was coming from the opposite position. As a lesbian, she is feeling increasingly separated from women who are not gay. She sees around her examples of straight women oppressing other women (i.e., in contributing to the defeat of the Equal Rights Amendment in some states) and thinks that would go on in therapy as well. She believes gay women are much more committed to women than straight women. However, at this point in time she is still unsure about her position on this issue (Marsha).

Finally, two therapists seemed to feel that it would be better for lesbian clients if they went to a lesbian therapist. One heterosexual therapist has found that many of the gay women she has seen were so

worried about her position on sexuality and felt so frightened in the groups that her therapy with them was fairly unsuccessful. Therefore, she feels that for "women who are gay in a long-term sense and have gone through all that paranoia and mess for a long time, it would be better to have someone who's gay to work with." However, for women who are coming out, she feels that as a straight therapist, she has been able to be "a kind of bridge, saying, 'It's OK; it's fine with me that you do' and that's been important and good" (Ellen). Lastly, one therapist explained her own background in struggling with her commitment to women and her sexual identity and felt that because of that she had a great deal of awareness that was more than intellectual as a heterosexual woman about homosexual women. However, she still felt that all that could not bring her as close to the experience of lesbianism as actually living it (Sue).

Difficulties with Feminists and/or Lesbians. Five feminist therapists, when answering the question of when it had been hard for them to incorporate feminism and therapy, spoke about their difficulties with some other feminists who have taken aspects of the feminist value- and belief-systems and used them to justify not confronting themselves or changing in therapy.¹¹ They explain that often, these are women who diagnostically would be called borderline paranoids or schizophrenics

¹¹Several women also mentioned in this context that they like working with women who are in the process of developing a feminist consciousness, who don't fit the traditional feminine stereotypes, or who are feminists already. They point to the receptivity of these women to therapy and to a feminist consciousness, and their ability and desire to have the therapy relationship be more egalitarian and less traditional. Because they are already questioning, feminist therapists find therapy with these women exciting. "The women who are not feminists are more boring to me and harder to work with" (Holly).

and have integrated the mind-set and beliefs of the women's movement into their own distorted system. When this happens, the woman then either uses the feminism against herself or against the therapist. In the former example, a therapist explained that when she tried "to say something that would be having compassion for herself, she would come up with a good reason why she shouldn't and couch it in feminist terms" (Karen). In the latter instance, a therapist reported that trying to work with such a woman "drives me bananas."

Ordinarily if it was somebody who wasn't psychotic, there's a lot of places to support and to help a woman see that, "Hey, it's not just you." That [support] is a major part of feminist therapy . . . [but supporting it for these women supports their whole system] and that's real hard [for me] to deal with.
(Nancy)

One therapist (who is herself a lesbian) finds that some of her most frustrating clients have been lesbians, for similar reasons:

Some of my most frustrating clients, the ones I've really felt like throwing up my hands with, have been gay women. Because of their victim thing and their continually stroking themselves with rage about men. I've had a couple of radical lesbians who say [angrily, accusatorily], "How come she should forgive her father!?" . . . They're frustrating. They have a big feminist [radical lesbian] Parent that says, "Be Strong. Don't Relate to Men."
(Holly)

Two women indicated that their belief systems often made it hard for certain feminists or lesbians to hear them or accept directions they felt the therapy needed to go in. A Jungian therapist senses that because of Berkeley's politicization, many of the things she says are heard as reactionary statements about women. While she doesn't think they are, she finds it hardest to work with women who "feel very bristly" when she tries to explain the loss she sees in their developing just the masculine sides of themselves. Another therapist says that her ideas

about the development of a person's sexual orientation lead her to believe that some of a lesbian's yearning for contact with a woman comes from a lack of good modeling from her own mother. In doing therapy with these women, she sees them as needing to explore their relationships with their mothers, and has "a feeling that's probably not too palatable to a lot of people who really don't want to think about mother at all" (Cheryl). This therapist also reported that she found it hard to work with some of the younger clients who were coming to her recently. She describes them as bright, high-energy, "go-getting" women, and yet finds that in part because of that they don't want to make the commitment to therapy necessary to develop trust. They "come in and then move out," disappointed and perhaps angry, hurting the group by their sudden leaving and frustrating her (Cheryl).

Power Issues

Since the issue of power was discussed in the literature both in criticisms of traditional therapy and as an important aspect of feminist therapy, interviewees were asked, "Do you think about power issues in the work that you do?" If they seemed puzzled or talked exclusively about personal power (as used in Gestalt), they were asked more specifically, "Do you think that in your relationship with your clients there is a power differential or do you see it as a relationship between equals?" Over 75 percent (14 of 19) of those interviewed believed that there was an inherent power differential in therapy, a structured institutionalized inequality in the therapeutic relationship in which the therapist was dominant and the client subordinate. Among those who perceived a power differential to exist, there were differences in how they incorporated that belief.

Therapy as Inherent Power Differential. Among those who believed that a power differential was inherent in the therapeutic relationship, some viewed this inequality as based on the therapist's leadership or limit-setting role and therefore her responsibility for and position of ultimate control of the therapy situation.

They're coming into my group, ostensibly anyway, on my terms. . . . It's my tape recorder. By and large I'm the one that turns it on and turns it off. I say, "We'll start now" and "I'd like to take a break now." Those are all power things. (Pat)

Although one therapist felt she had skills in therapy while her clients had skills in other areas, others spoke of the differential in skills between them and their clients.

I think that there's probably always a power imbalance because of the nature of the contract. They're calling me for help. They're not calling a friend for help. If I call a friend for help [or do it myself], I've got a different kind of power thing going than if I call a professional person for help of any kind . . . , even . . . a professional mover or floor layer. By nature of the contract, I've already got an imbalance in power going. I'm going to see someone that I feel has more expertise in some area or another than I do. . . . I assume that people who come to me are . . . missing some information . . . They don't know how to get more in touch with what's going on inside them. So I'm going to be a guide for them, to help them get through that. (Leslie)

Although this experience or skill differential does not mean in their eyes that they see themselves as doctors to sick patients or gurus to the unenlightened, nonetheless it does happen that their clients expect them and need them to remain in a role apart from friendship and depend on them in a way that they do not depend on their clients.

It just is inherently an unequal relationship. They depend on me in a way that I don't depend on them. I think of it mainly in a parental model. . . . In terms of what happens in the hour and in terms of what happens in therapy--how often we meet, how long we meet, whether or not they're in a group . . . , how involved they are--I'll never insist on things . . . but the inevitable thing that happens is that they feel very invested

in me. I feel invested in them but I don't feel dependent on them. When I'm a patient it's the reverse. You feel needy and helpless and less independent, and so you feel less powerful, and in some ways you are less powerful. (Beth)

Among the responses of those who saw a power differential to exist, four ways of incorporating that belief emerged, with some taking one position clearly and others several. The position taken least frequently was the acknowledgment of the existence of a power differential, coupled with the belief that its existence didn't really impact on the therapy. In other words, some feminist therapists felt that having a differential in therapy skills or in control of the sessions could remain context-limited.

A second position (held by nine of the 15 viewing therapy as a power imbalance) was acknowledgment of the power differential in the therapeutic relationship as a given, and an attempt to make the relationship as equal as possible within the context of that basic inequality.

A third position among those who viewed a power imbalance as existing was to stress the acknowledgment itself of the issue of power in therapy and the potentials for power abuse by the therapist, thereby moderating the impact it has when denied.

There definitely is a power difference. It's liberal to assume that there's not. . . . I think it's important to recognize that and then instead of playing into it to recognize it and try to work through that. (Karen)

Generally, this means being attuned to power issues between the therapist and the client, to the ways a therapist can use her power to hurt or to control, to the dangers and pulls toward power abuse. (Specific examples of the ways they deal with power issues are discussed in Section III, under Descriptions of Feminist Therapy.)

Both the second and third positions above see power as a negative force, at least insofar as it functions in maintaining imbalances between people and has the potential for abuse. A third group perceives power in a much less negative fashion, as neutral or as having both the potential for good and for ill. Those adhering to this position speak of attempting to use their power, gained in part because of the power differential, for the good of their clients. One speaks of her power as a "therapeutic form as well as a philosophical stance" (Betsy), at times varying it depending on the dynamics of the therapy process (i.e., if the client is very dependent and gives away power, deciding with some not to take any and with some to take all that is given). Others use their power to provide an environment that is safe enough for clients to feel able to question and grow.

I think power in itself is neutral and can be used well or used badly. One of the things that people are coming into the group to do is to be in a place where someone's who's safe and friendly and has their well-being at heart will take care of the [structural] things . . . Part of the therapeutic process is that a person looks for and hopefully finds someone who is powerful enough to offset their script pattern. (Pat)

One feminist therapist speaks here of utilizing her power to elicit from people their power so they no longer need hers. Two women find that as powerful figures, they are used by clients and trainees as models of women who are assertive, potent, self-respecting, and feel and use their own power for positive ends. One therapist feels that because she is powerful in the therapeutic relationship, she has the potency to clarify "crazy" thinking in ways that aren't judgmental or hurtful, a new experience for women.

Most women haven't gotten feedback from people about parts of them that they don't like, except when the feedback has been devastating or judgmental or putdown or religious. And for

them to see someone really be able to do that makes them feel differently about themselves. . . . That's the power I'm aware of, the power to help a person see themselves in a hopeful helpful way and to incorporate the power [that I] model.

(Alice)

However, the power "for good" is equal to the power "for bad," and at times the latter mistakenly gets used. "What really scares me is when I've made mistakes and have had a hurtful outcome. . . . [It] worries me that somebody should have that kind of influence and power" (Alice).

Some of the feminist therapists who saw a power imbalance existing in therapy also spoke of its existence in other social contexts as well, and felt that their belief in the power-structured nature of relationships and the roles of dominance and submission inherent in them was an added awareness they brought to therapy. In their analysis and in the therapeutic process, they are sensitive to issues of power between people in their groups and between their clients and others in the society. One therapist explained that she believes most people who come to therapy do so in part out of their unhappiness in power-structured relationships (Teri). Another said:

I think a lot of people either don't know [about] or are scared to touch . . . the area of . . . power balance between people and in situations. . . . I believe that there's such a thing as "I'm OK, You're OK." [But] I also believe that some people have more power than others, and it's damn hard to get there when somebody's either got more money or more prestige or a higher job or is simply physically larger. To not be aware of power issues can lead to people's being confused, with the therapist saying, "This is the way it is and this is the way it works and let me diagram it for you" and the person knowing it in their gut that "it ain't that way." (Pat)

Therapy as Relationship between Equals. Five women did not feel that a power differential was inherent in the therapeutic relationship. As they saw it, the relationship between therapist and client could be one

of equals or, for one woman, one in which the client had most of the power (Ann). If a client experiences a sense of powerlessness, that has more to do with ways in which clients give away their power to the therapist or the process of coming to someone for help.

One therapist strongly disagreed with "the more radical feminist therapists" who feel that therapy is one more destructive perpetuation of situations where a woman is "one down" and who therefore focus intensely on attempting to arrive at an equality in the power balance. She feels that it is common for people entering therapy to feel vulnerable, to not feel powerful; but she sees that powerlessness as a function of the lack of security and lack of power in all areas of their lives which brings them to therapy rather than anything done "to" them by the structure of the therapeutic relationship. While she attempts to acknowledge "the intrinsic powerlessness that can be there when [people] begin therapy," that powerlessness does not make her more powerful. Her power remains constant throughout the process of therapy, while the clients' sense of their power increases as therapy progresses until they no longer feel powerless (Nancy). A power differential does not exist, one therapist explained, because helping and needing help are interchangeable.

These people come to me feeling like they're screwed up, like I'm going to help them. I say, "That's ridiculous. You only feel screwed up because people tell you you're screwed up and you've come to this role." I could be where they are and they could be where I am, and we have been in these different places with each other. . . . I really don't feel I have any power. It's . . . in all of us. It's a matter of how much we are willing to let it out. (Diane)

For one therapist, confronting the role expectations and stereotypes her clients place on her has involved struggle and risk, but she believes doing so is the way to achieve a real equality between therapist and client.

I think that in the past I have been very uncomfortable with somebody putting me "one up" . . . ; but I have a tendency to pretend that they weren't doing it and so not be real explicit and say very directly, "I want to be equal with you and this is how I'm going to be equal. . . . This is how I'm not in that role [you put me in]. . . . I don't see myself as a person who tells you what to do or gives you advice. If you want my opinion and we can agree on that, [then] I might give you my opinion."
(Joyce)

Answering Client Questions and Self-Disclosure

Two consecutive questions in the interview asked feminist therapists if they answered client questions and if they talked about themselves during therapy (self-disclosure, self-sharing). If they did, they were generally asked if they thought doing so had anything to do with their feminism. Most said they answered questions and self-disclosed, although many qualified the instances when they would do so, saying it depended on the client, the question, or the appropriateness of the situation. Many said that answering client questions and self-disclosing had to do with their feminism, but some said that it had more to do with their training.

Answering Client Questions. A belief in answering client questions was posited against the more traditional therapeutic and Gestalt views. In the traditional framework it is important for a therapist to understand questions within the context of the client's pathology and to be somewhat removed from the client in order to be effective. Gestalt sees questions as projections best dealt with by "turning them around" and having the client be the therapist and answer in fantasy. Of the 18 feminist therapists interviewed, one said that she generally did turn questions around. The others said that they answered questions, five as a general rule and 12 depending on the question, the person, or the situation.

Those seven who said that whether or not they answered a client question depended on the question being asked differentiated between "straight" questions which come (in TA language) from the adult ego state and are based on the client's legitimate desire to know more about them, their work, their opinion, and other questions which they hear as disguised statements or as the client abdicating her own power in asking them what she should do. They answer the former but not the latter. However, one therapist said that if a client asked a question like, "What do you think I should do now?" and she answered by asking, as more traditional therapists do, "What do you want to do?" then she would be discounting the client. She tries instead to deal with the process of power abandonment.

What I usually say is, "Look, I have some ideas about what would be good for you, but I think it would be better for you to answer the question yourself. I think you'd feel better. I think it's more powerful for you to answer it yourself. I want to know what you think you should do. And I'll fill in the holes. But do your share of the work." (Teri)

Sometimes she also uses the group to answer questions rather than always holding that power herself.

Those who said that whether or not they answered a client question depended on the person asking differentiated between clients who repeatedly asked questions to get assurance or advice or perpetuate a power imbalance by placing the therapist in a "status position" and clients who were genuinely requesting information as one equal to another, answering the latter but not the former. One therapist gave an example of a woman she was seeing who asked her a number of questions because she wanted her therapist to be another human being and not a "vague shrink," and she said she answered all those questions. She is also

particularly willing to answer questions asked by women beginning to make changes in themselves as women who want to know if she has ever gone through what they are experiencing. However, she finds she answers these questions more with general statements of support than with specific information about her life.

Several said that whether they answered questions depended on the therapy process itself. When a woman comes in initially to see one therapist, she answers as many questions as she can and encourages the client to ask the next time others she may have forgotten. However, once therapy begins, she searches out more what's going on for the client in asking (Nancy).

Among those five women who generally answered client questions, doing so has to do with their belief in being more direct and "straight" with clients, their desire to "not play games." One therapist in this group called not answering questions "a cop-out" on the part of the therapist, and feels that when therapists aren't open to clients, the client puts energy into "psyching" the therapist out rather than into dealing with her own problems. Similarly, another therapist said that the model of not answering questions is "there to protect the therapist, to keep you behind a wall" (Beth).

Of the 12 women asked whether their answering client questions had to do with their feminism, four said that it did; four that it had to do with power and through the power with feminism; two that it didn't have to do with feminism but with their training; and one that it just had to do with being "straight." Those who saw answering client questions as having to do with feminism explained that the connection

was their focus on the importance of shared womanness and shared humanness between them and their clients. One woman said she felt feminism had also helped her not always answer questions because it supported her in "not always being nice" and asserting her right to her own personal boundaries, barriers and defenses. For four therapists, answering client questions had to do with not wanting to become more of a power figure in the therapy relationship than was already inherent in their role or to further mystify the therapy process. They believe that clients have certain "rights" in the therapeutic relationship, one of which is to have their questions answered.

Often I'll answer questions that I wish hadn't been asked simply because I think that's fair. An example [was when] I was interviewing someone who wanted to be in a self-awareness group here. After I'd asked him a number of questions, he . . . started asking me questions. In a sense, what he was doing was reversing the process. His questions were fair. I was a little uncomfortable because people coming in to be interviewed by me don't usually ask me questions; but I thought, "turnabout's fair play." I don't like a power relationship in which I can ask all the questions and nobody can ask me anything. (Pat)

One therapist added that she saw answering clients' questions as giving her clients permission to be inquisitive, to take power over their environment (Teri).

Self-Disclosure. "Talking about yourself," self-disclosure or self-sharing were explained here as different from value-sharing or opinion-stating (discussed at the beginning of this section under Values and Directiveness). Self-disclosure was presented as a more personal sharing, often having to do with one's own experiences in areas similar to those the client is presenting. Of the 19 feminist therapists interviewed, 11 said that they did self-disclose, six that they did so only when appropriate, and two that they did not or did so only very selectively.

Those who said they self-disclosed and focused in their answer on their reasons for doing so rather than qualifications for when they would not were scored among the 11 who self-disclosed. Self-disclosure often has to do with a willingness and desire to get involved, and feminist therapists see themselves as having this a much greater priority than "traditional" therapists do. Said one therapist, "I very much believe in self-disclosure and so I do a lot of that "(Sue).

The things I talk about are very much related to me and how I'm living my life. . . . I'm not spilling out a philosophy that I've learned in order to fit their situation. I'm coming from me, and what I feel the strongest. I get emotionally involved. I don't stay aloof. I'm not afraid to care about someone and let them know that. I left [behind] all those rigidly defined structures and philosophies. (Diane)

Several made the distinction between self-disclosure, which they strongly believed in and did, and "working on myself," which they avoided.

In their responses, they gave examples of the kinds of self-sharing they typically did and their rationales. Sometimes what they share has to do with times when they have had similar dilemmas or problems to those their client is presenting.

I'll share some things about myself, like if someone is working on a "Don't Be Close," and is stuck and all upset because they're stuck, I'll say, "Well, I've been stuck on that one too," and share a particular therapy experience I've had. (Holly)

Another reason stressed by some for self-disclosure was a desire to demystify themselves as therapists, to counter the image of themselves as people who "have it all together." For some, the things they share are often purposively tied to feminism. As they share their own experiences, they are aware they are also sharing ways in which feminism has had a positive impact on their lives. "I'll relate what my experience was . . . particularly around feminist things, how much better I feel as

a woman and as a person now than I did back in that other kind of life" (Peg). In part, they are consciously talking about themselves to model (as discussed in Section III under Descriptions of Feminist Therapy). Several of these women also said that a dilemma for them at times was knowing how much or when to share, or sharing when it was not relevant. One woman said that she felt in a dilemma when a client would ask her to share with them as much as they shared with her, particularly because achieving a more equal therapeutic relationship was important to her.

Six women said that they self-disclosed when appropriate, depending on the client, their relationship with the client, or other aspects of the therapeutic situation. What they shared and why they shared it were very similar to the examples given above. However, they were more concerned about choosing the times when sharing was appropriate and not contra-indicated. They gave examples of clients who they feel would be unable to handle appropriately a knowledge of personal things about them and of instances in which they feel it is more important to "work the client through" a particular issue than to share their own experiences, no matter how experientially relevant. One woman explained that she shares "consciously," meaning that when she does so, she always has definite therapeutic ends in mind.

I'll sometimes talk about myself to model. I'll sometimes talk about myself, my intention being to build trust, to make contact. Within the therapeutic setting, I do so in a very stylized manner. How I talk about myself with my friends is different than how I do in a group. I'm not willing to make myself vulnerable, the "if I tell you all about myself you'll think I'm a nice person . . ." I'm pretty choosy about what I disclose. I'm also willing to do it when I think it's going to be helpful. (Pat)

Two women said that they shared themselves "very selectively" or "not on a regular basis," feeling that talking about themselves was

very often not relevant to their clients' lives and at times implied that the therapist's way was the way their clients "should" be.

Sixteen of those 17 therapists who said they did self-disclose were asked if doing so had anything to do with their feminism. Eleven said that it did, particularly with issues of power and how that related to feminism, and five that their self-disclosure didn't have to do with feminism. As in the connections to feminism of answering client questions, self-disclosure is done to break down the client's sense of isolation by knowing that her therapist, also a woman, has had similar problems and struggles and to model changes in feminist directions that have been positive ones for the therapist. Self-disclosure often comes, it seems, out of a desire to demystify oneself as a therapist, to diminish any power the client gives to the therapist in her role as being a person "better than, more together than" (Karen) the therapist really is as a person. As explained in Section III, this attempt to diminish the power imbalance was an aspect of feminist therapy mentioned by many feminist therapists. In this context, one feminist therapist explained that her rationale for self-disclosure had to do with her attitudes toward power (connected with her feminism), her belief that clients do know what they need and what is best for them. So when one client told her that it had been very meaningful for her when his therapist shared things about her life during therapy, she has tried to remember to do that. Even though she's "not super-comfortable with that all the time," she says, "I try to go as far as I can to meet what each person wants" (Beth).

The five women who self-disclosed but didn't feel doing so had to do with feminism said that they knew other therapists who were not

feminists, who also valued and saw the usefulness of self-disclosure. One said that self-disclosure came out of the human potential movement (which she considers sexist) and criticized the women's movement for claiming that anything women did more easily--like self-sharing--was therefore "superior and wonderful" (Teri). Another therapist said that she thought self-disclosure was "more connected with being straight" than with being feminist. Two Gestalt therapists said that for them, being self-disclosing has come not from feminism but from Gestalt's emphasis on "being more authentically there and saying where you are" (Leslie).

Therapy as Political or Apolitical

Respondents were asked, "Do you see what you do as political or apolitical?" If they wondered what "political" meant, they were encouraged to use their own definition and explain it. Of the 19 feminist therapists interviewed, 14 perceived their work (or part of their work, or the ramifications of their work) to be political rather than apolitical.¹²

Therapy as Political. Among the 14 women who labeled their work political,¹³ several major themes emerged. These include the rejection

¹²One feminist therapist, a Dean of Women Students, differentiated between her direct counseling, which she calls "semi-apolitical," and the work she does in coordinating programs for women and teaching Women's Studies, which is political (Sue). Therefore, the political aspects of her work are included in the discussion of the political position, the counseling in the apolitical.

¹³Interestingly, although 14 feminist therapists considered their work political, when asked, "What do you think a person gets from you that she wouldn't get from someone who wasn't a feminist therapist?" they did not discuss the political ramifications of their work as one of the critical differentiations between feminist therapy and other therapies.

of traditional (both electoral and activist) definitions of "political," the development of a new definition of what is political focusing on power and the interconnectedness of the personal and social realms, and the belief that all therapy is ultimately a political statement. In the traditional sense of the political as having to do with electoral politics or positions on national issues, only one of these feminist therapists included that in her definition (Sally). Others differentiated their definitions of "the political" both from that and from the more radical definitions of the political as having necessarily to do with organizing and demonstrating. Only one woman strongly stated that the goal of her therapy was involvement in feminism and thereby radical political action focused toward systematic change.

My ultimate goal as a feminist therapist is for [my clients] to get hooked up [with feminism] or become feminists themselves. If they become feminists themselves, they will love to be with other women, and will support other women, and will be involved in women's groups, and will try to further the women's cause, which is my goal--not an individual solution but a total change of the system. They would have to be involved in something. . . . I would certainly label that a very clear expectation.

(Marsha)

Others disagreed with this stance, saying that their goals and their definition of what is political are broader, perhaps but not necessarily including political activism.

Hopefully, part of what happens is a person feels her strength more and helps to build the movement more, getting together with other women, . . . just not staying in your own little niche but going out and building something. . . . I know that there are some people who say that a woman isn't healthy unless she goes out. [I don't totally agree with that]. . . . What can be political can be broad. For a woman who's just in the home a lot, . . . going out and with a few other women organizing some kind of cooperative child care, that's political.

(Karen)

Another therapist disagreed because of the contradictions in that stance with her humanistic belief in self-direction and individual autonomy.

Some other feminist therapists feel that their work with the client must terminate or culminate in the client's doing political activity. To me, that's a narrow-minded way of looking at it. That's destructive in the way that it puts out an already-formulated route for somebody to go, [while] the important part of [feminist therapy] is women in all areas having real freedom of choice and living that out and asserting themselves in whatever they're doing.

(Nancy)

Two other feminist therapists disagreed in the context of revolutionary strategy rather than the humanistic philosophy above. One woman explained that while she believed in "the revolution," she focused on the here and now.

People live here and now. Whatever social change that may be going on years from now . . . , there is still getting up in the morning, deciding what you want to have for breakfast, what you're going to do after that and who you're going to be with. Unhappy, lonely, scrunched up people don't make good revolutions.

(Pat)

Another explains that there is always a place for artists as well as organizers, and therefore that she doesn't "lay heavy trips on people" like saying, "If you really have your shit together, you'd be out organizing" (Teri).

Those feminist therapists who saw their work as political generally defined the political as having to do with power, often acknowledging that as their own or a new and non-traditional definition of what 'political' was.

Somewhere I've read that political is use of power . . . Everything I do [in therapy], in a sense, is use of power.

(Sally)

On the most basic level, politics has to do with power and the distribution of power. . . . What goes on between people has a political effect, because it has a relationship to power and the distribution of power in relationships.

(Teri)

The themes of action and Feminist Humanism (see Section III, Descriptions of Feminist Therapy) are reiterated here: the belief that women have power as individuals which they are not--but can be--in touch with, that they can and need to make their own decisions about their lives, and that awareness of oneself leads to change. They are saying that when a woman moves from a position where she feels powerless to a position where she feels powerful, that is a change not only in how she feels about herself but in the political realm as well because it means women are now making decisions about their own lives and changing the distribution of power in relationships. At that point, these changes are not only personal changes but changes in the social process as well.

I get boggled when people try to separate personal change from social change, because I don't think you can separate the two. People are personally affected by social changes, and societies are affected by personal change. (Pat)

This interconnectedness of the personal and social realms, the sense that the personal is political, was alluded to frequently in discussing the political nature of feminist therapy. One therapist made the distinction here between traditional definitions of the political which focus on goals and her definition which focuses on changes in process instead of changes in outcomes. She sees her therapy as process-centered and therefore political in a new way (Carol).

Several women added to the political dimension of their work the idea of therapy as consciousness-raising about the connections between a woman's life experiences and the social (or political or economic) system. One woman commented that when she teaches (which she considers a part of her therapy), she does so from a definitely feminist stance and does not even attempt to or care about presenting the anti-feminist

position. She sees this as taking a political position. Another therapist sees her therapy as correlated with and a statement of her politics. In addition to helping her clients become aware of the connections between their personal lives and the social system, she attempts to "turn people onto options" to those systemically sanctioned (and therefore power-restraining) life-styles, and sees doing so as political because it impacts on people's powerlessness.

One of the reasons people feel powerless is because they don't know what their options are. I think one of the roles of a radical psychiatrist or an advocate psychiatrist is to turn people on to their options. You don't have to live alone, isolated, in a studio apartment that costs 200 bucks a month and work in a straight job eight hours a day. You can get together with other folks, live in a house together, share food, labor. (Teri)

She and another therapist both spoke of their own lives as political statements which they modeled in therapy. For one, it is choosing to work half-time, for the other it has to do with finding work to do that is meaningful to her and useful to others outside of the institutions of the "straight" culture, modeling "taking power in my life to feel good" (Teri). A third feminist therapist said that her low fees designed to "give women a fair break in therapy," her encouragement of people making changes in spite of the system, her lack of bias toward gay people, and her acceptance of a person's politics were all political statements (Holly).

Six women questioned whether anything as impactful as therapy could be apolitical, believing that all therapy--whether done by a feminist therapist or a Freudian psychoanalyst--is political and that "no position is a position" (Karen). "It is not that we feminists are making it political--it has always been political!" (Marsha). Among

these therapists, even those who don't make explicit political statements or attempt to influence their clients towards feminism feel that their politics comes through in their work.

I'm political in the sense that I'm conscious of political relationships. I'm conscious of power relationships that come up in some way or another, and have a position about them. I don't think I can avoid being political, really. I'm political in . . . how I work with people. I'm political in what kinds of issues I talk about with people I work with. I'm taking a political position in working part-time and saying I believe in it.
(Joyce)

Therapy as Apolitical. Five of those six women who defined their work (or, for one woman, part of it) as apolitical said that they labeled themselves in this way because they focused on individuals and didn't view as their goal effecting change in the structure or functions of the social system. One explained that she does very long-term therapy with clients, often twice a week and therefore works with only 15 people. She doesn't see how doing that "is going to change the society [or] make much difference in the world" (Beth). This therapist was formerly very active in radical politics, especially the anti-war movement, and her apolitical stance at this time has to do with feeling that although she "drained" herself doing so, what she did there ultimately didn't do any good. At this point, she feels comfortable being apolitical because she doesn't see any political options that she can believe in. Although many of the women another feminist therapist sees are feminists who consider her work political, she doesn't because those who see her who aren't feminists already "can leave without having one bit of change in that sense" (Ellen). A third woman sees mostly "middle-class middle-income suburban women who are not really ready to jump on a bandwagon" and she doesn't feel an obligation to bring them to awareness until they are

ready to make the connections themselves (Peg). Finally, one woman categorized here as apolitical actually defines her work as spiritual and therefore removed from the political/apolitical dichotomy.

"Political" I usually think of in terms of activist and I'm not an activist except in how I live my life. . . . Political means to me group-collective-working and I don't feel that way. What I feel I'm doing is sharing how I feel about things--my spirit.
(Diane)

Issue of Losing Potency by Incorporating Feminism

Feminist therapists were asked if they ever felt at times that things they believed were important to do in incorporating their feminism into their therapy meant that they did things that their clients weren't ready for or diluted the therapeutic potency they might have if, for example, they did not answer questions or remained more unknown. In other words, they were asked if there were for them conflicts between being a feminist therapist and being a therapist. In answering, three basic responses emerged among the 17 feminist therapists interviewed on this question. Three said that this was a dilemma for them that they had not yet resolved; five said that they felt even if they were less potent at one moment or said something a client was not ready to hear, their having done so would ultimately be an asset to the therapy relationship; and nine, the majority, said that the readiness of the client and their assessment of the therapeutic situation at that point in time governed what they did.

Concern with Losing Potency. The three therapists who said this was a current issue for them explained their dilemmas. One said that she wondered whether there were times that her feminist perspective on a woman's situation might be getting in the way of her really being

able to see how disturbed a person was. She also compares her work with that of her husband, who self-discloses much less than she does and maintains more control, and wonders if he is more effective or only more egocentric.

As I watch my husband work, for instance, he's strictly in control and reflects back all kinds of stuff like that . . . Sometimes I get pissed about that. Sometimes I see that as an ego trip. And yet it's very effective and it's probably more therapeutic too.
(Cheryl)

A second woman said that she had been thinking a great deal recently about the issue of potency, and whether she loses potency by exposing so much of herself or whether that is balanced by the power she negates in not remaining hidden.

What I do know is that it's very important to me that people see me as I am and that there's a real relationship going back and forth. I know . . . that I go out on limbs . . . in exposing myself--I'm pretty transparent. . . . That's really the meat of the thing for me. I keep trying to make sure that I'm so obviously who I am that people can't lay power on me to any great degree. And I'm not really sure whether that's making me a less effective therapist.
(Ellen)

Feminism as an Ultimate Asset. Five feminist therapists said, in response to the question, that they went on the assumption that any immediate loss of potency that may occur by their responding out of their feminist values would ultimately be compensated for in the quality of the overall relationship. They stressed their belief in the importance of a therapist not being a blank screen, and feel that their sharing and answering questions facilitates the establishment of the solid relationship necessary to "get through a lot of negative stuff that will come up later. . . . I think that the most important thing is to do what you feel comfortable with, to be really real, as you really are" (Beth). They are saying that to do some of these things is a necessary part of

being congruent with their values and belief system, and emphasize the ultimate potency of being themselves. One woman explained that these decisions are never clear but that as a therapist, "you have to weigh everything. Maybe in a certain situation you would be diluting your potency, but that would be weighed against not responding--which is more destructive." If she loses material at one point by answering too quickly, it will come out at some other time. She went on to share an experience which validated her belief in going ahead with the feminist aspects of her therapy.

One of the arguments people use against sharing themselves is, "What if the person isn't ready--it can be destructive." My argument has always been, "Well, that may be so but I think there are more cases where they are ready and it's destructive not to." Something happened [yesterday] which I felt very validated about. . . . I have been seeing [this woman] for a little over a year, and I've been sharing myself with her all along. . . . Yesterday . . . she said, "I've come to see you as really an equal, and stopped putting you up." And it's true--she was always putting me up, and I did what I could to step down. She said, "I see a difference. You've always shared yourself with me, but I wasn't ready to hear it, so I just turned it off when you did. In the past few weeks, I've been listening and letting it sink in." I thought, "Far out! When she wasn't ready, she didn't hear it and she turned off."

(Karen)

Three of the feminist therapists in this group criticized the Freudian model of therapy (see also Other Therapeutic Issues), arguing that no matter how potent or powerful the analytic method in which the therapist remains a blank wall, doing so places the therapist in roles they don't want to be in and carries with it assumptions about people they reject.

Not disclosing and not making yourself human is very powerful, and a lot of good material can come out of that and a lot of fucking people over can come out of that. If I'm going to err, I'm going to err in the direction of opening my mouth too much.

(Betsy)

Therapy is More Important than Feminism. Nine feminist therapists, the majority of those interviewed, said that whether they did certain "feminist" things in their therapy was always governed by the readiness of their clients and their assessment of the therapeutic situation at that point in time. This was more important to them than whether their behavior was particularly "feminist" at any moment.

It's not an either/or thing. . . . I think eventually if you don't make some connections to the political structure, you're copping out . . . But sometimes I'm asked a question and I really would like to deal with what they're asking me, what it is they want to know. Other times I have no qualms about answering them right away. . . . We get back to the old thing about clinical intuition . . . There's some people who are good therapists and some people who are not, regardless of what they do.
(Marsha)

They explained that a number of considerations always go into their decisions about what they do at any point in therapy--the timing, their own wants and needs, non-verbal cues, and, in the case of answering questions, what kind of question it is.

One woman distinguished between feminism as therapy (explicated by Mander and Rush 1974) and therapy done by a feminist. Both are feminist therapy, but her maintenance of a priority focus on the dynamics of the therapy situation over the feminism puts her in the second category while those doing feminism as therapy focus on the feminism first (Nancy).

Other Therapeutic Issues

Theoretical Orientations. At various points in the interviews, comments would be made spontaneously about different theoretical orientations of therapy, in particular positively about Gestalt, negatively about

the Freudian psychoanalytic model, and both positively and negatively about the Jungian model.¹⁴

Five therapists discussed Gestalt, saying that they felt its theoretical orientation and method of practice lent themselves well to feminist therapy.

[Gestalt] is not the traditional patient/therapist model. My orientation as a Gestalt therapist is always to be who I am, to say my feelings. If I'm angry, be angry; if somebody's doing transference onto me, to not let it develop . . . [I work on] having a person get in touch with her own strength and taking responsibility for herself. So those are all ways which lend themselves very well to feminism. (Karen)

Several mentioned the congruency between feminist therapy and Gestalt's dual focus on individuals taking responsibility for their lives and on the therapist refusing to accept power.

I'm constantly giving the individual responsibility for themselves. I'm only a vehicle. They can use me to get in charge of who they are as women. . . . I see that my whole job--and this is a lot what I got from my training in Gestalt--is to make women take responsibility, so that they can say "yes" and "no," so that they learn how to ask for what they want, learn how to get in touch with themselves. (Carol)

The neat thing about Gestalt is that [it helps me] back away when I feel I'm getting out of hand. There are lots of ways for me to back away and throw the power back on the other person, because of the Gestalt work I do. That what . . . Gestalt . . . is all about--throwing the power back. People try to give it to you--you give it back to them. (Ellen)

¹⁴Bioenergetics and Transactional Analysis were also mentioned, but by only one or two therapists and generally positively with little in-depth explanation. Therefore, they are not included here but encompassed, when relevant, into the discussion of the question during which they occurred. Likewise, "traditional therapy," while referred to frequently (generally critically), is not equated here with the Freudian model because what "traditional therapy" actually refers to in each instance is context-bound.

Analysis of the data from the questionnaires returned by the sample frame is congruent with interview responses. Of the feminist therapists in the sample frame, 72 percent indicated Gestalt as a theoretical orientation, while only 17 percent indicated a Freudian orientation and 12 percent a Jungian one.

Those feminist therapists trained in Gestalt also mentioned some of their criticisms of it. It assumes that a therapist can be value-free, an assumption many feminist therapists feel is not possible and/or not desirable. At times although they see Gestalt as highly effective for "heavy" work because it is so "clean," removing the therapist from the interaction, they feel that as a feminist therapist they want to provide more contact and involvement. Similarly, although a strength of Gestalt is its focus on individual responsibility, that can also be one of its disadvantages in that by focusing so much on individual responsibility, it ignores ways in which the society impacts on individuals. "Gestalt tends to be too much individual responsibility and not enough how society fucks you over" (Karen). One therapist (referring to the work of Steiner 1974) wondered if perhaps using Gestalt was merely another way of helping women do what they already have permission to do--to feel (or, in TA terms, to be in their child ego state)--and not helping them learn to think and problem-solve (or to be in their adult ego state).

Seven feminist therapists discussed psychoanalysis or the Freudian model specifically. Six of the seven were very critical in their remarks. They saw that model's focus on transference, therapeutic distance, interpretation and resistance as increasing the power the therapist has over the client.

I was trained in the Freudian model . . . and that has inherent in it a kind of attitude that if the patient doesn't want what you want, then the patient is being resistant. [According to my model,] if the patient doesn't want what you want, then the patient probably knows what he or she needs. And you need to try to accommodate their struggle, . . . to try and do what people want.
(Beth)

While discussing whether being a feminist therapist meant that they lost potency by not using some more traditional techniques, three therapists said that to practice analytic methods also meant that a therapist had to be assuming on some level that the client was sick or weak, an assumption which runs counter to their basic belief-system as feminist therapists.

To turn questions around and not self-disclose in general I think is a cop-out. . . . That's the whole objective bit, that the therapist is supposed to be a blank wall on which the person projects all their transference. I think that the whole psychoanalytic point of view assumes that the patient's pretty damn weak . . . It's a medical model, and it also puts the therapist in the role of rescuer--"Let me figure it all out and then I'll tell you what to do" or, "I know but I ain't going to tell you." and that's even worse. So then [the clients] put a lot of energy into psyching [the therapist] out, rather than putting energy into dealing with themselves, changing. I think the traditional model is ineffective. It keeps people in therapy for years and years. (Holly)

In this context, several mentioned transference. Some said that a positive aspect of Gestalt, in contrast to psychoanalysis, is that it did not encourage transference to develop. One therapist said that one thing she did with her feminism in therapy was not to label things a client said transference (as she felt an analytic therapist would) without carefully checking herself for any responsibility she may have in what occurred (Karen).

One therapist interviewed receives case consultation from a Freudian, and provided the one positive view of that orientation. She believes that many of Freud's more anti-woman notions have been discarded by most Freudians, and that other aspects of that approach are useful for her to integrate with her feminism.

I know what Freud says about penis envy--we all do. What I think is that a good Freudian shrink, and even a man, doesn't

work under some of those old conceptions. I think that's a good bone to pick, to focus in on formulating some of the new ways that we're looking at things, but in terms of what Freudian shrinks out there are really doing, I'm not so sure they're all doing interpretations back to a woman about penis envy.

(Nancy)

Three therapists discussed the Jungian orientation, one very positively and two more critically. A woman influenced by Jung's work finds the concepts useful in her feminist therapy. She believes that people need to incorporate both the feminine and masculine sides of themselves, and identifies (particularly in Berkeley where she practices) the most pervasive problem among both the men and women she sees as "a valuing of the masculine side [intellectual abilities, aggressiveness, assertiveness] and a losing of the values of love and affection and nurturing and gentleness" (Beth). In her therapy, she works to enable her clients to actualize whichever of the two principles they may have lost, in part by giving permission to the people she sees to value and incorporate the devalued "feminine" side of themselves. She explains that when she talks of the "feminine principle," she is speaking historically rather than inherently. However, she finds that it is "unpopular" to have this orientation. So it is not surprising that the two therapists critical of this orientation said that a way they incorporate their feminism into their therapy is to refuse to deal in male-female polarities, whether that would be having a dialogue between the male and female parts of a person or using the Jungian framework of animos/animas.

I want her to feel that her aggression doesn't have anything to do with her maleness--it's just her. To make that separation bothers me inasmuch as it eliminates a wholeness. If the aggression's going to come, it's going to come out of her femininity, because she's female.

(Ellen)

Finally, in discussing issues in incorporating feminism into therapy, one woman said she wished there was a psychology of women. "I wish that there was more systematized knowledge on the psychology of women, as a special class. Most psychology is really the psychology of men. . . . I feel myself sometimes lacking in concepts" (Holly).

Issues with Other Professionals. In response to the question about issues for them in combining feminism and therapy, four women discussed confronting the sexism of other professionals. One therapist explained that she is starting to get "touchy" about male therapists who "are doing some of the same old numbers," thinking, "By now they ought to know; they ought to have changed" (Pat). Another therapist explained that for her, the issue came up at staff meetings when she heard something she disagreed with as a feminist.

If I hear something I disagree with, do I stand up and say, "My position is different from that," and how. It's very scary for me to do that. It's very scary for me to make myself controversial. I have all kinds of fantasies of being able to do so and have a hard time carrying through with them. So [then] I feel I'm not being open about who I am. . . . It doesn't come down to a matter of being dishonest. It comes down to a matter of how much I take the initiative of putting myself forward and how can I do that in ways that will work or that I can handle. . . . And then I lay all kinds of trips on myself about am I really so weak and ineffective that I can't act on what I believe in and do I have to be in a closed interview room with somebody giving me status in order to be effective. (Joyce)

Recently, she has begun telling people this is a struggle for her, and talking with the women at work she particularly trusts. For another therapist, a struggle has been to break through an early decision to "never trust women." This is much more of a problem for her on a peer or professional level than in her therapy groups, particularly in terms

of finding herself not respecting the opinions of other women therapists and fearing they won't respect hers (Cheryl).

V. HOW DOES FEMINIST THERAPY PERCEIVE AND INCORPORATE FEMINIST ISSUES

During the interview, and particularly as probes to the question about what the issues were for them in combining feminism and therapy, feminist therapists were asked how they perceived and/or incorporated feminist issues related to therapy, in particular working with male clients, anti-professionalism, consciousness-raising as an alternative to therapy, therapy as merely an individual solution, working with women only in groups, the differentiation between cultural problems and individual problems, and the limitations of therapy. Their responses compose this section.

As explained in Chapter III, many of these issues were suggested by the review of the literature to be current ones debated among feminist therapists. However, interestingly, as mentioned in Section IV of this chapter, when asked to list issues for them in combining feminism and therapy, these feminist therapists raised almost three times as many therapeutic issues as feminist issues. Those feminist issues having to do with therapy are included in this section, while those having to do with feminism itself are included in Section II.

Working with Male Clients

Feminist therapists were asked if they worked with men or thought they could work with men. Of the 17 responding, all did therapy with

men under some circumstances or thought they could.¹⁵ However, some qualified their answers and some did not, and those qualifications were to greater and lesser degrees. Eleven said they thought they could work with men, and did not qualify their answers. Five women said they worked with men, but emphasized the difficulties, and one did not work with men in her private practice where she had a choice but did see men in the community clinic where she worked.

Yes, Can Work with Male Clients. Eleven therapists said without qualification that they thought they could work with men. Two women said that although they thought they could work with men, in actuality they saw only one man or none at all. Some gave examples of particular awarenesses they had about men, but did not indicate that this made their work any more difficult. For example, one woman saw women as more able to express their feelings, develop rapport with each other, and not needing "to go through 'macho' roles with each other." Therefore, she feels part of her feminist therapy with men is helping them express those things and pointing out their particular "stuck areas." However, she would still do essentially the same kind of therapy with both men and women (Diane). One said she makes political connections with both men and women. Another feels that although she sees some men who have trouble being assertive and "rationalize their difficulty with actualizing what has traditionally been a masculine role in terms of feminist . . . politics," the most pervasive problems she sees among both the men and

¹⁵Analysis of the data from the questionnaires indicates that 45 percent of the feminist therapists in the sample frame reported that women were a focus of their practice, while 18 percent reported a focus to be on men and women both, 18 percent on couples, and 11 percent on families.

women she works with is, in a Jungian sense, an over-valuing of the masculine side (Beth). Two therapists said they thought it was important for them to work with men, for their own benefits, so as not to be operating in a "female vacuum" (Alice).

Work with Men, But there are Certain Problems in it. Five women said that they did see men, but emphasized the problems they had or the qualifications under which they would work with--or thought they could be effective with--men. One therapist said that the problems men brought to therapy were completely different. She found women to be much more self-conscious and ill-at-ease with their bodies and felt that the issue of self-assertion for women was a much more continual, deep-seated problem. On the other hand, she finds that she feels much easier about making physical contact with women than she does with men, feeling with men more separated by her power as a therapist and feeling from the men "the sense of resistance to me as a woman sometimes" (Ellen). One woman finds herself at times impatient with men.

I'm also sometimes impatient with men. Partly not wanting any more to be very sympathetic with men's problems. It's kind of like, sometimes, "OK you guys. I went through it once before when you were being male chauvinists and nobody knew it and I was sympathetic and I understood and I supported you and held you up and all that. So now that you're changing your consciousness too, I don't want to go through the same trip. Go do it on your own." [I'm] not wanting to nurse anymore. (Pat)

This therapist also works in a setting in which the people she sees most frequently are men who "are not feeling and not being in touch by drugs and alcohol." She finds it one of the ironies of her work that for this particular group of people, feminism runs counter to their therapeutic needs.

The way to their hearts and minds and their souls is not through militant feminism by any means! And sometimes my being strong, my being tough, is a drawback. And yet it's the only way I know how to survive when people start yelling and screaming and throwing furniture around. So there's a bungle. They're expecting that as a woman I should be sweet and docile and be very nice to them and I'm not. At points like that, a feminist background I don't think is therapeutic, but it sure helps me survive. (Pat)

For another therapist, her problem in working with men is just the opposite. With the few men that she sees (who she considers already atypical because they are men who are involved with feminists), she finds herself being more understanding of the man's problems with expressing feelings than with the woman's. "I sort of feel sorry for [the men] or something. So I end up being real nice to them. . . . [Then] they play all sorts of games to avoid feelings--I'm aware that's a problem" (Holly).

Two therapists in this group who work with men but noted the difficulties discussed the particular limits they set with men.

One of the things I tell the men when I interview them [for the mixed group I do] is that they're going to have to struggle if they're going to be in the group. They're going to have to struggle with their sexism, with their chauvinism. And if they're not willing to struggle with that, then [they shouldn't] bother coming to the group. (Karen)

She finds that there are very few men for whom dealing with their own sexism is on their primary agenda for therapy. However, although she does not feel the same commitment to men in general as she does to women and knows it's an "unpopular position" to work with men, she finds her work with those few men who are willing to struggle with that particularly rewarding. The second therapist who works with men in a college setting described her experiences with a group of male students which led her to conclude that she can work with men "to a degree."

I became very involved with a couple of male students who were very interested in what feminism had to say . . . We had lots of long talks about what it was all about, and there were lots of "ah-ha!" clicking things. They were also willing to do a lot of reading . . . It took more patience to deal with men on my part. I could feel myself getting very frustrated, a lot because of the male behavior in terms of dominating conversations. I found myself having to outline some of the things I thought men were all about in terms of what society had done to them and . . . [say that although] probably they saw themselves as very open . . . people, . . . they were still engaging in some behaviors that were counter-productive to at least my growth and I found that offensive. . . . We talked a long hard time about that and ultimately I sent them to the Men's Resource Center at the Y. . . . I think they really had to deal with men to . . . get in touch, to really have their consciousness raised about themselves as men. But I still think that it was helpful for them to work [with me] on that, to talk to me about that, and to be able to develop a relationship. (Sue)

Do Not Work with Men when an Option. Finally, one therapist said that in her private practice, she does not work with men. "I do not choose to do that. I don't have the energy to spend. It's that I do not want to put my energies there." However, she does see men at the community mental health clinic where she works, and there is a certain amount of conflict in that for her. Despite her desire not to put her energies into men, she feels that in her role as a family therapist, it would be unethical for her not to work to the best of her abilities with the men in the families of the children she sees (Marsha).

Professionalism and Training

As discussed in Chapter II, Tennov (1973) argues that professionalism and feminist therapy are mutually exclusive. Her position was explained to the interviewees and they were asked to respond, as follows:

One woman in Connecticut writes that if a woman is a professional (meaning she has an M.S.W. or a Ph.D. or an M.D. or whatever), then she can't be a feminist or a feminist therapist

because that professionalism carries with it so much power and authority. What would your response be to her argument, and what is your thinking about the skills, training and/or professionalism necessary to do feminist therapy?

Fourteen of the 15 feminist therapists interviewed disagreed with this position, some very strongly, arguing that having a professional degree could but did not necessarily mean one identified oneself as a professional or abused one's power as she indicated was inevitable. Whether or not a therapist had used her professional degree to wield power over clients or to obtain the necessary skills to do good therapy depended, they felt, on the therapist and not on the attainment of the degree. In answering the question about skills, the response was generally that what the necessary training was to be a feminist therapist was fairly unclear, but whatever that additional training, it had to be based on solid clinical skills.

Professionalism. As several therapists explained, the issue was not professionalism but professional identification, whether or not a therapist had moved beyond the sheer fact of degree attainment to identify herself as a professional and therefore different from and superior to those without the degree--in other words, whether she used the degree to maintain an elitist position. They argued that it was as likely that a feminist therapist would have "lousy skills" as it was that a "professional" therapist would abuse her power, or that a paraprofessional would be highly competent and a professional incompetent. "I know some pretty powerful women who don't have a degree, and I know some real wimps who have degrees" (Alice). Those two feminist therapists in the sample who did not have college degrees disagreed with the argument as much as those who had advanced degrees.

Two therapists explained that they thought Tennov's position held less credence now than four or five years ago.

I think she's behind the times . . . Because more and more, fewer and fewer people are seeing degrees as that blanket credit card to get into heaven and have all people agreeing with you, as used to be the case. More and more people challenge authority . . . , and . . . believe [competency] is in the proof of the pudding. It isn't the degree that does it. . . . I think becoming a professional and getting a degree maybe has more mysticism for her than it does for me. For me, it was like getting a union card. I did all my work, paid my money, and I got a union card. Now the only way I'm going to be successful and have anybody see me as an authority is if I do well.

(Alice)

One therapist said that she "responded with anger" to the presentation of the argument. She continued, explaining that the "anti-professionalism nonsense" in the movement in the late sixties and early seventies happened because male radicals decided "being a professional was a bad thing and so of course women shouldn't do it either, just about the time women were getting up their courage to go be professionals." She feels angry that holding to this position has meant that women who could be professionals have accepted this rationalization for not succeeding.

I'm really angry about all the women who were bright and skilled and competent, who could be with me in the professional world, who decided to . . . cop out. I really see that as a "Don't Succeed" on the part of a lot of women. And I'm angry that they haven't gotten their shit together so that they're up front doing whatever they're doing instead of "whooshing" around somewhere in the back. I think that's just using bad politics as a rationale for not succeeding.

(Pat)

Another therapist said similarly that not only did she see no discrepancy between being a feminist and being a professional, but that she felt that "strong women who believe in themselves and believe in other women . . . have almost a responsibility" to become professionals and act as models for other women. The one therapist who did feel that

Tennov's argument had credence said that she dealt with the conflicts inherent in professionalism by accepting them, living with them, and attempting to minimize their potential impact in her therapy.

Training. The clear position among feminist therapists on how much training was necessary to do feminist therapy was: "as much training as it takes to do good therapy." The emphasis was that doing therapy--including feminist therapy--required therapeutic skills.

I think [to do feminist therapy] primarily you have to be a good clinician. If you're not good at what you do, it can really be a drag, to feminism, to the movement. . . . So I would say that the first thing that really matters is having a good solid background and training. . . . I do believe that feminist therapists owe it to themselves and to everyone else to get the best possible education, the best possible training, that they can. (Alice)

For some, those skills came primarily from supervision, for others from college and university training, from experience, or from one's own personal therapy. Five seemed to feel that degree-oriented professional training was important, explaining that as the system was currently set up it was one of the few ways for a woman to get good therapy skills, while five others were more critical of the training that went on in colleges and universities or didn't feel such training was necessary to be a good therapist. However, all returned to an emphasis on the importance of skills and training of some form or another. As one therapist said, "I find I'm much safer with my skills than I would be without them" (Ellen). They explained that because they had skills, they knew how to keep the power differential minimized, and they knew how to handle the severe problems women may bring to therapy. As discussed in Section IV (under Power Issues), some indicated that having therapeutic skills did mean they were different from their

clients but not necessarily more powerful. "I've got some skills that other folks don't have, but part of the work I do is transfer those skills. I have no investment in hanging onto them. I want everyone to have the skills I have" (Teri).

In discussing the particular training need for feminist therapy, one woman pointed out that aside from some skill-building in areas like assertive training, there was no training in feminist therapy yet. One therapist said that feminist therapists had to supplement good clinical training with women's studies and that perhaps this would mean segregating themselves for a portion of their training. Otherwise, no one seemed to know what the training for feminist therapy should be aside from the training for therapy itself.

Consciousness-Raising as an Alternative to Therapy

Following the implications of articles in the literature pointing to the profound changes in women who have been in a consciousness-raising group and those advocating consciousness-raising as an alternative model of therapy for women, feminist therapists were asked if they agreed with the argument that many women don't need therapy at all if they had a good consciousness-raising group. They disagreed, explaining that the statement was too simplistic and that while consciousness-raising could meet some needs of some women, it had the severe limitations of facilitating anger but not change, in addition to not being appropriate for the needs of very severely disturbed women.

Many feminist therapists began their comments by saying that the statement was true, for some women. They emphasized some strengths of consciousness-raising: it can give women support, a chance to express

themselves, practice self-assertion, and gain self-assurance and self-confidence. For these things, some feel it is probably better than one-to-one therapy. However, they objected to the assumption that because consciousness-raising had strengths, it was the answer for all women. "To say 'All a woman needs . . .' is like saying, 'All she needs is a good lay'" (Alice). They went on to discuss the limitations of consciousness-raising. One limitation mentioned by eight feminist therapists was that consciousness-raising tended often to be a "dead end" (Holly). It evoked anger and then could not provide channels for change, thereby "bogging down in a sense of outraged victimization" (Ellen), in complaining, playing "Ain't It Awful" games, advice-giving, mutual pitying, and "bullshitting" (Marsha).

I've seen too many women in consciousness-raising groups where it got to a point where all they did was express their anger. It was a good place to express their anger against men, and it didn't go any farther than that. . . . It was like the flip side of a coin--the anger then kept them in the same [unliberated] position. (Peg)

These therapists feel that therapy offers ways to work through the anger, to not stay "stuck" with it, to move beyond anger into action.

Hopefully, therapy ought to help a woman resolve the conflict and move on, to keep moving up in her own level of awareness and ability to deal with the world, and know how to be effective about what she now has her consciousness raised about--how she can get into action in an effective way and not just stay aware and infuriated. I think there's just no way you can help but be mad if you're aware. If your consciousness is raised and you haven't been angry, something's missing; but to stay embroiled in it rather than using your anger effectively, channeling it in a really effective productive way--that's where it's at. And I think that's where consciousness-raising sometimes . . . didn't carry through. It just wasn't equipped to carry through. That wasn't what it was designed for. (Alice)

Four other therapists also mentioned that women may need therapy to handle the implications of the consciousness-raising. One therapist explained that many women she worked with had been in consciousness-raising groups before but at a certain point felt that there were things they needed to deal with in therapy, "like the part of a person that would collude with her oppressor, internalize that, [or working on] not laying trips on other people or buying other peoples' trips" (Karen).

Five therapists said that there were some women who needed "more" than a consciousness-raising group could provide. "Some people need therapy," said one woman simply (Diane).

There are some women, just like some people, period, who do need help beyond [consciousness-raising], who do need to look more deeply into their own lives. Although their problems may be extremely confounded by the fact of their powerlessness in this society and their lack of support in terms of who they are as women and their perceptions and value systems being very discrepant with what is labeled health in our society, I think their problems are much deeper than [consciousness-raising can deal with], and they do need some kind of therapy, some kind of one-to-one help. (Sue)

One therapist explained that while on the one hand, therapy was often over-mystified, to believe that consciousness-raising could help all people with all problems was to over-simplify therapy (Teri).

While most therapists agreed that consciousness-raising had strengths despite some limitations, one woman called it a "total political flop" because "it took women away from struggling and got them into talking about it. . . . It got us away from action . . . and . . . my ultimate goal is always action and radical change" (Marsha). Nonetheless, she and another therapist said here that they feel that a consciousness-raising group would still be far superior to traditional analytic psychotherapy, but both also think that their models of therapy

for women are superior to either.

I think that if a woman has to choose between a psychoanalyst and a consciousness-raising group, she should be a consciousness-raising group. If a woman could have her 100 percent druthers about what would be the best thing, the best thing would be to be in a problem-solving group led by a feminist. (Teri)

If I can deliver something, hopefully they won't have to go to the consciousness-raising group. They will have bypassed that. They will go and be with women and seek women out and have that support, that foundation. (Marsha)

Finally, one therapist explained that she felt that the idea that women didn't need therapy if they had consciousness-raising had to be understood in its historical context. At the time when the position was argued most strongly, there were few therapists who identified with the women's movement, and no feminist therapists as such. For a woman to enter a therapy group at the same time that her consciousness was just beginning to be raised "would have been disastrous because we were all scared we were going to be labeled crazy. And I'm not sure that that was [a] totally unjustified [fear] in some cases" (Pat).

Issue of Therapy as an Individual Solution

One probe posed the following theoretical issue raised by the literature review:

Given the idea that it's the social system that produces many of the problems women bring into therapy, do you ever ask yourself if therapy is only an "individual solution," fixing one person at a time while the whole system's continually producing more problems?

Of the 16 feminist therapists responding, six said they did see therapy as an individual solution and went on to explain their viewpoints, seven said they thought both an individual and a societal focus were needed,

and four said they did not see their therapy as merely an individual solution.¹⁶

An Individual Solution. Those who saw therapy as an individual solution explained their dilemma. On the one hand they feel strongly that women (and people) will continue to be oppressed and therefore have emotional problems as long as the society continues to socialize women into second-class citizens. Thus they see the impacts of their therapy as always ultimately limited and minimized by the society. "In a sick society, how healthy can you get?" (Karen). To a certain extent, acknowledging that dilemma at least destroys any attempts at pretense. They speak of their work as "bandaiding" and "patch-up work," and seem to feel that in their acknowledgment of the limits of their therapy comes a more realistic perspective in which therapy goals are set not toward individual change but toward social (and, for one at least, revolutionary [Marsha]) change. Another therapist has come to accept the irony that what she does best (small-scale work) is least likely to provide the larger-scale solutions she thinks are ultimately necessary.

I think [the argument above] is a real problem, and I think that's true. I'm aware of that. I'd like to see larger-scale solutions. I've come to pretty much accept that the way that I work best is on an individual or small-group level. I guess in some ways I value political action more and think that's more important, but that's not where I'm at and so I accept that. (Joyce)

Two women said that one thing they did with the irony they faced was focus on groups, for one on building support groups for women as a way

¹⁶One gave mixed answers and is counted twice.

of "spreading the word" (Holly), and for the other any situation in which one person can impact on more than one other person, such as work in schools and with large groups (Ann).

Need for both Individual and Societal Focus

Seven therapists interviewed said that they felt that therapy was not "just an individual solution" because changes in individuals impacted on the social environment, and vice versa. They believed that a dual focus--on individual change and on societal change--is necessary. They explained that as women begin to change, feeling their own strength and power, the institutions around them will change, ultimately changing the society.

I feel that there is no way of railroading somebody who won't be railroaded. As people begin to feel their own strength and say "no," that the institutions and the people around them are not going to be able to do the old trip with them. I think that's even more effective than going in and trying to make some sort of mass movement that has a large contact but is not too sustaining.

(Cheryl)

One woman said that in her opinion, a lot of people trying to change society are doing so angrily and therefore ineffectively.

As I see it, a lot of people go out in anger, angering the very people they're trying to make points with. That comes from their own personality, [the attempt to] get rid of their own anger they've stored up against mommy and daddy for so many years. [If you] get that out of it, then they can go out and be strong and deal with those [societal] issues.

(Sally)

They feel that a good therapy experience can better prepare women to make changes in their lives, confront the sexism around them, and perhaps raise their children differently--"there's going to be some cumulative effect" (Alice). One therapist concluded that she doesn't see herself at all as getting people to adjust to the system. "It's not bandaiding--

it's people with power" (Ellen). However, another therapist did say that at times it seemed to her that the changes she was effecting on an individual level were being "snowballed out" by those aspects of the society which countered her efforts. Nonetheless, she feels that as long as there are individuals who want what she offers, it's worthwhile to provide it.

I have to agree. It does seem that the [societal] effect is really snowballing way out of proportion, helping undo [my individual work, which seems] very slow and cumbersome and in terms of impact is just . . . nowhere near meeting [the need] . . . It's like the difference between sending out handbills and having a five-minute spot on coast-to-coast TV--you get a lot more done. And that's how I feel about some of the more negative cultural things. I try not to be too pessimistic about it but I've got to admit . . . I get depressed about that. But just because it's slow and it isn't having nationwide impact doesn't mean it shouldn't be done for the individuals who want it.
(Alice)

Not an Individual Solution. Four therapists said that they did not consider their work an "individual solution." One said she felt her work was, instead, "a partial political solution" in that it enabled people to stop internalizing the messages from the society which got expressed as psychiatric disturbance (Teri). Another therapist explained that she disagreed with the argument presented for two reasons. First, it assumes that the actual structure causes all emotional problems while she believes that there is no possible social structure "that could be created that would leave people conflict-free" and therefore that there will always be a need for therapy.

There are these opposites--good and evil--in the world and in people. It's inborn. It's part of life. Life includes death. Whatever social structure occurs, you have to acknowledge that fact. . . . I don't think women have to be oppressed . . . , but life is hard. People die. There are tragedies that there's no way that the world can be organized to avoid. (Beth)

Second, she feels that however unfair it may be, it is possible for some people, those who are the more privileged and not concerned with issues of day-to-day survival, to achieve self-actualization and create a fulfilling life in this society. Again, she disagrees with an underlying assumption of the argument presented, that all individual solutions are inadequate.

Two therapists don't see therapy as an individual solution because they've adopted a more laisse-faire attitude toward societal or revolutionary change. One therapist feels that "we have the power to be happy or sad, that we really make our own misery, . . . our own liberation or unliberation." She does not believe any woman is really subjugated, but rather that her priorities, be they security or the fear of growth or change, have led her to choose a subjugated role. From this view, therapy can help people deal with what's happened to them. Out of that, some people will want to go out and effect systemic change and some won't (Diane). The second therapist explained that she doesn't feel that being in a therapy group takes away from people doing political activities the rest of the time--"Everybody has seven days a week." In addition, she believes that in this country, there is still a time ahead of "figuring out" in which she as a therapist can be helpful.

[We need to learn] how to be brothers and sisters to one another, to grow together, to get rid of the things that we don't like and promote the things that we do. I think we still have a period of figuring out what ways work and what don't; are there any sorts of therapy which are helpful, are there any which are not. I'm willing to help people explore. If self-awareness groups here help people feel better, decide what they want in life, what kind of a society they want, then I think that I'm doing a good thing. . . . Unhappy, lonely, scrunched up people don't make good revolutions. Whether or not people want to make a revolution after they get happy and friendly and unscrunched, I don't care. (Pat)

She concludes that if people don't want what she has to offer, they won't come to her.

Working with Women in Groups versus Individually

Whether or not they felt it was important for women to be seen in groups rather than individually for feminist reasons was the next issue raised in the interview. The position was based on the argument summarized in Chapter II that working with a woman individually removes the support and sense of unity with women provided in a group and does not encourage women to work and struggle together. Of the 16 feminist therapists responding, 14 felt groups were very important for women. However, five qualified their responses by saying that some women can't handle or don't need a group, and five said that their feelings about groups being better than individual therapy didn't have anything to do with feminism.

Those 14 women who felt it was important for women to be seen in groups rather than individually said that a group both moderates the therapist's power and gives women support and exposure to a wider range of women's choices in ways that individual therapy can't do, or can't do as well. A therapist who does groups for pre- and occasionally orgasmic women finds the groups to be a crucial aspect of the therapy.

One of the major elements of the group . . . is that it's a group . . . When they come together, one of the things that happens is that they no longer feel like a freak . . . That support that the women give each other is probably the most important thing that goes on in the group . . . A woman in isolation will get so discouraged she'll just keep thinking that there's still something wrong with her. That's what the group [changes].
(Nancy)

One therapist explains that a group is the place where women can learn to turn their nurturing abilities toward each other, as well as providing the therapist opportunities to structure experiences so women turn to each other instead of to her. She also pointed out that before she found a structure for herself in TA and Gestalt, the women's groups she did facilitated victim positions. "We would sit around playing Ain't It Awful. . . . To sit around and feel powerless and blame it on men and male structures was something that was going on a lot" (Holly). Another found, similarly, that in her women's groups, the women tended to pity each other, "so frequently the only kind of feedback that is going on is this kind of pity which just curls the spine." When she is aware of this, she works to get at the jealousy between women she feels is underneath (Ellen).

Five therapists said that they felt groups are very important for women but that there are some women for whom a group is not appropriate or who don't want group therapy. They point to women who will not or are not ready to work in a group, and women for whom relating to other women is not a problem and want (and utilize well) their own individual therapy experiences.

Five women said they preferred to work with people in groups rather than individually not for any feminist reasons but because they believe therapy done in a group progresses more quickly and is more effective.

Differentiating Cultural and Individual Problems

One question began: "One thing the literature on feminist therapy stresses is the importance of not attributing cultural problems to

individual women. Does that distinction make sense to you?" Of the 17 feminist therapists responding, nine said that the distinction did make sense to them, seven that the cultural and individual were too inter-related to be distinguishable one from the other, and one that she saw all problems as political. The rest of the question and the probes following were designed to elicit the theoretical responses of feminist therapists to this position and then examples of how they made the distinction between cultural and individual issues, if they did so, and what they did with cultural issues in the context of therapy. Further probes were designed to focus on what they did if a woman presented cultural problems as individual or personal problems and if she presented what they saw as a personal issue as cultural (in other words used cultural realities to absolve herself from making individual changes--the TA game of "Wooden Leg" or "If It Weren't For Being a Woman"). Sometimes, further explanation was given in posing the question, referring to the work of Chesler (1972):

Chesler says that one of the ways that traditional psychotherapy "drives women crazy" is by taking cultural problems and labeling those the problems of individual women that need to be dealt with in therapy. It seems that feminist therapists are not wanting to imply to any woman that cultural problems are her problems. But it can go two ways. A person may be "blaming" the externals, the culture when in fact there is some real work she needs to do. On the other hand, there are times when a therapist can focus the work internally or intrapsychically when they may be externals that need to be changed, when a consciousness of certain oppressive realities needs to be fostered. Do those distinctions make sense to you?

Because of the complexity of the question and the length of responses, not all interviewees were asked all aspects of the question or all probes. In asking the rest of the questions and the probes, however, it became clear that often there were no clear answers, no one way

feminist therapists deal with, for example, the cultural when it is presented as personal. The following discussion, therefore, will present the complexity of issues raised rather than any agreed-upon solutions.

Cultural and Individual Differentiation. Those who made a distinction between cultural and individual problems stressed the reality of cultural problems that exist for women.

I think women have to know when they're being assaulted by cultural pressures, that it's not some personal inadequacy of theirs that's causing them to be oppressed. (Beth)

The oppression is real. It's out there. The anger is important. Anger has a definite place in the world, and I don't think it should all be spent in therapy. I think it's a healthy reaction that women especially feel. (Holly)

However, the second woman goes on to say that "what's important is what they do with the anger." This is a theme that is repeated by others: given that cultural oppression exists and that it impacts on a woman's emotional well-being, what is she doing with her awareness, to what degree is she contributing to her own oppression, and to what degree is she taking personal responsibility for cultural oppression. They point to the "delicate integration" (Betsy) of cultural and individual problems and the complexity involved in understanding and in working with these issues in therapy.

There's been a fine line when I've wondered, how am I going to approach this. Am I going to approach this in a "therapy way" or in a "consciousness-raising way"? . . . Let's say there are two people who are at the same job and one is really fucked and the other isn't. Now is one more radical than the other and seeing more, or is one really having problems with authority figures. . . . And if someone doesn't struggle with authority figures, is that her problem or shouldn't you have trouble with authority figures cause aren't authority figures fucked? (Karen)

Often, the problem is further complicated in that women have incorporated aspects of that which is oppressing them into their own heads. One woman quoted this analogy: "It's really hard to fight a war when the enemy's outposts are inside your own head." She continues to say that women need to "get in touch with the ways that they oppress themselves, that they cooperate with it and that they put themselves down" (Beth). Once women become aware of this, the degree to which they "collude with their oppression" (Teri), then it is up to them to decide what to do in the future. The issue becomes pointing to personal complicity without discounting the cultural realities and raising consciousness without embracing blaming.

If a woman's coming down on herself, if she's taking personal responsibility for cultural oppression, that is very important to sort out so that she can get out of that self-blaming, self-deprecating role. She needs to know that there's a reason why she got married other than being overly dependent . . . This is very complex. The difficulty with it is that if she's into self-blaming, she may easily get into blaming something else. A lot of things in the beginning consciousness leave a woman turned over from the point of blaming herself to just blaming society.
(Nancy)

In this context, four of these women discussed the issue of rape. They see the traditional view as believing that women who get raped have subconsciously "asked for it" or, in a Transactional Analysis framework, been people who are in victim positions. This view, they believe, discounts the reality of sex-role oppression. If a woman were raped, given the cultural context in which they view it, they would focus not on her "victim script" but on her rage.

I think that rape is a social and cultural problem. I think that it's possible that women get raped who do not set themselves up for it. . . . I think that some women were raped because they didn't have their eyes open and didn't take good care of themselves. But that's no reason for her not to be very very angry

about the fact that some guy tricked her . . . So I think it's tricky.. On the one hand, I would want to help a woman figure out how it might have been avoided. I'm always concerned with helping people take power in a situation where they were fucked over, so that it can get transferred to the next situation and won't happen again. But I do not discount that men have no right to rape women, and that men raping women is a function of cultural and social and political oppression. I'm advocating for the woman's rage. Mobilizing a woman's rage is not necessarily reinforcing a game of Wooden Leg. (Teri)

She goes on to explain more about how she often sees the label of "Wooden Leg" as a discount of social and political realities.

If the game were [identified] in a liberal or conservative male-led TA group, a woman would say, "My husband is really fucking me over," and the therapist would say, "You're playing, 'If It Weren't for You,'" which is a discount of the sex-role oppression which is going down and is not useful at that moment. (Teri)

These women were asked what framework they used to differentiate between "games" and reality-based victimization, between righteous indignation and childish rebelliousness. One explained that what she looks for are the power issues in the incident. "Who's done what to whom. Who pays. Who benefits. Just like we used to do [in the radical movement] when we analyzed corporations" (Pat). At a certain point, however, it comes down to each therapist deciding, based on her perspective and her feelings and her values, where she draws the lines. "Any time I'm perceiving something, I'm making a judgment" (Betsy).

As an example of sorting, several therapists explained issues they deal with around marriage. One therapist explained that generally, she believes that in relationships, "men take power, the culture gives them power; but women give it up." The question, however, is whether the therapist can always realistically expect a woman to take back that power she's given up, whether when a woman says she needs to leave a

relationship to find her identity that's appropriate or not really necessary.

With some men, yeah [she can take her power back] 'cause there's enough flexibility in the relationship or the feelings are strong enough or something. With some relationships, after 15 years of doing it one way, he's not about to start letting her [take her power back]. To say to a woman in some of these situations, "You've got to take your power back," is not assessing the reality of that [situation].
(Betsy)

These five therapists who differentiated between cultural problems and personal problems were asked how they would know if a client were presenting the personal as cultural. Basically, they said that they dealt with such situations by incorporating both the cultural and the personal and focusing on what the client was going to do about her situation. One therapist explained that she first focused on, "What's going on outside you that's making you feel bad?" Then, once that is "illuminated and demystified," she goes for, "How do you collude with it?" (Teri).

Cultural and Individual Intertwined. Seven feminist therapists said that for them, a distinction between the cultural and personal did not make sense because they saw cultural problems and personal problems as so intertwined. In general, to a greater degree than those above who distinguished between cultural and personal problems, these therapists tended to focus on the individual, and thereby on the individual's problems. Cultural problems become manifested in individuals and thereby become problems for an individual to deal with.

I don't think I . . . make . . . that distinction [between cultural and personal]. They're so interrelated. What has been forced on me by the culture becomes a personal problem. It can sometimes be very helpful, very freeing, to recognize the source of, say, my lack of self-confidence, that I wasn't supported to be very self-confident; but insofar as I didn't develop that,

it's my personal problem now because I didn't gain those skills all along the way. (Sue)

Where does the dichotomy fall? An individual's problems are the things that he's feeling. He's got social and cultural things placed on him that would make it harder. There are cultural and society rules you accept, and some you don't accept. Ones that you accept that give you a problem are your problems, they become individual problems. (Ann)

From this perspective, they are less concerned with the sorting discussed above and more focused on things an individual can do. Since cultural problems are seen as just another aspect of an individual's problems, problems with cultural overlays or input are dealt with in the same way in therapy as any other problem. One therapist trained in Gestalt therapy explains that "you get them to start . . . expressing it directly and then say goodbye to it. . . . Then you can start defusing." A therapist trained in TA works to decontaminate the adult ego state. A therapist oriented more toward action said that the issue for her is not whether a problem is cultural or personal, but whether the client wants to work on it and what they want to change. If they want to make changes, there are direct ways of doing so, such as assertive training (Sue).

While the actual therapy processes seem to be very similar between these therapists and those who distinguish between cultural and personal problems, the difference seems to be in the complexities or lack of complexities they perceive in the sorting process. Sorting becomes for the therapists in this group more a question of good therapeutic skills and of which issues are appropriate for therapy.

I think if you aren't out there in the situation and you don't have documentation and can't see . . . the institution's point of view, you can't know [what's really going on], so it makes sense

to be personal. If it were a discrimination issue [for example], why is she coming to you instead of an attorney. (Alice)

Another therapist explained that the way she would determine if what a client called a cultural problem was one or not would be if she could locate some game that the client was playing on this and on other issues as well (Sally). They do not deny that there may be cultural implications, but focus on the personal implications perhaps to a greater degree than those in the first cluster, with a goal of enabling a woman to "understand how her own personal thing is making it impossible to deal with that situation" (Alice). One therapist gave an example from her own early experience of a time when someone presented to her what sounded like a cultural problem and she mistakenly did not look to the more intrapsychic, personal aspects of what he was saying.

The first man I ever worked with . . . was having problems with what was going on in the world, the awful hurting that was going on, and felt a great need to rectify what was going on. I started working towards what he could do and missed the boat completely because it had a lot to do with feelings he had himself of guilt as a child . . . So I think I see things more in terms of a person. I haven't lately seen anything that's really cultural, although I do talk about it. (Sally)

All Problems as Political. Finally, one therapist does not make any distinction between cultural problems and individual problems because she sees all problems as basically political. "I don't see any distinction between the personal and the political. I don't see that difference. . . . I'm not saying it's just the oppression of women that leads to all forms of mental illness but I'm coming close to saying that" (Marsha). At the same time, she explains that although this is her basic perspective, she would not immediately explain the political development of suicidal feelings to a woman who is severely hurting in that way. Rather, she

makes therapeutic interventions, is sensitive to timing and to the nature of her client's distress, and waits until it is appropriate to introduce her perspective. However, it seems that for her sorting is also less of a concern because her basic assumption is already that a woman's emotional problems are basically political in nature. In response to an example given of a woman complaining of discrimination at her job when it seemed her own unresolved conflicts were at least playing some role, she said, "You can say to her, 'Yeah. Discrimination does take place.' To me, that's a reality. What do you say, that it doesn't?" However, she explains that for her the real issue is helping women get in touch with their connections to other women, in part by getting them in touch with their rage.

If you can help that woman, first of all to validate that those are very real experiences for her and to get in touch with her rage involved in being a woman, [then] you don't have to worry about the boss . . . You have to worry about getting people connected to their roots. What it's like being a woman. . . . Then she will have as an individual . . . to make some choices. . . of what to do with her life. You cannot make them for her. . . . I really firmly believe that I am the revolution in some ways, and . . . I hope they join me. If they don't, that's their choice. But then don't come to me afterwards and tell me you're depressed. (Marsha)

Limitations of Therapy

Feminist therapists were asked if they ever asked themselves, "Does therapy work? What's the point of therapy? What are the limitations of therapy?" The objective of the probe was to elicit perspectives suggested by the literature review on therapy in relation to the larger society, in particular issues about therapy being an individual solution (asked specifically in another probe), encouraging adjustment to the status quo, or being irrelevant when survival was an issue. Interestingly,

few responses incorporated any of these ideas. Most feminist therapists spoke specifically about therapy itself, and its objectives, limitations and successfulness in the context of their own work rather than incorporating any larger perspective. Generally, feminist therapists felt that therapy did work. Three had some questions, and three were more critical. Of these last three, one discussed the "point of therapy" by incorporating a political analysis.

Of the 16 therapists responding, ten said they felt therapy did work. Many began by saying they asked themselves that question often, especially when they were discouraged, but still believed in what they were doing. They seemed to feel that there were particular things that therapy could offer, and those things they felt it did well, among them enabling clients to gain a sense of their own power and self-esteem so they can set and achieve their own objectives, freed of societal conditioning. One therapist explained that she basically believes that what she does works but is also willing to accept that something else would work as well (Joyce). Another therapist distinguished between therapy as she did it, which she feels confident works, and others' therapy which in some cases she thought was useless (Teri). One discussed the possible irrelevance of feminism when survival is an issue, but did not discuss the limitations of therapy (Alice).

Three therapists raised some questions about therapy. One said she asks herself if therapy really works, believing that it did from her own experiences and yet seeing many friends make just as many changes without therapy. "Sometimes I feel there is a certain sham in it being a profession" (Cheryl).

Three feminist therapists were more critical of therapy. One said that for herself, she would go to a spiritualist before she'd go to a therapist, feeling that therapists tend to focus on staying within rigid techniques and often use therapy for their own ends. She says she doesn't see therapy "as a giving, . . . as a loving [relationship]-- it's a doing something to somebody" (Diane). Two women questioned the ultimate goals of therapy, one by referring to the literature on the ineffectiveness of therapy and the political ends for which therapy has always been utilized. "Psychotherapy . . . has always been political . . . , it has been used to maintain a very coercive system" (Marsha). This therapist does not feel it is possible for any woman to be healthy in this society, via therapy or any other means. She is moving toward a perspective in which she sees the oppression of women as leading to their mental illnesses, and therefore always views psychotherapy as "patch-up work" at best, remedial work which will hopefully enable a woman to function well enough to join with other women to effect the basic changes that are necessary. Therefore, she questions whether feminists should even be in therapy.

I don't know, if a feminist comes to therapy, if I wouldn't try to reinforce something else . . . I don't know if I want to reinforce the idea of her coming to therapy as a feminist. In other words, does a feminist need psychotherapy, . . . especially the . . . one-to-one thing. There may be other things [that would be much better], maybe group support, maybe getting involved with women in other capacities. (Marsha)

CHAPTER V

SUMMARY AND CONCLUSIONS

I. SUMMARY OF RESEARCH FINDINGS

Who Are the Feminist Therapists?

Analysis of the questionnaire data did not produce the expected differences among the three areas studied. The range of responses in the Bay Area was greater, but no more non-traditional than Portland or Seattle (a cursory overview of the interview data finds this conclusion supported). However, what does seem evident about these feminist therapists is that the diversity of the group in many descriptive aspects becomes, if viewed as evidence of non-traditionality and non-institutionalization, a common theme among them. As generalized from the questionnaire analysis, a "typical" feminist therapist is a woman living in the Bay Area, most likely an M.S.W. in practice five years, working full time if not in private practice then for a public agency such as a community mental health clinic, where she sees clients, particularly women, individually and in groups, specializing in some aspect of women's problems, and basing her work either on an eclectic or Gestalt theoretical orientation. However, any such summary of characterizing information does not adequately portray the degree to which feminist therapists differ one from another in the specific details of their lives and yet to which the diversity consistently takes avant-garde rather than traditional, non-institutionalized rather than

institutionalized forms.

For example, when asked to describe their theoretical orientations, 33 different ones were listed, of which 24 (73 percent) could be considered newly developing and non-traditional. Similarly, feminist therapists are more often in private practice than working for an agency, whether public or private. A significant number have not utilized formal academic training in traditional fields (i.e., psychology, social work) to learn therapy. Areas of specialization are as likely to be rape, women in the middle years, feminist body work, or alternative lifestyle and adjustment as depression, phobias, and low self-esteem.

From the personal histories of feminism and portraits of feminist therapists, however, the common elements of their developing identification with feminism are striking, particularly because this identification is not something taught in any school or advanced by any one leader. Rather, these women came to feminism because its message had relevance for them, because it removed their feelings of isolation, providing them with a sense of support and commonality with other women, and perhaps most importantly, because incorporating feminism had a profound impact not only on their consciousness but on their lives. Becoming a feminist has meant for many significant and sometimes radical changes in self-concept, in life-style and in relationships with other women. Most of these feminist therapists trace their identification with feminism to the late sixties and early seventies, and in this sense, they came to feminism as a group; but for each one, the identification was an individual process. Similarly, it seems that they became feminist therapists in much the same way, not because they were taught

to do feminist therapy or modeled after a Perls or a Freud (i.e., a male model) but because they as individuals found their own way to incorporate feminism and therapy. Either as feminists learning to do therapy or as therapists identifying with feminism, their feminism impacted on their therapy and their therapy on their feminism, and a meshing occurred so that the two became no longer discrete parts of their lives but integrated as their feminist therapy.

How do Feminist Therapists Define Feminism?

From the responses in this section, it seems that there is basic agreement among these feminist therapists on certain values and ways of perceiving as encompassing the feminist belief system (described in the literature review as the Feminist Critique), the two major components of which are the belief that women differ from men because of social conditioning on the basis of sex-role stereotypes, and that that socialization has been destructive and oppressive for women, further institutionalizing them into certain restrictive and conflictual roles, behaviors, and careers which perpetuate their secondary status and produce emotional distress. However, as these feminist therapists define feminism, it goes beyond the socio-political analysis of the Feminist Critique to encompass Feminist Humanism, a highly positive belief in the ultimate capacity of each woman for self-actualization based not on sex-role stereotypes but on her own self-knowledge and human potential.

In defining feminism, those definitions involving beliefs outnumber those involving processes three to two, and those processes listed were, in general, less concrete behaviors than different forms of implementation of the beliefs they parallel, with the definition

beginning with the word "enabling," "developing," "helping," "struggling," and "changing." "Confronting," "advocating," and "getting together" are slightly more concrete words but even here it seems that what feminism believes is much clearer (and perhaps more important) than what it does.

When asked to specify basic (or minimum) criteria for being a feminist therapist, certain divisions within this population of feminist therapists can be observed. There is a distinction between those whose criteria for being a feminist therapist are basically that the person be non-sexist, self-actualized, humanistic, and open to all people and life styles, and those whose criteria demand a deep-seated commitment to feminism, coming often out of that profound impact (both in raised consciousness and subsequent life-style changes) that the movement has had on a woman. The criteria listed by those in the former group, unlike those in the latter group, do not seem based upon the particular oppression of women but rather focus on the development of all human potential. Similarly, the former criteria do not encompass high demands for basic life-style change, risk, sacrifice, or basic and significant changes in feelings and attitudes as do the latter. Within the former group there is concern that just being a feminist is not sufficient for being a feminist therapist, and in fact, because of what is seen as the anger, judgmental certainty, and directiveness of some feminists, may even be detrimental. Within the latter group, the belief is that being a therapist and being a woman, and even being non-sexist and humanistic, does not make a person a feminist therapist.

What is Feminist Therapy?

If a theoretical orientation of therapy is defined in the traditional sense as encompassing a series of propositions, a model for problem assessment, a series of techniques, and a training methodology, then from the responses to the questions in this category, the one thing that can be said of feminist therapy is that it does not exist. However, there are therapists who have incorporated feminism into their therapy and who call themselves feminist therapists. This analysis will suggest that feminist therapy must be understood more as a social movement than a psychology, and less a theoretical orientation in the traditional sense than a belief system and a series of ways that belief system is put into practice. As a belief system, it is again striking that with none of the accoutrements of most therapies--no feminist therapy journal, no (or very few) training seminars, no leader or mentor--and that despite numerous internal differences, the commonalities among feminist therapists in three metropolitan areas, each in a different state, are so strong. As feminist therapists describe their feminist therapy, it is based on a belief system composed of the two complementary parts of the feminist value-system--Feminist Humanism and Feminist Consciousness--of particular changes in the therapy relationship and in the role of the therapist which enable the therapy process to become congruent with the value-system, and of two processes--raising consciousness and emphasizing the commonality of all women--which enable the value-system to be not merely utilized by the therapist but in turn transferred to the client. In explaining the beliefs and processes of feminist therapy, it is important to note that as described above,

definitions of feminism focus on beliefs rather than processes and therefore as a therapy needing processes, feminist therapy has had, in many ways, to develop for itself processes that will be congruent with its belief system.

This may explain both the lack of specific techniques of feminist therapy and the high degree of interrelatedness between the values of feminist therapists and the ways in which they incorporate them. For example, feminist therapists indicate that one thing they do is ask certain kinds of questions about roles and role behavior designed to break down sexual stereotypes, and that they encourage the women they see to similarly question these assumptions. In this sense, questioning and fostering questioning can be seen as a technique; however, it is also a value in that feminists value women looking critically at heretofore unquestioned roles and stereotypes. Similarly, in speaking of one's values or biases, the feminist therapists frequently mentioned the value they attach to being "up front" about their views. However, the process of doing this, of sharing and clarifying their values, becomes in turn a means by which they model this behavior and bring into question the values or assumptions their clients may hold. This difficulty in distinguishing values from process says a great deal about feminist therapy, for it reflects the congruence found--and emphasized--in this form of therapy between the therapist's values and the process of therapy.

Feminist therapy utilizes its value system in what may be a unique way: as a conscious, acknowledged filter. As the client speaks, feminist therapists explain that they have an added perspective--their feminism--through which what they hear is filtered. If the analogy

holds, this may in part explain how it is so difficult for them to describe what they do, for what they are attempting to describe (i.e., what the client says and what they do) is already influenced by and filtered through their feminism. Feminist therapists are saying that what they hear has already filtered through and been heightened by their Feminist Humanism and their Feminist Consciousness. It has already given them a different or added perspective on a woman's potential for self-actualization, on her roles, on the nature and causation of her problems, and on the social structure. After something passes through the feminist filter, they then rely on their theoretical orientation, whatever it may be, to choose an appropriate response or technique, but the point is that their feminism has already impacted on that choice and ultimately that techniques are less important than that whole shift in values engendered by their feminism.

In addition, the feminist belief system carries with a concern that the relationship between therapist and client be as equal as possible, and feminist therapists view changes in their role from that of the therapist in traditional therapy as necessary to bring this about. They see themselves as more concerned with power issues, more willing to self-disclose and more "up front" with their values than traditional therapists.¹ They also feel that it is necessary for the traditional

¹Since these changes were listed by 16 of the 19 feminist therapists interviewed as what they did with their feminism in therapy and as what someone got from them that they wouldn't from someone who wasn't a feminist therapist, it is suggested that the fact that they were mentioned only occasionally in the response to the particular question asking for a definition of feminist therapy has more to do with that being the last question asked in which the objective seemed to be to give the briefest possible response than with any inherent conflict in the results.

client role to change from one of introspection to one of action, from one of dependency on the therapist to one of support from other women. These changes in the therapeutic relationship to institutionalize mutuality must be understood in the context of the feminist value-system. If changes in awarenesses are the cognitive manifestations of feminism, changes in the therapeutic relationship are the process manifestations. Without these changes, feminist therapy would be incongruent in process and cognition.

Finally, in addition to utilizing their feminism as a filter and thereby perceiving differently what happens in therapy and changing the therapeutic relationship to be egalitarian, half of the feminist therapists mentioned raising consciousness and emphasizing the commonalities of all women as two intertwined activities they do with clients. In some ways, this can be seen as the therapist returning to the client again through the filter of feminism, for in essence these activities are designed to change the client's perceptions (to raise her consciousness) which in turn impacts upon her processes (how she relates to and identifies with other women) through feminism.

Responses of feminist therapists to the two dichotomous quotations furthers the analogy. Ten feminist therapists (of 19) criticized the first quotation for omitting the feminist filter, while 12 did not feel that making political connections (which omits process changes and focuses only on changes in cognition) was the critical aspect of feminist therapy. As the definitions of feminist therapy show, client self-actualization is seen to be as critical a part of feminist therapy as social awareness and social action.

However, even though such analogies are supported by the data analysis and are helpful in understanding how feminist therapists utilize their feminism, it is also important to focus as well on the diversity of responses and clear difference of opinion among feminist therapists. These differences fall along a humanistic/radical continuum. Those in (or moving toward) humanism are unsure to what degree feminism has changed their therapy and if a feminist therapist needs to identify herself as such or be a woman, agree that feminist therapy is helping a client meet his or her goals and develop his or her potentials, and give egalitarian definitions of feminist therapy. On the other hand, those in (or moving toward) a more radical position stress the integration of feminism into their therapy and the need for feminist therapists to be women who have a strong identification with and commitment to feminism, emphasize the impact of social and/or political influences on a woman's goals, potentials, and ultimate self-actualization, and give sexually differentiated definitions.²

How Does Feminist Therapy Perceive and Incorporate Therapeutic Issues?

There is no one way feminist therapy perceives and incorporates therapeutic issues, but a common focus is the needs of the client. For example, when discussing whether incorporating any processes important as a feminist (such as reducing the power differential, self-disclosing, and so on) reduced their potency, most feminist therapists responded by

²Each feminist therapist did not consistently respond from the same position on the proposed continuum on all questions. Thus, a therapist who generally emphasized the cultural aspects impinging on a woman might also say that a man could be a feminist therapist. These descriptions, therefore, represent composite positions.

saying that whether or not they did these things depended on their client's needs. In other words, while they constantly utilize feminism as a filter for flow from the client to them, they do not necessarily utilize it for flow from them to the client. They take a similar position on issues such as whether a heterosexual therapist can work with a lesbian client and whether they answer client questions, again saying that it depends on the client and the situation. They generally take a position against diagnosis, but are willing to use it if necessary. Thus, in terms of therapeutic issues, feminist therapy takes a relative rather than an absolute position.

In their answers to questions about values and directiveness, power and self-disclosure, another theme among feminist therapists appears--they are concerned about the nature of the therapeutic relationship. They do not want a power-structured relationship in which the therapist is "one-up" and the client is "one-down." Some would argue that this is because women have so often been "one-down" or in an inferior, secondary position in the society that it would be totally contradictory to then perpetuate that hierarchy in feminist therapy. However, it seems that this may be less the rationale than a more basic value-position which highly emphasizes the positiveness of involvement, mutuality, self-determination, and openness. Whereas the feminist critique presented the cognitive aspect of the belief system, these values can be seen as the complementary process aspects. These processes thus become the means to counter or minimize the power imbalance they see as inherent in therapeutic relationships and thereby the influence of their cognitive beliefs and values on their clients. Accordingly,

most feminist therapists are "up front" with their values not because they want to influence their clients with those values but because of the openness and minimization of influence that acknowledgment of one's values brings.

In the area of structure, encouraging client "shopping" for a therapist and having a commitment to fee negotiation, while not always acknowledged as feminist things that they do, also have to do with changing the relationship between them and their clients. For example, if a client chooses a therapist, if therapy becomes a service she selects and purchases, then that will have impacts on the therapeutic relationship and the therapeutic processes.

It is in the area of how directive to be, how much to raise consciousness and how much to respect the client's self-determination that some therapists seem to experience the greatest conflict as feminist therapists and that there are the greatest differences within the group as a whole. The diversity of position along a humanistic/radical continuum is again evident. Those who are more humanistic stress self-determination, even though that may mean a client chooses to behave in "traditional" or non-feminist ways. On the other hand, those who are more radical acknowledge their desire for their clients to become feminists (or, for those who are somewhat less radical, to become aware of feminism) and see a focus on self-actualization as complicated by the issue of to what degree a person can in fact self-determine in an environment in which goals and potentials are influenced by social conditioning and social realities.

Their responses to the question of whether therapy is political or apolitical is helpful in unifying this analysis. Feminist therapists explain that all therapy is political; but they define "political" in a different sense than electoral politics or even feminist or movement-oriented activism. They focus on the political as having to do with all aspects of power, from the very personal to the largest social level. Thus, what happens on a personal level, in terms of the client's power as a woman and the therapist's power in the therapeutic relationship, becomes critical, for those are the political statements that they make and it is in its political statements, in the changes it is making in women's personal power and in relationships between women, that an important difference between feminist therapy and other therapies seems to lie.

How do Feminist Therapists Perceive and Incorporate Feminist Issues?

From an analysis of responses to the question about issues for them in combining feminism and therapy, it seems that for feminist therapists, therapeutic issues (how to be a therapist and incorporate feminism--i.e., how directive to be, etc.) are more important for them than feminist issues (how to be a feminist and incorporate therapy--i.e., whether therapy ignores social realities, etc.). These feminist therapists generally disagree with those issues from the literature review on which some feminists take very strong positions. Thus, many do feel they can work with men, that being professional is not in contradiction with being a feminist, that therapy is different from consciousness-raising (and that consciousness-raising in fact has certain limitations),

that groups, while desirable, are not always the answer for all women, that therapy does work and is useful, and that feminism by itself is not necessarily therapy. In responding to the questions about whether therapy is an individual solution and whether they differentiated between cultural and individual problems and how they worked with each, as many feminist therapists stressed the integration of the individual and the societal, the individual and the cultural, as differentiated between them. Among those who did differentiate, some acknowledged these to be issues for them; but it is important to note that they arose only when presented as interview questions and not spontaneously as did, for example, the issues of directiveness.

Perhaps what this illustrates is that feminist issues in therapy as presented in the literature and issues for feminist therapists are not the same. This may in part reflect the bias of the literature toward that militancy or toward a judgmental certainty and directiveness which some feminist therapists criticized when discussing feminism. In any case, as responses to both therapeutic and feminist issues indicate, there is nothing inherently radical about feminist therapy. Some therapists are in fact radical in their feminism and in their politics, but there is, if not a split, a continuum of responses along a humanistic/radical continuum.

II. CONCLUSION

Within the feminist movement, as Chapter II described, there exists the divisions of liberal feminism, cultural feminism, and socialist feminism. As it was described in this study, feminist

therapy has little to do with liberal feminism. Its goal is not reform through legal and political change but changes in individuals and institutions coupled with the development of alternative institutions through the incorporation of feminism to produce basic cultural changes. In this light, it is important to see feminist therapy as one of many such incorporations, in conjunction with Women's Studies, women's health clinics, women's art and media, among many others. Feminist therapy is not an anomaly but a manifestation of deep-seated changes in consciousness and process. Similarly, while three feminist therapists spoke of their anti-capitalism or socialism as well as their feminism, for the most part these feminist therapists seem to view political feminism as less important than cultural feminism. The insistence of cultural feminism on the inter-connectedness of the personal and the political, on the importance of consciousness-raising, on the development of egalitarian non-hierarchical and philosophically congruent internal structures of social relationships, on an understanding of the particular oppression of women, and on the value of women and their relationships to one another, all find expression in feminist therapy.

As cultural feminists, Mandler and Rush (1974:13-14) suggest that the key word in the new feminism is integration.

It might be said that feminism is an integration of various heretofore incompatible elements built on a collective base of thought-action-feeling. Feminism integrated the subjective and objective, the rational and intuitive, the mystical and scientific, the abstract and concrete aspects of the universe and considers them harmonious parts of a whole rather than in opposition to one another. . . . We see a universe where everything . . . is integrated and inter-dependent, not separated and conflicted.

The summary of the research findings suggests that integration and congruency are critical aspects of feminist therapy. There is a goal of

integration of beliefs and processes, of the personal and the political, of internal therapeutic structures and larger feminist values, of feminism and therapy; and the criteria for integration is consistently based on an attempt to minimize contradictions and achieve internal congruency. Thus, feminist therapists stress action as well as introspection, focus on congruency between their client's needs and what they do, explain that the political has to do with personal power, and reject definitions of feminist therapy which do not include changes in processes as well as changes in consciousness, for both the client and within the therapy relationship itself. It is not that anyone explained to feminist therapists that they needed to be concerned about their power as therapists, about client shopping, about directiveness, to be feminist therapists. Beginning from their basic movement toward congruency by integrating two important parts of their lives--their feminism and their therapy (or perhaps, earlier, with their lives and their feminism)--and despite often very apparent individual differences in politics, they have continually incorporated beliefs and processes, and chosen processes which are congruent with their beliefs.

As each feminist therapist described her feminist therapy, this integration and congruency existed, and as all the descriptions are synthesized and summarized, again what is apparent is that same integration of beliefs and processes, with congruency between them. Thus, as utilized by the therapist, Feminist Consciousness and Feminist Humanism are the cognitive aspects of feminist therapy, used as filters, and changes in the therapy relationship to institutionalize mutuality are the process aspects, integrating the feminist value-system and the

therapy process, while what is then transferred to the client, consciousness-raising and changes in a woman's relationships with other women, reflects a similar integration in what the feminist therapist returns to the client of her feminism.

Integration is in fact the making of multiple connections, and perhaps feminism and feminist therapy can be seen as the making of connections, not just between the personal and the political, but on all levels--connecting feminism and therapy, connecting women to each other, connecting one's personal problems to one's social awareness, connecting one's beliefs to what one does, connecting what one does in therapy to how one lives one's life. Thus, unlike most therapy, feminism is not merely a means to alleviate stress used from time to time but a way of life for the therapist and potentially for the client as well. "Therapy" becomes normalized, connected to rather than divided from everyday life.

However, there is one area in which the making of connections seems lacking, and that is in the realm of the feminist therapist's political positions, not so much individually but as a group. As early as 1971, Freeman noted a division within the feminist movement between those adhering to an egalitarian ethic and those adhering to a libertarian ethic. In essence, this division exists within feminist therapists as well; and while each feminist therapist has made her own integration of feminism and therapy congruent with her own political position, this is an area in which the group of feminist therapists as a whole lacks integration. Thus, an important conclusion of the research is the awareness that feminism is not in and of itself inherently radical. Feminist therapists can be radical politically, and some are. Others may have a

radical view of the therapy relationship but not of society, and still others are concerned that increasing radicalness runs counter to their Feminism Humanism. From the discussion of the issue of values and directiveness, it seems this is an area where there is the most personal concern and yet group disagreement. Hopefully, out of this a needed integration will come.

At the same time, it is important that this focus on political difference and disagreement not lose sight of the differences between feminist therapists and other therapists. This is an area in which future and more rigorous research would be helpful--for example, comparing feminist therapists to other therapists, to other women therapists both sympathetic and antagonistic to feminism, and to other "non-sexist" therapists both male and female. The research of Pendergrass (1974) and Sundland and Baker (1962) suggest internal comparisons which could be made, or bases for comparison between feminist therapists and therapists who do not identify themselves as feminists. However, perhaps the most revealing direction for future research would be actual comparisons of the practice of these different groups or of their responses to audio- and/or video-taped stimulus presentations. Without this information, to pose a continuum of feminist therapists in which the end-points are humanism and radicalism belies the existence of a much more important continuum among therapists in which the far end is not humanism but sexism, a double standard of mental health, and a highly traditional model of therapy. Furthermore, for the feminist therapists interviewed, the time during which they have been making the connections has been relatively short--for the most, five or six years or less.

In the beginning, it seems feminist therapy developed as an antithesis to what feminist therapists found hurtful, oppressive and destructive in the male-dominated institution of traditional therapy. It began out of an attempt to be different from something rather than to be something. However, as more therapists and feminists are looking to connect feminism and therapy and to remove both sexism and traditional abuses of power from their therapy, meeting with each other in peer consultation, publishing books and articles, developing training and systems of referral, it is becoming clearer what feminist therapy is, what are those basic areas of consistency and inner congruity that exist among feminist therapists, what makes it different from other therapies, and in what areas feminist therapists differ from each other. Furthermore, as more therapists label themselves as feminist therapists and as more feminists learn therapy skills, feminist therapy will increasingly begin to impact upon the institution of therapy and on the lives of women. As feminist therapists continue to make connections, to struggle for congruency, and to develop new ways of further integrating feminism and therapy, feminist therapy will itself become increasingly integrated and congruent. The process of doing this thesis has enabled those integrations and connections to begin for me in ways that are congruent with me and with my feminism. It is my hope, in turn, that the descriptions it provides of feminist therapy as it now exists and is practiced on the West Coast will be helpful in furthering that same integration for others.

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APPENDIX A

COVER LETTER FOR QUESTIONNAIRE

2566 N.W. Lovejoy
Portland, Oregon 97210
December 4, 1974

I am doing my thesis on feminist therapy through the School of Social Work at Portland State University. That choice has grown out of my own experiences and needs. Being in therapy myself with a woman conscious of feminist concerns was very important for me. Currently, I see primarily women in the college's student counseling center, and am attempting to bring to that situation a similar consciousness. However, I feel a real need to know what other women are thinking, directions they are moving, and ways they are merging theory and practice.

The thesis will be in two parts: a literature review and the results of interviews with women in Portland, Seattle, and the Bay Area who consider themselves to be feminist therapists or counselors. My goal is not to test the validity of feminist therapy or to compare feminist therapists to other therapists but to begin to characterize feminist therapy as it now exists.

Based on the thesis will be a shorter paper which hopefully can serve as a self-education tool for people who want to incorporate aspects of feminist therapy into their own work. I also plan to send it to those I interview as a form of feedback between us and among those women I have contacted.

So that I actually interview as wide and yet representative a range of women as possible, I am developing a "sample frame" of women who identify themselves as feminist therapists and are willing to be interviewed. The questionnaire on the next page asks for the background information I need to select a sample. Unlike the questionnaire, the interview itself will be primarily concerned with your practice and your theory behind that practice. Women and centers who have shared with me their referral lists of therapists have asked for feedback and additional names of and background information on women in their areas. I will be using the information you provide on these questionnaires for that purpose as well.

I really do need your help and cooperation and hope in turn that you will want to share what you are doing. To make what I am doing "research-valid", it is important that I receive replies from each of you. I would also be very interested in receiving anything you may have written about what you are doing. Please return the questionnaire to me in the enclosed envelope by December 18. I appreciate your taking the time to do this.

Sincerely,

Luan Thomas

APPENDIX B. QUESTIONNAIRE

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Several questionnaires are enclosed where I have known of people working together. If there are not enough, numbered pieces of paper will work. If you do respond for a group, please list all names as well as the group name and indicate differences among you where possible. The questionnaire is structured to make it easier to fill out. I would welcome any amplifications or comments in places where you don't feel "fit" by a category.

Name(s):

Address:

Phone(s):

1. Do you consider yourself to be a feminist therapist or counselor? (I have not defined this further, wanting your answer to reflect your own personal standards and criteria)

___yes ___no

2. What is your general theoretical orientation, in addition to your feminism? (check all which apply)

___Adlerian	___gestalt	___TA
___assertive training	___humanistic	___other (please specify)
___behaviorism	___Jungian	
___bienergetics	___primal	
___co-counseling	___psychodynamic	
___eclectic	___Reichian	
___Freudian	___Rogerian	

3. How long have you been doing therapy (total time, whether feminist or not)

4. What degree do you have?

___high school	___Ph.D. in _____	___MSW
___BA/BS in _____	___M.D. (specialty) _____	___other (specify)
___MA/MS in _____	___RN	

5. What is the focus of your practice? (check all which apply)

___children	___women and men both	___psychological testing
___adolescents		___educational and/or
___women	___individuals	___vocational counseling
___lesbian women	___groups	___other (please specify)
___families	___workshops	
___couples	___training	

6. Are you

___in private practice	___member of a collective
___employed by a public agency	___enrolled in school
___member of a college or univ. faculty	___other (please specify) _____

7. Do you specialize in a particular area(s) or problem(s)? ___yes ___no
If yes, what are they?

8. Are you willing to be interviewed? ___yes ___no (if no, please explain briefly)

9. Are there other women you know of in your area who I could contact? if so, please list their names, addresses, and phone numbers.

10. Are there any comments you wish to add?

APPENDIX C

LETTER OF ACKNOWLEDGMENT

2566 N.W. Lovejoy
Portland, Oregon 97210
3 February 1975

I received the questionnaire you returned to me on feminist therapy and really appreciated your taking the time to fill it out. From the questionnaires returned and marked "yes," I chose a total of 20 women to interview. That was real hard to do and I ended up having to be pretty random and arbitrary. So, due to some vagary of fate, your name wasn't one of those that ended up in the "sample." Nonetheless, I felt supported by your willingness to talk with me.

Enclosed is the list I have gathered of those women who identified themselves on the questionnaire as feminist therapists. I tried to include as much of what people said as possible, and hope if you are on the list that you feel represented fairly.

Some of you have indicated an interest in receiving a copy of the shorter paper I'll be writing based on my thesis. I would be glad to share that with you, but for sheer financial constraints. However, if you want to send me 50¢ to cover Xeroxing and postage, I'll be glad to send you a copy when it's ready (probably in June but perhaps over the summer).

Again, thank you for your participation.

Sincerely,

Susan Thorne

APPENDIX D

SCHEMATIC REPRESENTATION OF INTERVIEW FORMAT

TOPIC AREAS	INTERVIEW QUESTION	INTERVIEW PROBES	DESIRED INFORMATION
1) Who are the feminist therapists?	Did you become a feminist first and then a therapist, or a therapist first and then a feminist? (1)	--Major influence(s) in changing (1) --How time is divided now, in percent of a 40-hour week (2)	--Process one goes through in becoming a feminist therapist, and major influences on that process --Relative level of involvement with therapy
2) What is the range of techniques utilized in feminist therapy and what are the new techniques or variations on traditional techniques being developed?	What do you do with your feminism in therapy? (3)	--Example of person seen, incident or interaction in which it "worked" (3) --Example of person seen or situation where it was "hard" to apply feminist therapy (4) --How do you deal with structural issues of time, fees, introductions (position on shopping for a therapist), other first interview issues (contracts)?-- Are those changes feminist? (5) --Specific techniques used frequently/modified/invented as feminist (3)	--Forms which the integration of feminism into therapy takes; behavioral descriptions of feminist therapy; case examples from practice illustrating a feminist therapy approach and/or feminist therapy techniques
3) How do feminist therapists describe their own feminist therapy?	What do you think a person gets from you that she wouldn't get from someone who wasn't a feminist therapist? (6)	--Do you think about power issues? Do you see therapy as a relationship between equals or do you see a power differential? (7) --Do you see what you do as political or apolitical? (8) --Self-disclosure (9) --Answering client questions (9)	--How do feminist therapists see their therapy as differing from what other non-feminist therapists do? As a corollary, what do they consider to be the critical aspects of feminist therapy?
4) What are the theoretical orientations and positions of feminist therapy?	I received this comment on a questionnaire: "I have been trained to believe that good therapy means helping the person develop his or her own potentials and achieve goals chosen by him or her. How does feminist therapy differ from that?" How would you respond to that? (10) I'd like you also to respond to this quote from a paper presented at a conference on women and mental health: "Feminist therapy must include making clear the political connections between a woman's personal life experiences and her socially reinforced sense of powerlessness." (10)	--Does a therapist have a "right" to espouse politics and promulgate values in therapy vs. idea of being "up front" (11) --How much of a feminist does a person have to be to do feminist therapy? (12) --Could a man ever be a feminist therapist? (13) --Can you work with men? (14) --Can a therapist who's straight work with women who are gay? (15)	--Continuum of theoretical orientations (moral, political) re. feminist therapy with indication of perceptions of end points of continuum and their own position; information regarding degree of commonness necessary to work with clients (i.e., men, lesbian women) differing from therapist

5) What are the attitudes of feminist therapists towards feminism and towards therapy?

What questions, issues or struggles, if any, are you going through right now in combining feminism and therapy? (16)

Issues from readings

- Response to the position that professionalism can never be feminist because professionalism carries with it, inherently, so much power and authority? What skills, training and/or professionalism necessary to do feminist therapy? (17)
- Response to the argument: "A woman doesn't need therapy; all she needs is a good consciousness-raising group" (18)
- Do you ask yourself about the limitations of therapy, does therapy work, what's the point of therapy? (19)
- Is therapy only an individual solution? (20)
- Ought women to be worked with in groups rather than individually? (21)
- Problem of wanting to utilize self-disclosure, answering client questions, etc., as a feminist vs. dealing with "is the woman 'ready' for this?" or "am I losing potency by doing this?" (22)
- What framework do you use to do this sorting; which problems are cultural for you? (23)
- What if a woman presents the cultural as personal? (23)
- What if a woman presents the personal as cultural (i.e., "Wooden Legs" with the cultural) (23)

One thing the literature on feminist therapy stresses is the importance of not attributing cultural problems to individual women.

a) Is this distinction meaningful to you?
b) If so, how would you sort this out, and what do you do with the "cultural" in therapy? (23)

How do you see diagnosis? (24)

If you had to say, how would you define feminism? (25)
If you had to say, how would you define feminist therapy? (25)

6) How do feminist therapists define feminism and feminist therapy?

--Current areas of concern or conflict for those doing feminist therapy: positions or issues debated in the literature; areas where feminist ideas may "limit" one's therapy, heighten contradictions, or where the "fit" or meshing is difficult

--Whether cultural/individual sorting of presenting problems is an issue for feminist therapists, if so, how that sorting occurs and how the "political" is dealt with within the context of therapy

--Orientation towards diagnosis, mental health, mental illness and psychoanalysis

--Definitions of feminism and feminist therapy

What was being this interview like for you?

APPENDIX E

BERKELEY FEMINIST THERAPY REFERRAL COLLECTIVE

Sandy: The Therapy Referral Projected started . . . [at the Berkeley Women's Center in] January or February of 1973. . . . There were a few therapists on file that we could refer to that somebody knew and had spoken to. There wasn't any kind of evaluation system. . . . A . . . preliminary questionnaire [was devised and] sent to therapists which on the bottom said, "Do you know any other therapists we could send this to?" That was how we began to get names. . . . Then it began to catch on. Other therapists heard about it and wanted to get on at the referral center because it was a good way to get referrals. . . . Then, that fall, I . . . developed a list of questions that I felt were important to ask, some guidelines for interviewers

Laura: [Now] we have a whole book of forms that have been sent back of therapists we haven't had time to interview. One way that we started to narrow that down was to tell therapists that we were only going to send referrals to them if they accepted some low-fee clients. That eliminated some. . . .

Sandy: The difficulty for us in a lot of ways was we were going through a lot of internal struggles at the center. There's always a changing [volunteer] staff here, . . . so it's real hard to maintain a therapy referral project with people knowing the therapists that they're referring to when [the referral staff] keep coming in and out. It's a pain in the ass to keep calling up the therapist and saying, "We want someone else to interview you now." So we would write up . . . a basic summary of each interview with each therapist that we could have on file, and if somebody had a dissenting opinion, that would be written too. . . . I think in some ways . . . that the onset of the women's movement left a lot of room for women who had already become therapists and were in private or group practice to say, "Well, far out, I'm a woman, therefore I'm a feminist therapist," and kind of exploit the women's movement.

Laura: Also, women frequently in answering the questions and in filling out the questionnaire, try to figure out what answers we want. . . .

Sandy: So partly a sorting thing [again] is financial. . . . The other issue for me is an intuitive sense about a woman and it's real subjective in terms of whether or not I think she's a feminist in certain ways. [Yet] the range of women coming in here wanting therapists is so great that I can't always say, "No, you can't be in our files because we would never find anybody who would match up to you." Somebody who I might think

is not feminist somebody else might think is feminist. It's terribly complicated. There have been some cases of women where I just wouldn't trust their therapy at all, in terms of them not having any political reality, any sense of the struggle that women go through and any willingness to share their own struggles with another woman. . . .

Laura: [If a woman wants a referral] generally, we don't refer over the phone; we ask her to come in. We were doing them Thursday nights from 7 to 9 and we extended them. At one time it started out with a rap, and that petered out; we'd like to get it going again. We'd like to try out having women come and talk to each other for an hour and then do individual referrals . . . [which vary] from 10 minutes to half an hour. I think we all do [the referring] really differently, too. But the similarities are mostly that we try to get some sense of where the woman's coming from, what she's looking for, what she expects, and how much money she can pay. . . . Sometimes women come in and really want to talk, right then. And sometimes women come in and say, "I want this kind of therapist. This is how much I can pay." Usually it's somewhere inbetween Usually it comes down to [me referring to] the people that I have had some kind of personal contact with. . . . Like, Sandy might refer to the therapists that she knows best, and I would refer to the ones I know 'cause those are the ones that I feel most comfortable with. Ideally, you all would know them all more.

Sandy: I feel comfortable making a referral to somebody I haven't met if someone else in my group has met them. What I usually do is tell the woman, "I haven't met this person. I've heard this and this and this about her. If you feel uncomfortable with that and want to know more, then I can get you in touch with the person who interviewed her." There are some therapists in the file who have been interviewed by women who were at the Center and are no longer at the Center. We haven't done a re-interview of them. We try to make three referrals, encourage the woman to shop around for a therapist, [tell her] that she's not nuts if she doesn't like a therapist--she should trust herself.

Laura: I've had a lot of experiences too where women really are afraid to do that, and you really have to encourage them. They say, "What do I do after I go to one interview? Is it OK to then . . . ?" They don't believe it's OK [to shop around].

Sandy: It's such a woman's thing to say, "I'll hurt her feelings too much if I tell her I don't want to [be in therapy with her]," so I make it a point of saying, "Everybody on our files knows that it's a Women's Center policy [to encourage shopping] and have agreed to it. You tell her you were referred by the Women's Center and that you're shopping."

Laura: This gets said a lot: "I feel like I can talk rings around a therapist. I want someone who won't let me do that." Or, "I want someone who won't push me too much." Those are the kinds of things that give you a sense [of who to refer to]. . . . Also sometimes women have really strong feeling about age . . . [or] credentials. . . . That doesn't happen a lot but if someone says that I talk about [it].

Sandy: Also trying to get a sense . . . if they [really] need to be in therapy. For the most part, somebody who comes in here and says she wants to be in therapy, . . . I generally say OK. But a couple of weeks ago, for example, there was a woman who came and she didn't know what she wanted. She knew she wasn't feeling very much support in her job. She was feeling bad about herself; but it wasn't like she was going through some traumatic crisis in her life. . . . I really pushed her to be in a support group with other women and then if she felt she wanted to work individually with somebody or be in a more intensive therapy group, then she should come back and she shouldn't feel hesitant about that. . . . One of the things that we're trying to do here is show women that there are alternatives to being in therapy, that to get support from other women around certain issues and to get strength from other women is a real viable healthy alternative to being in therapy.

Laura: I refer a lot of women, if they are going on to individual therapy, to be in a consciousness-raising group as well. That's important to me to offer that as an alternative. . . . We also have a feedback form we use, for after the client has been to the therapist. We haven't had a lot of success in getting those back. . . . When I don't get the form back, I always kind of assume that it didn't work out.

Sandy: I don't assume that. The forms that we send out are kind of laborious to fill out . . . [but still,] we don't have any way of checking up other than a phone call, and that was an issue we dealt with for a while because we didn't know if it was a breach of confidentiality, or intruding on somebody's ability to choose [to call them] . . . [but] not getting anything back, we don't know how good the people are that we refer to . . . from a client standpoint and how many people are really making use of what we do.

On the following page is a copy of the hand-out they give women who come in for therapy referral.

On Choosing a Therapist: The Berkeley Feminist Therapy Referral Collective

Choosing a therapist is a personal process. As women, we have been trained to make the assumption that "the therapist knows best" without paying attention to our own needs and feelings. This is one way that we give away our power.

It has often been our experience that women seeking therapy enter the first meeting feeling that they are "sick" or "crazy" and therefore have no grounds on which to be discriminating or critical in sizing up the situation.

We have put together some guidelines intended to help you stay in touch with your own strength when determining whether a therapist is someone you want to work with. The main thing to keep in mind is to trust your feelings and reactions, and that "shopping around" for a therapist is O.K.

Things to Be Aware Of:

1. How am I feeling with the atmosphere? i.e., our introductions, the room. Am I comfortable, uncomfortable, anxious, excited?
2. What are my first impressions of the therapist? Am I feeling comfortable enough to ask questions of concern to me?
3. Do I have the space to direct the conversation if I want to?
4. How do I feel when the therapist chooses not to answer a question? (Be aware of the questions she's not answering.)
5. Has the therapist heard what my needs are?
6. What would I feel uncomfortable talking to this woman about? What things would I be afraid to tell? How would I be afraid to behave?
7. How much is the therapist telling me about me?

Questions you might want to ask:

1. What's your philosophical background, therapy orientation, training?
2. What can I--what can't I--expect from therapy, from you?
3. Money: are fees negotiable? etc.
4. Time contracts: Example: let's meet for 3 months and then re-evaluate how we're feeling. Do you feel open to evaluation?
5. Availability: Would you be available to me at other than regular appointment times? As in a crisis?
6. How do you feel about sharing your personal experiences with me?
7. How do you feel about homosexuality, heterosexuality, single mothers, etc.
8. Types of therapy available: Do you offer individual, groups, family, couple, etc.?