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I am submitting herewith a dissertation written by Kayce Meginnis-Payne entitled "Feminist Identification & Feminist Therapy Behavior: What Do Feminist Therapists Do With Their Clients?" I have examined the final copy of this dissertation for form and content and recommend that it be accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy, with a major in Psychology.

Cheryl B. Travis, Major Professor

We have read this dissertation
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Accepted for the Council:

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Associate Vice Chancellor and
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FEMINIST IDENTIFICATION AND FEMINIST THERAPY BEHAVIOR: WHAT DO FEMINIST THERAPISTS DO WITH THEIR CLIENTS?

A Dissertation
Presented for the
Doctor of Philosophy
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Kayce Lane Meginnis-Payne
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DEDICATION

This dissertation is dedicated to the girls and women who have the courage to live feminism, everyday, in the smallest of ways.

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I would like to thank my Mom, Dr. Sharon Meginnis, who was my first feminist teacher, and my twin sisters Carson and Lauren Osberg, whose energy and vitality keep me on my toes.

Finally, I would like to thank my husband, John, for the joy and stability he brings to my life. His laughter and love are the most precious of gifts.

ABSTRACT

The theoretical principles of feminist therapy are well documented. Less is known, however, about the ways in which therapists enact these principles in clinical practice. This study explored the impact of feminist identification on the self-reported use of feminist therapy behaviors. Therapy behaviors most commonly utilized by feminist therapists were measured, and their relationship to guiding notions about therapy explored.

Data were collected from 84 therapists. Participants completed a survey that assessed Global Feminist Identification (GFI), feminist therapy practices via a memorable case description, and responses to a feminist therapy behavior checklist (FBC). Additionally, 9 of the 84 therapists participated in a semi-structured interview.

Analyses of variance indicated that GFI was a significant predictor of the FBC total score and three of five subscale scores: analyzing sex-roles, encouraging a redistribution of power, and minimizing hierarchy in the therapist-client relationship. Data from the semi-structured interviews suggested that feminist therapists conceptualized the objectives of feminist therapy as: validating and legitimizing women's realities in order to help women clients take action; emphasizing the impact of marginalization in order to challenge traditional conceptualizations of pathology; and empowering clients through egalitarianism in the client-therapist relationship. Memorable case

descriptions indicated that only 2 of 16 feminist therapy tenets were regularly incorporated by feminist therapists, including: expanding girls and women's alternatives, options, and choices, and focusing on the cultural, social, political, economic, and historical factors of women's lives. Most feminist therapist were not social activists, nor did they promote social activism among their clients. Few feminist therapists highlighted the importance of attending to issues of diversity, challenging their own biases, or self-disclosing to clients.

In order to support its claims of providing a unique service, feminist therapy must be more than "well-intentioned therapy with women." Therapy must be conducted with the purpose of trying to improve the status of women, and therapists must define themselves publicly as feminist. The need for research that identifies how feminist therapists understand their behaviors to be feminist, and how clients' goals for therapy are transformed as a consequence, is identified.

PREFACE

My exposure to feminism occurred early. During the feminist movement of the 1970s, I witnessed my mother's professional and personal transformation when, with extraordinary talent and effort, she pursued an advanced degree and went from being a secretary to being a licensed psychologist with her own private practice. My mother wore pant suits and played Helen Ready records and, although it was not easy for me to be one of the few girls who got trucks and 10-speeds instead of Barbie™ dolls at Christmas, I grew to admire her adventurous and independent spirit.

My mother raised me to believe that I could do anything that boys could do, but her teachings did not prepare me for society's ambivalence and even rejection of these ideals. Throughout my life I have been surprised at the hesitation, misinformation, and even anger that feminist-based ideology can provoke. Indeed, these experiences have taught me how deeply entrenched traditional conceptualizations of gender and power remain.

My undergraduate education was my first opportunity to learn systematically about the ways in which women's experiences are uniquely shaped by a patriarchal culture. My interests were ~~peaked~~ piqued and, from there, I earned a certificate in women's studies, worked at Planned Parenthood, and went on to study clinical psychology with an emphasis in women's health.

My biases toward the usefulness of feminist analysis in psychotherapy are evident. The goals for the current project emanated from my own desire to learn how to better integrate the traditional clinical training that I received in graduate school, with what I believe are critically important principles of feminism. This task of integration is one that--I have learned--proves challenging for other therapists as well.

This project is political; it strives to change the way therapists think about their work, and the way instructors and supervisors educate their students. It is my hope that with this and future studies, the principles and practices of feminist therapy will not only become more clearly defined, but will also become more widely incorporated into traditional training programs and into psychotherapy practice in general.

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CHAPTER 1

INTRODUCTION AND REVIEW OF THE LITERATURE

The theoretical principles of feminist therapy are well documented. Less is known, however, about the ways in which therapists enact these principles in clinical practice. Throughout the past thirty years, psychology's attention to the topic of feminist therapy has been geared toward first, distinguishing it from mainstream therapy, and second, defining its theoretical parameters (Enns, 1993). Feminist therapy could not have originated without these early steps, and they remain foundational for research, theory development, and clinical practice today. If feminist therapy is to gain increasing legitimacy in a field inundated with hundreds of competing approaches to treatment, however, additional steps are needed. Empirical investigations are necessary to refine technique, improve and expand service delivery, and address questions about efficacy and outcome.

Only a handful of empirical studies on the practice of feminist therapy currently exist. These studies are examined later in the review. First, out of homage to the women who constructed this entity called feminist therapy, and in the interest of creating a knowledge-base for understanding the implications of the current study, the origins of feminist therapy and the theoretical principles behind its practice are reviewed.

Origins of Feminist Therapy

Feminist approaches to psychotherapy originated in the 1970s in response to an increasing awareness that traditional therapy practices can be harmful to women. Empirical evidence suggested that standards of health in psychotherapy were based on male norms and rendered women inherently pathological (Broverman, Broverman, Clarkson, Rosenkrantz & Vogel, 1970). A review by the American Psychological Association Task Force on Sex Bias and Sex Role Stereotyping (1975) generated guidelines for therapy in an effort to reduce common therapist behaviors that were detrimental to women, including: 1) fostering traditional sex roles, 2) devaluing women, 3) using psychoanalytic concepts in sexist ways, and 4) promoting the sexual objectification of women.

Despite increasing attention to gender issues, modern-day psychotherapy is at risk for pathologizing women just for being female. The Diagnostic and Statistical Manual (American Psychiatric Association, 1994), which serves as the life-blood of diagnosis, treatment planning, and third-party reimbursement for therapists, has been charged repeatedly with gender-bias (Garb, 1997; Kupers, Ross, Frances & Widiger, 1997; Sprock & Yoder, 1997; Widiger, 1998; Zoccolillo, 1993). Women are prescribed psychotropic medication at twice the rate of men and are generally considered to be "overmedicated" as a group (Skodra, 1989; Ashton, 1991). In family therapy, therapists are more likely to pathologize mothers and idealize fathers (Avis, 1987; McCollum & Russell, 1992).

Gender-bias in psychotherapy process has also been established. For example, therapists interrupt female clients three times more than than they interrupt male clients (Werner-Wilson, Price, Simmerman, & Murphy, 1997). More seriously, women are at greater risk than men to being sexualized and harassed when seeking mental health care. Although the actual numbers are unclear, estimates indicate that between 7% and 15% of male psychotherapists engage in sexual contact with their female patients (Solursh, Solursh, & Williams, 1993). Additionally, approximately 90% of the sexual misconduct that has been formally reported to the Ethics Committee of the American Psychological Association occurred with male therapists and female clients (American Psychological Association, 1995, 1996; Gilbert, 1999).

In addition to being concerned with gender-bias, feminists are concerned about the harmful consequences of conducting therapy within a medical model. Although this model can be problematic for all clients, it can be especially problematic for women. As Morris (1997) states:

> ...we are still faced with a deterministic and hegemonic mental health system which names and medicalizes psychological distress...[This] is particularly problematic for feminist theorists and therapists who view women's psychological problems as always in some way related to the politics of gender inequality...[The medicalized approach results] in the pathologizing and privatizing of women's psychic pain and of our resistance to oppressive practices (p. 66).

Thus, mainstream psychotherapy, as an outgrowth of the culture itself, may inadvertently sustain the patriarchal system. Feminists have worked to transform psychotherapy

practices such that they promote health, empowerment, and social change for all.

Feminist Therapy: The Basics

Feminist therapy seeks to empower girls, women, and other marginalized groups by targeting the social, political, and economic factors that contribute to individual suffering. While the immediate goal of feminist therapy is to help clients moderate the effects of oppression, the long-term goal is to eliminate the oppression itself (Dambrot & Reep, 1993). According to Lerner (1987), without changing the "rules, expectations, and structures of...culture," individuals and families cannot become more healthy (p. 51-52). In her ground breaking book, Subversive Dialogues, Laura Brown (1994b) defines feminist therapy as:

> ...[T]he practice of therapy informed by feminist political philosophy and analysis, grounded in multicultural feminist scholarship on the psychology of women and gender, which leads both therapist and client toward strategies and solutions advancing feminist resistance, transformation, and social change in daily personal life, and in relationships with the social, emotional, and political environment. What makes practice feminist is not who the clients are but how the therapist thinks about what she does... (p.22, italics removed).

Feminist therapy, like all therapy, is political: it encompasses an overarching framework and agenda for "how the world should be" (Ault-Riche, 1987; Avis, 1987; Hill, 1992). Ideally, this "world" is a place where all people can develop personal power without diminishing the power of others (Wolfe, 1995, p. 167). Although the principles of feminist

therapy are focused primarily on the effects of patriarchy, they are thought to be useful with the problems presented by any person or system that is negatively affected by oppression, including men, couples, and families (Brown, 1994b). Therapy is feminist to the degree that it challenges oppression and inspires changes that empower women and other marginalized groups. For instance, men who deviate from normative standards (e.g. men who are ethnic minorities, gay, poor, or obese) can benefit from the tools that feminist therapy offers.

Approaches to feminist therapy are varied and complex. In fact, subcategories of feminist therapy--such as liberal feminist therapy and radical feminist therapy--have been constructed (for an excellent review of the variations in feminist therapy, see Enns, 1997). Despite their differences, feminist therapies incorporate core elements that define their practice.

Worell and Remer (1992) propose three common elements of feminist therapy practice, including: (1) consciousness-raising that emphasizes the influences of social and political structure; (2) egalitarian client-therapist relationships in which power differentials are minimized; and (3) the validation of women and their perspectives. Brown (1994b) proposes three similar elements of feminist therapy practice that include: (1) recognizing that individual experience occurs in a specific context (i.e. "the personal is political"); (2) utilizing gender and power as categories of analysis to understand human experience; and (3) valuing

the diversity of women's experiences. Enns (1997) proposes six common elements of feminist therapy practice, including: (1) understanding "the personal is political"; (2) viewing "symptoms" as coping strategies for survival; (3) incorporating therapist self-disclosure and self-examination in the process of therapy; (4) viewing clients as competent; (5) fostering an egalitarian client-therapist relationship; and, (6) promoting client's rights within therapy via informed consent and the clear articulation of goals.

The most detailed set of feminist therapy principles was developed by participants of the first National Conference on Education and Training in Feminist Practice in 1993 (Wyche & Rice, 1997). Participants of the conference were doctoral level psychologists who, "through dialogue, dissent and [total group] consensus" systematically generated 16 core tenets of feminist therapy (Worell & Johnson, 1997, p. xiii). These tenets promote therapy behaviors such as: analyzing context, analyzing power, recognizing that misogyny and violence against women are damaging, emphasizing clients' strengths, creating egalitarian and collaborative client-therapist relationships, and empowering girls and women to recognize and claim their individual and collective power (see Appendix A).

By synthesizing the proposed elements of feminist therapy and syphoning them through a feminist therapy ethics framework (Feminist Therapy Institute, 1987; see Appendix B), the core elements of feminist therapy emerge. These elements have not only assumed a primary place within the feminist

therapy literature, but are also consistent with contemporary feminist political philosophy (Brabeck & Brown, 1997; Marecek & Hare-Mustin, 1991). The core elements of feminist therapy practice include: (1) analyzing context, (2) acknowledging issues of diversity, (3) exploring power dynamics, (4) using social constructionist evaluations, and (5) working within a feminist ethics framework. Each core element is reviewed.

Analyzing Context

A contextual analysis identifies the ways in which social, educational, occupational, economic and political factors affect individual experience. Investigating cultural context and its impact on the individual and collective lives of women is a central component of the feminist therapy process (Boyd, 1990; Chrisler & Ghiz, 1993; Comas-Diaz, 1987; Dambrot & Reep, 1993; Enns, 1987, 1988, 1997; Goldner, 1991; Grumet, 1988; Haffey & Cohen, 1992; Hertzberg, 1990; Hill & Ballou, 1998; Johnson, 1994; Kissman, 1991; Laidlaw & Malmo, 1991; Lebowitz, 1993; Margolies, 1990; Morrow & Hawxhurst, 1998; Mowbray, 1995; New, 1993; Price, 1988; Prozan, 1987; Pugliesi, 1992; Rothblum, Berman, Coffey, Shantinath & Solomon 1993; Sands & Howard-Hamilton, 1995; Sieber & Cairns, 1991; Simola, 1992; Skodra, 1989; Srebnick & Saltzberg, 1994; Terry, 1992a; Tiefer, 1988; Whipple, 1996; Wolfe, 1995; Worell & Remer, 1992). As Enns (1997) describes:

> The personal is political reflects the belief that the personal problems women encounter are connected to the political and social climate in which they live. These problems are influenced by and reflected in the external realities of men's and women's lives. Many feminist counselors prefer to use the phrase problems in living rather that the

> term pathology in order to convey the feminist view that counseling issues are inextricably connected to the social, political, economic, and institutional factors that shape personal choices (p. 8-9).

Although mainstream psychotherapy acknowledges the influence of culture on interpersonal and relational development, feminist therapy considers cultural relativism--i.e. the recognition that all aspects of a person's life are influenced by culture--the primary factor in case conceptualization and the development of treatment goals (Hardy, 1993). This perspective is important not only when working with problems related to gender, but also when working with problems related to race, class, or sexual orientation.

Feminist therapists utilize contextual analyses to assist clients in determining which problems are a result of personal factors and which problems are the result of oppression (Wyche & Rice, 1997). Contextual analyses explore the effects of socialization and cultural expectation with regard to narrow definitions of what constitutes "success," "attractiveness," or "sexiness." Contextual analyses highlight the way society affords certain opportunities to the privileged and denies opportunities to the oppressed, and explores the impact these practices have on "individual" experience. Ultimately, contextual analyses enable therapists to conceptualize client behaviors as understandable reactions to the environment rather than as individual "pathology."

A feminist contextual analysis is particularly attuned to the effects of patriarchy. Feminist therapists work to understand the ways patriarchy plays a role in poverty, role-overload, sexual harassment, rape, violence, single-parenting, stress in relationships, limited educational opportunities, unemployment, and unequal pay (Rothblum et al., 1993). A patriarchal society not only promotes bias and discrimination against women, but also promotes "misogyny-training" and "false-self training" (Pipher, 1994). Within these experiences, women learn to evaluate themselves through the eyes of their oppressors and loathe themselves for failing to meet the unrealistic and destructive standards set by the culture. This self-hatred has been conceptualized as an internalization of the misogynistic culture (Pipher, 1994).

In addition to investigating current cultural context, feminist therapists also rely upon historical contexts to give meaning to clients' behaviors and experiences. For example, feminist therapists acknowledge the fact that history has rendered women invisible, perpetuated a fear of violence, and attributed women's lack of power, money, and status to hormonal "weaknesses" (Price, 1988). With this historical perspective, current-day problems such as teen pregnancy are not viewed as "individual" problems of irresponsibility, but are viewed as understandable consequences of living in a society that has historically promoted the display of sexuality, objectified women as sex-objects, overvalued the importance of motherhood in women's

identities, and limited reproductive choices and possibilities.

Acknowledging Issues of Diversity

Feminist therapists recognize that North American culture tends to punish those who do not embody normative standards, including people of color and people of non-European descent, as well as people who are poor, older, obese, and physically disabled. Despite its primary focus on women and the effects of patriarchy, feminist therapy maintains an all-encompassing, "anti-oppression" stance (Brown, 1994b). Feminist therapy is not only committed to eradicating the oppression of women, but all marginalized groups.

Thus, feminist therapy is pluralistic and inclusive (Barrett, 1990; Brown, 1991a; Boyd, 1990; Comas-Diaz, 1987; Hill, 1990; McNair, 1992; Rosewater, 1990). As such, feminist therapy does not automatically assume that gender is the primary category of oppression (Brown, 1990, 1991a, 1994b; Comas-Diaz, 1987; McNair, 1992; Prilleltensky, 1996). Feminist therapists cannot even assume that gender is a common ground of experience without first examining how cultural, economic, educational and other factors have mediated clients' experiences of being male or female (Skodra, 1992).

Despite the fact that feminist therapy emerged from the experiences of Caucasian, middle-class women (Rosewater, 1990), feminist therapy now assumes a multicultural stance. Now, one must assume that, "...feminist comes attached to

other descriptive words, like black and white, as well as lesbian and heterosexual" (Barrett, 1990, p. 51). Thus, because it emphasizes multiple sources of oppression, feminist therapy is a viable approach to the issues presented by ethnic minority clients (Berman, 1989; Comas-Diaz, 1987; McNair, 1992; Sieber & Cairns, 1991), immigrant clients (Sieber & Cairns, 1991; Skodra, 1989, 1992), working-class clients (Chalifoux, 1996; Palmer, 1996), clients with disabilities (Prilleltensky, 1996), clients of physical distinction (Solomon, 1993), Jewish clients (Schlesinger, 1991), and gay and lesbian clients (Enns, 1993).

Analyzing Power Dynamics

Feminist therapy promotes an on-going analysis of power both within and outside of therapy. Therapists help clients explore the power dynamics within their families and the larger social environment (Barrett, Trepper & Fish, 1990; Comas-Diaz, 1987; Enns, 1988; Goldner, 1991; Grumet, 1988; Gutsche & Murray, 1991; Hertzberg, 1990; Hill, 1992; Lerman, 1994; Lerner, 1987; Rothblum et al., 1993; Terry, 1992b; Worell & Remer, 1992). Power analysis is based on the theory that a person's behavior is shaped by the degree to which he or she has, or is denied, access to power. Differential power can cause people to behave differently, ultimately influencing their decisions about relationships, education, leisure, career, and family.

Those who are disempowered are often labeled in pejorative ways (e.g. "nags," "co-dependent," "passive-aggressive," "borderline") that disguise external sources of

disempowerment and oppression. Power analyses enable clients to understand that at least a portion of their individual distress occurs as a reaction to being disempowered. Power analyses assist clients in recognizing that their experiences are not solely a product of their individual goals, perspectives, and abilities, but emerge from the larger socio-political context, and the way that context impacts people of a similar gender, race, age, etc. Thus, the consequences of disempowerment within the context of intimate relationships and families, but especially within social groups, institutions, and cultures, is regularly examined.

One form of power analysis is sex-role analysis (Ault-Riche, 1987; Avis, 1987; Bograd, 1987; Chaney & Piercy, 1988; Good, Gilbert, & Scher, 1990; Hardy, 1993; Rabin, 1989; Sands & Howard-Hamilton, 1995; Terry, 1992b; Wolfe, 1995). Sex-role analysis educates clients about the inequality of status and power between the sexes and reframes clients' definitions of problems to include the impact of cultural expectation and socialization (Chaney & Piercy, 1988; Gutsche & Murray, 1991). Sex-role analysis is merely one form of power analysis designed to target the effects of sex-based oppression. Power analyses are also used to target oppression based on race, ethnicity, sexual orientation, age, size, and ability.

In addition to exploring power dynamics in the client's relationships outside of therapy, feminist therapists apply power analyses to the context of therapy itself (Berliner, 1992; Brown, 1991b, 1994b; Bograd, 1987; Dambrot & Reep,

1993; Enns, 1988; Hardy, 1993; Johnson, 1994; Laidlaw & Malmo, 1991; Lebowitz, 1993; Lerman, 1994; Margolies, 1990; Mowbray, 1995; Pugliesi, 1992; Sands & Howard-Hamilton, 1995; Simola, 1992; Skodra, 1989; Soloman, 1993; Worell & Remer, 1992). In general, feminist therapists are attentive to the implications of their position of authority and strive to create egalitarian relationships with their clients. Egalitarian relationships require therapists to work to equalize power by attending vigilantly to the therapeutic process, emphasizing not only the outcomes of goals and decisions, but the ways in which those goals and decisions are made (Brown, 1991b; Lerman, 1994).

Egalitarian relationships enable clients to practice identifying and voicing their own perspectives. When clients are encouraged to challenge their therapists (e.g. "What you are saying does not fit with my experience"), they develop an important skill that is transferable to relationships outside the therapy room. Egalitarian relationships enable clients to learn that meanings are negotiated between people and that there is not one "set reality." With this knowledge, clients recognize that all assumptions can be challenged.

Feminist therapists create egalitarian relationships by asking clients for feedback, negotiating how decisions about fees and number of sessions will be made, and disclosing information about what led to the use of certain techniques. Power differentials are reduced when therapists attempt to demystify the therapy process by carefully reviewing informed consent, identifying the pros and cons of therapy, and

teaching clients tools for evaluating their own progress (Brown, 1994b; Chaney & Piercy, 1988; Enns, 1997; Worell & Remer, 1992). Power differentials are also reduced when therapists use first names for both clients and themselves (Dambrot & Reep, 1993; Laidlaw & Malmo, 1991), welcome client inquiries about their values and methods (Laidlaw & Malmo, 1991), avoid pathologizing clients with the use of diagnostic labels (Brown, 1990; Enns, 1993; Mowbray, 1995; Dambrot & Reep, 1993; Laidlaw & Malmo, 1991), and self-disclose when doing so is in the best interest of the client (Brown, 1991b, 1994a, 1994b). Feminist therapists assume a collaborative role when, at the request of outside agencies and insurance companies, they complete reports and paperwork together with their clients (Sheinberg, 1992).

The ultimate goal of power analyses, both in the client's life and in the client-therapist relationship, is to empower clients (Berliner, 1992; Haffey & Cohen, 1992; Guthrie, 1995; Gutsche & Murray, 1991; Hardy, 1993; Lerman, 1994; Terry, 1992b; Wyche & Rice, 1997). Empowerment is not a unique therapeutic goal: psychodynamic therapy attempts to free clients from the effects of unconscious defenses, while cognitive-behavioral therapy attempts to free clients from their "irrational" thoughts and behaviors. Feminist therapy, however, attempts to free clients, as well as <u>all</u> marginalized people, from the effects of chronic oppression.

Feminist therapy empowers clients <u>individually</u> by helping them to trust themselves, to value their own perspectives, and to identify their strengths. Feminist

therapy encourages clients to develop egalitarian relationships, social support networks (Chaney & Piercy, 1988; Chrisler & Ghiz, 1993; Sands & Howard-Hamilton, 1995; Solomon, 1993), skills (Chaney & Piercy, 1988; Laidlaw & Malmo, 1991), self-care (Laidlaw & Malmo, 1991; Hirschmann & Munter, 1995), and self-acceptance (Hirschmann & Munter, 1995). Feminist therapists recommend clients pursue goals that focus on educational achievement, professional advancement, and physical strength. Feminist martial arts, for example, teaches women self-defense skills at the very same time it teaches them that they are entitled to defend themselves (Guthrie, 1995).

Feminist therapy recognizes that empowerment emerges in context and in relation to others, and therefore also attempts to empower clients collectively. Thus, feminist therapy encourages clients to participate in consciousness-raising groups or group therapy to instill a collective sense of struggle and meaning, reduce isolation, and build support networks (Avis, 1987; Berliner, 1992; Laidlaw & Malmo, 1991; Rosewater, 1990). Feminist therapy emphasizes clients' participation in social activism since it affirms the idea that distress does not occur from within the individual alone, but from the interaction between the individual and his or her context. Social activism enables people to fight oppression on behalf of the group to which they belong, while at the same time advocating for themselves. Social activism can take many forms, and the clinical appropriateness of each form varies from client to client. Examples of social

activism include: (1) involving oneself with community agencies such as women's centers, rape crisis centers, and Big Brother/Big Sister programs; (2) educating relevant groups such as parents, teachers, school administrators and law enforcement personnel on the status of women and other marginalized groups; and (3) working to impact legislation, funding and public policy through financial contributions and political lobbying (Worell & Remer, 1992).

Attending to power dynamics within the client-therapist relationship ultimately enables therapists to honor clients' perspectives. Although feminist therapists possess knowledge and expertise regarding psychotherapy, clients--more than anyone else--have the clearest understanding of their own lives (Brown, 1994b; Dambrot & Reep, 1993; Enns, 1997). Clients have survived and coped with their difficulties long before seeking the assistance of a therapist. Thus, feminist therapists work within a paradox. They work within an established framework of a priori assumptions regarding the centrality of oppression, and at the same time strive to view clients as the experts on their lives. By utilizing the principles of power analysis, feminist therapists are able to work successfully within this paradox, offering their own perspectives while at the same time valuing the perspectives of their clients.

Using Social Constructionist Evaluations

Feminist therapy promotes the use of social constructionist evaluations to challenge normative standards and taken-for-granted assumptions. Social constructionism

suggests that reality is not an "objective" phenomenon, but is created through language (Hardy, 1993; Terry, 1992a). From a social constructionist perspective, there is no single "truth"--meaning is relative and determined by context. Social constructionism highlights that the dominant perspective of reality is often viewed as appropriate, valid, and universal. This privileging of a particular reality ultimately benefits and sustains those people and institutions already in power.

Feminist therapists apply social constructionist principles to commonly used psychological terms. Conventional terms can overlook the influences of social expectation and minimize the role of context in determining individual experience (Bograd, 1987). For example, the terms "enmeshed" and "fused" are labels that tend to punish women for adhering to socially expected behavior and divert attention from the familial and cultural influences on relationships (Bograd, 1987). Thus, although a woman may engage in behavior that is unhealthy both for her and her family, feminist therapists recognize that labeling her as "enmeshed" locates the problems in the individual rather than in the family context and cultural context as a whole. When they can, feminist therapists avoid the use of terms that pathologize individual clients and fail to acknowledge the transactional nature of relationships and larger social contexts.

Feminist therapists apply social constructionist principles to challenge traditional conceptualizations of

"healthy" and "unhealthy." Dominant and privileged perspectives tend to define behavior that challenges the status-quo, such as expressing anger or being assertive, as "unhealthy." By similar standards, behavior that maintains the status-quo, such as overcompliance and passivity, is considered "healthy." Social constructionist evaluations enable therapists to create functional meanings of "health" collaboratively with their clients.

For example, traditional conceptualizations of "healthy families" are based exclusively on those families that include men (Rice, 1994); this, despite the fact that single-parent families led primarily by mothers now comprise over 25% of all families (Kissman, 1991). Parenting is traditionally considered inadequate without the participation of fathers; this, despite recent findings that neither mothers nor fathers are "essential" for childrearing (Silverstein & Auerbach, 1999). Divorce and its impact are often considered "socially alarming" for women, despite the fact that, post-divorce, women report greater happiness, self-esteem, adjustment, and satisfaction than men (reviewed by Rice, 1994).

Social constructionist evaluations are useful for reframing the traditional framework of therapy. For instance, mainstream therapy is regularly used to promote weight-loss in women. Using therapy for this purpose, however, not only condones oppressive beauty standards for women, but may be unethical due to high rates of failure and the fact that weight-loss has not proven to have clear health

benefits (Chrisler, 1989, 1993). Thus, rather than reinforcing normative and unhealthy weight-loss practices that tend to benefit the diet industry alone, feminist therapists can help clients develop their intellectual strengths, engage in self-care, become more assertive, sustain physical fitness, and become cultural activists (Chrisler, 1993).

Social constructionist perspectives enable clients and therapists to normalize, as opposed to pathologize behavior. Although traditional therapy assumes certain behaviors are inherently problematic (Skodra, 1989), feminist therapy seeks to understand behavior as a reasonable reaction to contextual factors (Grumet, 1988; Sheinberg, 1992). For example, when people are dismissed, ignored, and trivialized over time, reactions characteristic of depression may occur. Social constructionist evaluations enable therapists and clients to conceptualize the source of the depression as "the problem," rather than the depressive symptoms themselves. Feminist therapy may, in fact, view this "depressed" behavior as a signal of healthy resistance to a pathological environment.

Diagnosis is one of the areas most challenged by social constructionist reformulations. The Diagnostic and Statistical Manual (American Psychiatric Association, 1994) seeks to classify mental disorders based on a presentation of symptoms. These symptoms are often categorized as representations of "mental illness" regardless of their origin (e.g. regardless of the fact that they may be a natural response to discrimination, disempowerment, or

oppression). Over the past twenty years, feminist therapists have debated the utility of diagnostic labels. Thus far, feminist therapists are undecided about whether it is possible to create diagnostic labels that do not inherently pathologize the behavior of the oppressed (see review by Enns, 1993; Brown, 1994b).

It is important to note that social constructionist evaluations are used by feminist therapists in a paradoxical way. On the one hand, feminist therapists rely on social constructionist evaluations to challenge the arbitrary and capricious nature of the status quo (e.g. Who says "success" must be defined this way?). On the other hand, feminist therapists maintain a bottom-line standard that some perspectives <u>are</u> indeed better than others. Thus, although meaning is constructed, it is never value free. In order to evaluate social constructions of meaning, feminist therapists must continuously investigate the question, "Who benefits?"

<u>Working Within a Feminist Ethics Framework</u>

Feminist therapy promotes a strict adherence to feminist ethics. In fact, Brown (1991b) suggests that the process of feminist therapy is indistinguishable from feminist ethics as they both hold context central, acknowledge diversity and multiple experience, analyze power dynamics, and ultimately empower clients in a collaborative and client-centered way. Feminist ethics are the foundation upon which feminist therapy's goals of empowerment and social change are based.

Ethical guidelines for feminist therapy practice were first developed by the Feminist Therapy Institute (1987; see

Appendix B). These guidelines address five areas: (1) cultural diversities and oppressions, (2) power differentials, (3) overlapping relationships, (4) therapist accountability, and (5) social change. Some aspects of feminist ethics have already been examined in this review. It is worthwhile, however, to explore each area independently and contrast them with the conventional code of ethics established by the American Psychological Association (APA: 1992).

Cultural Diversities and Oppressions. The Feminist Therapy code states that therapists should attempt to provide services to a wide range of clients and develop flexibility around the delivery of services. Therapists should evaluate their behavior for evidence of stereotypes, misinformation, bias, and discrimination (Boyd, 1990; Chrisler, 1993; Solomon, 1993), and investigate the potential impact of this behavior on the therapy process. Feminist therapists must examine inconsistencies between their ideology and their practices (Enns, 1993). For example, therapists must examine their own beauty standards and investigate whether they have internalized "fat oppression" (Chrisler, 1989).

The traditional APA code of ethics states that psychologists should obtain "training, experience, supervision, and consultation" with regard to "human differences" such as gender, race, etc. The APA code also states that psychologists must avoid "unfair discrimination." It does not reference, however, the importance of therapist accessibility or flexibility with regard to services, nor

does it specify the need for on-going self-evaluation with regard to the inevitable biases that therapists have.

Power Differentials. The Feminist Therapy code states that in addition to attending to the power dynamics in the client-therapist relationship, therapists must avoid usurping clients' power and model the effective use of personal power. Therapists should work to create egalitarian relationships by self-disclosing, negotiating formal and informal contact with clients, and educating clients regarding their rights as "consumers of therapy."

The APA code states that psychologists should "avoid harm" and avoid "exploitive relationships." It also states that psychologists should discuss with clients informed consent and the anticipated course of therapy. The APA code makes no mention of therapist self-disclosure, however, and does not comment on the process by which therapists can avoid harm and exploitation (e.g. monitoring the power dynamics of the client-therapist relationship).

Overlapping Relationships. Both the Feminist Therapy code and the APA code state that therapists must assume personal responsibility for monitoring multiple or overlapping relationships. They also state that issues of client confidentiality are imperative, and that therapists should avoid sexual intimacies with current or former clients. The APA code concedes, however, that therapists may engage in sexual intimacies with former clients after two years have passed, provided the therapist can actively demonstrate that he/she has not exploited the client. The

Feminist Therapy code has no such provision.

Therapist Accountability. Both the Feminist Therapy code and the APA code state that therapists must work within their designated area of competency, monitor their personal and professional needs and vulnerabilities, and seek additional professional training and consultation when necessary.

The Feminist Therapy code advises therapists to consistently educate themselves with regard to feminism and psychology. The Feminist Therapy code also advocates a proactive stance on fostering therapists' emotional health, stating that therapists must work to improve their "emotional well-being" and "engage in self-care activities in an on-going manner." Promoting proactive self-care for therapists is relatively unique. This, despite the fact that being a therapist can create difficulties such as real or perceived restrictions on public behavior, continuous pressures to address the needs of the community, and expectations of "competence and complete psychological function" (Brown, 1991b, p. 333). Thus, therapists are encouraged to invest regular time and energy into spiritual, physical, social, and intellectual pursuits. At some point, it is wise for all therapists to be in therapy themselves.

Social Change. Although the APA code states that psychologists should guard against the "misuse of influence," it does not assert that therapists should work proactively toward broad cultural change. The Feminist Therapy code states, however, that therapists must "actively question"

therapeutic practices in the larger community and intervene when doing so is both possible and appropriate. Therapists should also pursue social change via education, advocacy, and lobbying. Caplan (1992) proposes that feminist therapists apply at least 10% of their work-time to activist pursuits in order to renew their commitment to social change and remind themselves about the role of oppression in individual suffering. The Feminist Therapy code suggests that therapists are models of social activism, not only for clients, but for community members at large.

Summary. Despite similarities in the Feminist Therapy code and the APA, the emphasis that each places on certain aspects of practice, and especially on the processes underlying those practices, is unique. It is important to note that the APA code acknowledges a host of specific therapeutic issues not addressed by the Feminist Therapy code, including, for example, documentation, assessment and interpretation, advertising, privacy, sexual harassment, fees, and termination of services. The APA code is the standard that all licensed psychologists are required to meet. The Feminist Therapy code, however, can provide therapists with an additional or alternative way to conceptualize not only the guidelines for ethical practice, but also the guidelines for feminist practice itself. As Brown (1991b) says:

> The questions by which decisions about ethical action develop are no longer simply, "What are the rules and how do I follow them, " but "What is my relationship to the community in which I live; work; and share with clients, former clients, and

> their support networks," and "How is my well-being and self-care an essential component of my ability to think and act ethically?" (p. 334).

These questions represent the foundation of feminist practice that the Feminist Therapy Institute Code of Ethics (1987) attempts to address.

Feminist Therapy: Empirical Investigations

The theoretical literature provides most of what is known about feminist therapy: the underlying philosophy, the ideal guidelines for practice, and the goals for treatment. Few empirical studies on feminist therapy have been published, and thus, little is known about the ways that feminist therapy is actually practiced. Several factors are hypothesized to contribute to this paucity of research.

First, people interested in feminist therapy are frequently located outside the mainstream (i.e. outside the context of academia) and, thus, may not have available the institutional resources necessary for research. Second, feminist therapy researchers who do operate from within mainstream institutions may find it difficult to obtain funding for projects or secure acceptance for papers and publications since the gatekeepers to these professional honors can be unsympathetic to feminist-oriented work. Finally, feminist therapy researchers and clinicians may be ambivalent about subjecting their work to traditional methods and measures of evaluation which they consider to be grounded in patriarchal paradigms.

There is some concern that feminist therapists may simply be unwilling to risk negative evaluation about a practice they consider sacred. Eventually, a balance needs to be achieved between honoring the practice of feminist therapy as an entity not dissectible by conventional methods of research, and recognizing the necessity of valid and reliable evaluation in order to uphold ethical standards regarding therapy efficacy and outcome. Although few empirical studies on the practice of feminist therapy are available, they serve as a foundation for future studies and are reviewed here.

Feminist Identity and Feminist Therapy Behavior

Studies have examined the relation between feminist identity and the use of feminist therapy behaviors. Chaney and Piercy (1988) developed the Feminist Family Therapy Behavior Checklist, an instrument designed to measure a therapist's use of feminist therapy behaviors. This checklist is the only empirically-validated scale available for observational use with feminist therapy. When Chaney and Piercy (1988) used the Feminist Family Therapy Behavior Checklist to explore feminist therapy practice, they found that self-identified feminists--both men and women--used significantly more feminist therapy behaviors with their clients than did therapists who identified as non-feminist.

Additional studies using modified versions of Chaney and Piercy's (1988) checklist have produced similar findings. Juntunen, Atkinson, Reyes, and Gutierrez (1994) used a modified, self-report version of the Feminist Family Therapy

Behavior Checklist with women therapists. Results suggested that therapists who identified as feminist therapists used more feminist therapy behaviors than therapists who identified as non-feminist. Results also suggested, however, that non-feminist therapists reported "frequent use" of feminist therapy behaviors (p. 332).

Dankoski, Penn, Carlson, and Hecker (1998) used Juntunen's et al., modified version of the Feminist Family Therapy Behavior Checklist to survey members of the American Association for Marital and Family Therapy. The authors found that therapists who identified with a feminist theoretical orientation reported using more feminist therapy behaviors than therapists who did not identify with a feminist theoretical orientation. Like Chaney and Piercy (1988) and Juntunen et al. (1994), they found that most participants, regardless of feminist orientation were, "...practicing to a great extent the behaviors listed on the feminist therapy scale" (Dankoski et al., p. 100).

Finally, Black and Piercy (1991) developed the Feminist Family Therapy Scale, a self-report instrument designed to measure the degree to which therapists conceptualize the process of family therapy from a feminist-informed perspective. Results indicated that family therapists who self-identify as feminist were more likely to conceptualize from a feminist-informed perspective than family therapists who did not self-identify as feminist (Black & Piercy, 1991).

These four studies provide evidence that therapists who identify as feminist incorporate more feminist therapy

behaviors than therapists who identify as non-feminist. Surprisingly, however, most therapists, regardless of feminist orientation, seem to utilize feminist therapy behaviors. This finding leads one to ask, "What does it really mean to be a feminist therapist?" To suggest that the mere frequency of feminist behaviors used by therapists determines whether or not the therapy is feminist seems too simplistic. If almost all therapists utilize these behaviors, is feminist therapy practice unique?

Connections Between Theory and Practice

At least two studies have explored how therapists transform the principles of feminist therapy into actual practice. Hill and Ballou (1998) surveyed 35 members of the Feminist Therapy Institute, asking: "Have you adapted a specific therapeutic strategy so that it is feminist?" and "Describe one or more examples of ways that you make the substance or ongoing dialogue of therapy feminist." Results suggested that although work with clients is made feminist in a variety of ways, a primary component includes therapists giving priority to issues of power. Examples of how therapists incorporated this practice included, "...giving the client information about the therapy process and about specific therapy techniques...offering clients 'mini-teaching sessions' about the therapy process...[taking] seriously [the] responsibility for being explicit about the values [we] bring to the work...[inviting] client feedback and questions...seeking out consultation...[developing] a collaborative stance" (p. 9). A second component regularly

referenced by therapists was addressing the role of the culture in causing individual distress. Here therapists talked about, "...[asking] clients explicitly about the influence of gender on their experiences and perceived choices...[filtering] what clients say through the lens of gender...using other cultural lenses such as race/ethnicity, class, and sexual orientation...[recognizing that] 'there is suffering from unfair treatment in the world' " (p.10).

Additional factors discussed by therapists included valuing women's experiences (e.g. "...I stay with the client's sense of what is true...incorporate[ing] an understanding about experiences common to many women, such as women's difficulties with subordinating their needs to others, women's need to feel agency in their own lives, or women's disconnection from their bodies..."), integrating the analysis of oppression in the work of therapy (e.g. "...[using] dolls with varying skin colors in play therapy...[attending] to diversity...[being] sensitive to differences"), and pursuing social change with clients (e.g. "...[refusing] to put 'body impossibility' magazines in [the] waiting room...encouraging change...teaching children how to advocate for themselves...[making] political action part of treatment planning..." (p. 10-11).

In another study, Marecek and Kravetz (1998) examined the connection between feminist theory and behavior by exploring language practices of therapists. Three therapists were interviewed about the ways in which they incorporated power analyses into therapy. Conclusions suggested that

therapists attended to power dynamics between the therapist and the client, focused on ending men's abuse of women by empowering women as a class, and worked to transform "human consciousness to perceive the unity of all being and to espouse womanly ideals" (p. 35). Although the authors suggest that there are ideological contradictions between therapists attempting to empower women, and therapists working to make society more accepting of women's stereotypic "strengths" such as empathy, they view these multiple perspectives as useful, and the standardization of practice as unrealistic and limiting.

Feminist Therapy Effectiveness

Only two published studies on the effectiveness of feminist therapy exist, and each is limited in its usefulness. Ellis and Nichols (1979) compared feminist assertiveness-training groups with "traditional" assertiveness-training groups and found that the group participants evidenced equivalent increases in assertiveness. The authors concluded that assertiveness-training may be a powerful enough process that the addition of a "feminist consciousness-raising" component did not increase the group's effectiveness. They also considered the possibility that assertiveness-training is an inherently feminist process whereby adding "additional" feminist components does not alter the outcome.

D'Haene (1995) evaluated the effectiveness of feminist-based group therapy for adolescent girls. She concluded that this model was effective in developing girls' affiliation,

competency, and empowerment. Although D'Haene illustrates qualitative examples of her findings, the design of the study is poor, lacking a reference group, a control baseline, or the use of validity measures. Thus, although the findings are hopeful, they are debatable.

The lack of current, valid empirical findings regarding the effectiveness of feminist therapy is problematic. Although feminist therapy theory is well intentioned, without data to support its claims, its efforts can be considered questionable. Fortunately, Johnson, Worell, Chandler and Blount (1999) are working to establish feminist therapy effectiveness measurements based not only upon symptom-reduction, but also on positive outcomes not typically measured by conventional studies. These positive outcomes include: increased positive self-evaluation, gender-role awareness, personal control/self-efficacy, self-nurturance, problem-solving skills, assertiveness, resource access, gender flexibility, and social activism. Preliminary findings, although yet unpublished, are favorable. Results indicated that as clients reported experiencing more feminist therapy strategies, their general well-being--as measured by the positive outcomes highlighted above--increased. Additionally, findings revealed that clients who experienced feminist interventions continued to report positive outcomes and improvement one year later. Further development of this line of research is critical for establishing the effectiveness, validity, and ultimately, the wider acceptance of feminist therapy.

The Problem

The need for empirical investigations into the practice of feminist therapy is clear. Marecek and Kravetz (1998) claim that one of the consequences of feminist therapy assuming a marginal stance in relation to academia is a, "...scarcity of systematic examination and exploration--even simple descriptive studies--of feminist therapy process or outcome, and of feminist therapists themselves" (p. 18). Hill and Ballou (1998) state, "The next step for feminist therapy is a [thorough] articulation of the lived enactment of feminist therapy, the 'how to' of practice" (p.2).

In order for empirical studies of feminist therapy effectiveness to be valid, more information is needed about what feminist therapists actually do with their clients. Additionally, due to the fact that feminist therapy behaviors are common among all therapists, regardless of feminist orientation, research is needed to determine the impact of feminist therapists' intentions on practice. For instance, any therapist can create egalitarian relationships with his or her clients. Unless therapists utilize egalitarian relationships for the purpose of increasing clients' power outside the therapy relationship, however, the therapy may not necessarily be feminist. Understanding therapists' goals and intentions is critical for understanding feminist practice and setting the stage for outcome research.

The current study sought to investigate the practice of feminist therapy with the use of both quantitative and qualitative data. First, in order to establish a reference

point, the study attempted to replicate the findings of Chaney and Piercy (1988) with regard to feminist identity and the use of feminist therapy behaviors. Using a modified version of their empirically validated scale (Feminist Family Therapy Behavior Checklist: 1988), the study explored the relationship between feminist identification and the self-reported use of feminist therapy behaviors.

Second, the study examined therapist variables that may contribute to, or interfere with, the implementation of feminist therapy practices. The study explored the association of feminist identification with demographic variables such as gender, race/ethnicity, sexual orientation, age, and income. The study also explored whether feminist identification was associated with professional variables such as theoretical orientation, year of last degree, and having received formal feminist training.

Third, qualitative data were collected from memorable case descriptions in order to address the specific ways in which feminist therapy is practiced by clinicians who identify themselves as feminist therapists. Fourth and finally, qualitative data were obtained from semi-structured interviews with feminist therapists with the hope of answering questions such as, "What does it mean to be a feminist therapist?" and "What do feminist therapists actually do with their clients?"

Significance of the Study

Feminism plays a critical role in the practice of psychotherapy, and its inclusion may be essential, not only for the well-being of individual clients, but also for the broader psycho-social health of the culture. Based upon this belief, it is critical that feminist clinicians and theoreticians know more about the ways that feminist therapy is practiced, and the factors that mediate its use.

Learning how feminist philosophy is incorporated into practice benefits novice and experienced therapists alike. This study seeks to provide "real world" knowledge about feminist practice; knowledge that is especially important given that feminist approaches to treatment are not uniformly integrated into graduate education (Laidlaw & Malmo, 1991).

This study is likely to illuminate areas of confusion and inconsistency within feminist practice. Understanding how therapists are applying--or potentially misapplying--theories of feminist therapy enables educators to generate more useful instruction and more relevant guidance in their publications and workshops. Understanding the common practices and pitfalls therapists face when conducting feminist therapy may assist researchers in executing more appropriately designed outcome studies. Examining factors that are associated with therapists' use and non-use of feminist therapy behaviors may allow feminist therapy advocates an opportunity to challenge impediments that certain therapists face. Finally, this study may impact the future development of feminist therapy guidelines, practice

expectations, and ethical standards. Knowledge about the practice of feminist therapy is increasingly important as certification requirements regarding the title "Feminist Therapist" are currently debated.

CHAPTER 2

METHODS

Survey

Participants

A total of 529 survey packets were mailed. Approximately 100 members from each of four American Psychological Association divisions were randomly selected to receive survey material: Division 12 (Clinical), Division 17 (Counseling), Division 29 (Psychotherapy), and Division 35 (Society for the Psychology of Women). Approximately 50 members from each of two local psychological groups, the Knoxville Area Psychological Association and the Appalachian Psychoanalytic Society, were also randomly selected to receive survey materials. Eight-four completed surveys were returned.

Survey Materials

Survey materials included a seven-page survey; a stamped, addressed return-envelope; a stamped, addressed interview-contact postcard; and a cover-letter explaining ancillary benefits of participating in the study (Appendix C). These "benefits" were organized through a local business such that for each returned survey, a donation of $5 was made to the Knoxville Women's Center (KWC). The KWC is an organization that assists women in achieving economic self-sufficiency through skill training, interview preparation, and the provision of a suitable wardrobe for the workplace.

The survey consisted of four sections that measured: (1)

demographic and professional information; (2) Global Feminist Identification (GFI); (3) feminist therapy practices via a memorable case description; and, (4) responses to a feminist therapy behavior checklist (FBC).

The first section of the survey asked therapists to report the following demographic information: degree, major field, gender, age, race/ethnicity, marital status, sexual orientation, ABPP certification status, work setting, and annual income. Therapists were also asked to report professional information such as theoretical orientation, history of feminist training, the average number of clients seen per week, year of last degree, and a description of their client population.

The second section of the survey assessed the variable feminist identification, called Global Feminist Identification (GFI) for this study. GFI was conceptualized as involving aspects of personal identity, professional identity, and professional behavior. Participants were asked to respond to three questions on a Likert scale ranging from 1 (Not At All/Never) to 5 (Very Much/Always). The three likert scale scores were summed in order to formulate GFI. The questions included, "To what extent are you a feminist in your personal life?" "How often do you incorporate feminist techniques into your clinical practice?" and "In your professional practice, do you consider yourself a feminist therapist?" Participants were given an opportunity to explain their answers in an open-ended format (e.g. "Please describe 'feminist therapist' and explain why you circled the

number that you did.").

Although a scale that measures feminist attitude or feminist identity might have been used in the place of these self-report questions (e.g Attitude toward Women Scale: Spence, Helmreich, & Stapp, 1973; Ambivalent Sexism Inventory: Glick & Fiske, 1997; Feminist Identity Development Scale: Bargad & Hyde, 1991), the primary emphasis of the study was to capture feminist therapists' own self-definitions generated by their own conceptualizations. Thus, it was most important to explore the way therapists labeled themselves in relation to feminism, and to identify the behaviors they implemented as a consequence of those labels.

The third section of the survey examined the therapeutic strategies, techniques, and processes feminist therapists utilized via a memorable case description. Only the participants who considered themselves <u>feminist therapists</u> were instructed to complete this section. Participants were asked to, "...choose the most memorable [therapy] case that incorporated feminist philosophy and technique and seemed to work especially well."

Therapists were then asked to describe this client's demographics, presenting problem, and history. They were also asked to identify the goals of treatment, explain how the goals were chosen, and describe how the goals were informed by feminist theory. They were also asked to clarify what, in general, made the techniques and/or processes of the treatment feminist.

The memorable case description was used to assess what

feminist therapists actually do with their clients. The format of the memorable case descriptions enabled therapists to describe how they make their work with clients feminist, thus illuminating the ways in which they incorporate feminist philosophy into practice. Additionally, the open-ended nature of the questions forced therapists to generate meaning, rather than simply endorse simple checklist behaviors that are frequently susceptible to social desirability bias.

The fourth section of the survey measured therapists' behaviors with a feminist therapy behavior checklist (FBC). The FBC is a modified version of the Feminist Family Therapy Behavior Checklist (Chaney & Piercy, 1988; see Appendix D for a description of Chaney & Piercy's scale development). Modifications made to the checklist included, (1) converting the scale into a self-report measure, (2) rewording items geared toward family therapy only, (3) rewording items geared toward male or female clients only, and (4) reducing the total number of items from 39 to 20. Other researchers have used similar modifications of the Feminist Family Therapy Behavior Checklist successfully (Juntunen et al., 1994; Dankoski, et al., 1998). The coefficient alpha for the FBC used in the current study was .78.

The FBC asked therapists to, "...choose one client and indicate whether or not you engaged in this behavior with the client at least once during his/her treatment." Therapists were then asked to check yes or no in reference to 20 feminist therapy behaviors. All participants were asked to

complete this fourth section of the survey, regardless of whether they considered themselves feminist therapists.

The FBC provided an overall measure of therapists' self-reported use of feminist therapy behaviors. Total scores on the FBC could range from 0 to 20. The FBC also provided measures of therapists' self-reported use of five categories of feminist therapy behaviors. Scores for each category could range from 0 to 4. Categories included analyzing sex-roles, encouraging a redistribution of power, empowering clients, skill training, and minimizing the hierarchy between therapist and client.

Sex-role analysis behaviors educate clients on socialization, traditional versus nontraditional roles, and differences in status and power between genders. Encouraging a redistribution of power fosters clients' involvement in status-related activities outside the family, the development of egalitarian relationships, and movement beyond traditional sex-roles. Empowering clients targets increasing client assertiveness, competence, and social support networks. Skill training behaviors targets the expression of anger and other feelings, and the development of self-care. Finally, minimizing the hierarchy between therapist and client occurs as therapists assume a collaborative role, encourage clients to assess their own change and growth, and model both instrumental and expressive behavior.

Semi-structured Interview

Participants

Each person who received a survey was also asked to participate in an interview on feminist therapy. Those willing to participate were asked to return the interview-contact postcard included with the survey materials. Of the 529 people mailed a survey packet, 27 returned the interview-contact postcard. They were each then mailed a consent form (see Appendix E) and interview scheduling sheet. Nine therapists returned both the consent form and the scheduling sheet, and were subsequently interviewed.

The sample size was determined by the number of participants who were both interested and available to complete the interview. Sample size is often determined by a researcher's impression of content saturation (Strauss & Corbin, 1990), redundancy, or the feeling of completeness (Ely, Anzul, Friedman, Garner, & Steinmetz, 1991). The sample size for this project can be considered useful due to the fact that the content of the nine interviews illuminated areas of interest and concern regarding feminist therapy practice, and identified questions and directions for future inquiry.

Procedure

All interviews were conducted via telephone and lasted approximately 30 minutes. The tone of the interviews was conversational; the author frequently asked follow-up questions and participants were encouraged to elaborate their answers and give examples when possible. The author provided

verbal encouragement to participants by restating, summarizing, clarifying, and affirming when appropriate. All participants were forthcoming and talked easily about the subject.

Interviews were audiotaped and transcribed by the author. Most typed transcriptions were 10 to 12 pages in length. Identifying information was omitted from the written material.

Instruments

The semi-structured interview ~~was~~ comprised ~~of~~ a total of nine questions. Three basic questions were asked of each of the nine therapists. These questions were open-ended in nature and encouraged participants to reflect on the meaning of the term feminist therapist and the experiences that contributed to their development as feminist therapists. Questions included:

(1) Describe, in your own words, what it means to be a feminist therapist.

(2) How does that make you different from non-feminist therapists?

(3) Describe your evolution as a feminist therapist. How were you first exposed to these ideas?

Six additional questions targeted specific aspects of feminist therapy practice. Each question was asked only when a therapist had not previously mentioned the topic in an earlier response. The questions were based on the Feminist Therapy Institute Code of Ethics (1987; Appendix B) and

included:

(4) To what extent do you evaluate your own cultural context in your work with clients?

(5) How do you approach power differentials between you and your clients?

(6) What issues are central as you negotiate overlapping relationships between you and your clients?

(7) What role do self-care and professional development play in your work with clients?

(8) How do social and political activism play a role in the work that you do with clients?

(9) How have feminist therapy techniques assisted you in dealing with the issues of ethnically and culturally diverse clients?

CHAPTER 3

RESULTS

Five hundred, twenty-nine surveys were mailed to members of four APA divisions (Clinical, Counseling, Psychotherapy, and the Society for the Psychology of Women) and two local psychological associations (Knoxville Area Psychological Association and the Appalachian Psychoanalytic Society). Eighty-four therapists returned a completed survey and 9 of those 84 participated in a semi-structured interview. Twenty-four people returned a blank survey, indicating they did not do clinical work or had retired from the field. Five therapists returned a survey only partially completed. Thus, the response rate for completed surveys was 16%. As promised, a $420 donation ($5 per completed survey) was made to the Knoxville Women's Center.

Of the 84 participants, 49% (n = 41) considered themselves feminist therapists. Sixty-two percent of the participants were female, and 38% were male. The majority of the sample was heterosexual (91%) and married (73%). Ninety percent of the sample was Caucasian, with little racial or ethnic diversity (2.4% Asian, 3.6% African-American, 1.2% Hispanic, 1.2% Multi-ethnic, 1.2% Native American). Thirty-five percent of the participants were between the ages of 45 and 54, while 29% were between the ages of 55 and 64. With the exception of a 15% difference in gender distribution, the sample appears representative of the American Psychological Association member population (see Table 1).

Table 1.

Demographic comparisons between sample and APA members.

Variable	Sample (N = 84)	APA Members* (N = 84,426)
Gender		
Male	38%	53%
Female	62%	47%
Race/Ethnicity		
African American	3.4%	1.5%
Asian	2.2%	1.3%
Caucasian	90%	70%
Chicano/Hispanic	1.1%	1.9%
Multiethnic	2.2%	-
Native American	1.1%	.4%
Other/Not Specified	-	24%
Age		
34 and younger	5.6%	6.7%
35 - 44	18%	20.9%
45 - 54	34.8%	33.9%
55 - 64	27%	15.2%
65 and older	14.6%	12.1%
Not Specified	-	11.2%

*Source: APA Directory Survey (1997)

Ninety-two percent of participants had doctoral degrees, while the remaining had masters degrees (8%). Most had studied clinical psychology (71%) while the others had pursued counseling psychology (23%), social work (5%), and nonspecified fields (1%). The majority of the sample worked in private practice settings (54%) while others worked in university settings (21%), counseling centers (9%), hospitals (6%), community mental health centers (4%), and nonspecified settings (7%).

Therapists reported seeing an average of 19 clients per week, ranging from 0 to 50 (SD = 12). When asked to describe their client population, 57% of therapists reported they worked with female clients more often than male clients, while 36% of therapists worked with equal numbers of male and female clients (see Table 2). Seventy-eight percent of therapists reported working with individual clients more than families, groups, or couples. Eighty-three percent reported working with Caucasian clients more than Ethnic Minority clients. Finally, 94% of therapists reported working with more heterosexual clients than gay, lesbian, or bisexual clients.

Global Feminist Identification and Feminist Therapy Behavior

Global Feminist Identification (GFI) was formulated by summing the likert scale responses to the three questions: "To what extent are you a feminist in your personal life?" "How often do you incorporate feminist techniques into your

Table 2.

Therapists' descriptions of client caseloads.

Caseload Descriptor	Percentage of Therapists (N = 84) Responding Affirmatively
Treatment Modality	
Exclusively individuals	14
More individuals than groups/families/couples	78
Equal numbers of individuals and groups/families/couples	7
More groups/families/couples than individuals	1
Exclusively groups/families/couples	0
Gender	
Exclusively women	1
More women than men	57
Equal numbers of women and men	36
More men than women	6
Exclusively men	0
Race/Ethnicity	
Exclusively Caucasian clients	2
More Caucasian than Ethnic Minority clients	83
Equal numbers of Caucasian and Ethnic Minority clients	10
More Ethnic Minority than Caucasian clients	5
Exclusively Ethnic Minority clients	0
Sexual Orientation	
Exclusively heterosexual clients	1
More heterosexual than gay/lesbian clients	94
Equal numbers of heterosexual and gay/lesbian clients	4
More gay/lesbian than heterosexual clients	1
Exclusively gay/lesbian clients	0

clinical practice?" and "In your professional practice, do you consider yourself a feminist therapist?" Each of the three scores was significantly correlated (Pearson correlation coefficients ranged from .44 to .79, $p = .0001$)[1]. When one of the three scores was missing (as occurred in 10 of the 84 of the protocols), the missing score was estimated by averaging the other two scores. The mean GFI score for the sample was 10.12 ($SD = 3.49$). By dividing the distribution into approximate thirds, three levels of Global Feminist Identification were created--*low* ($n = 32$), *moderate* ($n = 30$), and *high* ($n = 22$). Cell sizes were not equal due to respondents with duplicate scores.

The relationship between Global Feminist Identification (GFI) and the self-reported use of feminist therapy behaviors based on responses to the feminist therapy behavior checklist (FBC) was explored. An analysis of variance of GFI (*low*, *moderate*, *high*) on the FBC total score indicated that GFI was a significant predictor of the FBC total score ($F = 11.95$, $df = 2$, $p = .0001$, $R^2 = .23$). Bonferroni t-tests on the FBC total score indicated that therapists *high* on GFI were significantly more likely to incorporate feminist therapy behaviors than therapists *low* on GFI ($p < .05$). Therapists *moderate* on GFI were also significantly more likely to incorporate feminist therapy behaviors than therapists *low* on GFI ($p < .05$). Significant differences in feminist therapy behaviors were not found between therapists *high* on GFI and

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[1] Exact p values are reported when possible.
Statistical findings are considered significant when alpha ≤ 0.05.

therapists moderate on GFI ($p > .05$; see Table 3).

In order to better assess the relationship between Global Feminist Identification (GFI) and specific feminist therapy behaviors, subscales of the feminist therapy behavior checklist (FBC) were explored. A multivariate analysis of variance examined the predictive value of GFI on the five subscale scores of the FBC (analyzing sex-roles, encouraging a redistribution of power, empowering clients, focusing on skill training, and minimizing hierarchy between therapist and client). Consistent with the ANOVA on FBC total score, the overall effect of Global Feminist Identification (GFI) on the five subscale scores was significant (Wilks' Lambda, $p = 0.0031$).

Scores on the five subscales were examined with separate analyses of variance to further explore the relation between feminist identification and the self-reported use of feminist therapy behavior. Results indicated that GFI level (low, moderate, high) predicted three of the five subscale scores: analyzing sex-roles ($F = 11.93$, $df = 2$, $p = .0001$, $R^2 = .23$), encouraging a redistribution of power ($F = 7.02$, $df = 2$, $p = .0015$, $R^2 = .15$), and minimizing hierarchy in the therapist-client relationship ($F = 6.27$, $df = 2$, $p = .0029$, $R^2 = .13$). GFI was not a significant predictor of empowering clients or focusing on skill training scores (see Table 3).

Comparisons between low, moderate, and high levels of Global Feminist Identification (GFI) on the three significant subscales were tested with Bonferroni t-tests. Results indicated that therapists high on GFI were significantly more

Table 3.

Self-reported use of feminist therapy behaviors

based on level of Global Feminist Identification (GFI).

	Levels of GFI					
	Low (n=32)		Moderate (n=30)		High (n=22)	
Feminist Behavior Checklist Category	M	SD	M	SD	M	SD
Analyzes Sex-roles[1]	1.97 $_b$	1.45	2.60 $_b$	1.25	3.64 $_a$	0.79
Encourages Redistribution of Power[2]	2.28 $_b$	1.11	2.90 $_{ab}$	1.18	3.41 $_a$	0.96
Empowers Client	3.59	0.61	3.77	0.50	3.82	0.39
Focuses on Skill Training	3.06	0.95	3.23	0.43	3.32	0.89
Minimizes Hierarchy[3]	2.91 $_b$	0.86	3.40 $_a$	0.67	3.59 $_a$	0.67
FBC Total Score [4]	13.81 $_b$	3.60	15.90 $_a$	2.52	17.77 $_a$	2.39

1 ANOVA p = .001
2 ANOVA p = .002
3 ANOVA p = .003
4 ANOVA p = .0001

Note: Mean scores (within rows) with different subscripts are statistically different.

likely to incorporate an analysis of sex-roles than were therapists moderate on GFI ($p < .05$) or low on GFI ($p < .05$). Therapists high on GFI were significantly more likely to encourage a redistribution of power than therapists low on GFI ($p < .05$). Finally, therapists high and moderate on GFI were significantly more likely to minimize hierarchy in the therapist-client relationship than therapists low on GFI ($p < .05$; see Figure 1).

Although results suggested that, in general, Global Feminist Identification (GFI) predicted the use of specific feminist therapy behaviors, most therapists--regardless of feminist identification--reported using feminist therapy behaviors. Out of 20 possible feminist therapy behaviors on the feminist therapy behavior checklist (FBC), therapists in this sample ($N = 84$) endorsed a mean of 15.5 behaviors ($SD = 3.32$; see Table 4). The FBC items that almost every therapist endorsed included:

I encouraged my client to assess his/her own change and growth. (100%)
I underlined my client's competence. (99%)
I taught my client to recognize and express his/her feelings. (98%)
I taught my client to assess and meet his or her own needs. (96%)
I encouraged my client to become more assertive. (94%)
I assumed a collaborative role with my client.(93%)
I supported my client's competence in both traditional and non-traditional roles. (91%)

Several of these universally endorsed behaviors comprised the two subscales empowering clients and skill training and may explain why GFI was not a significant predictor of their scores.

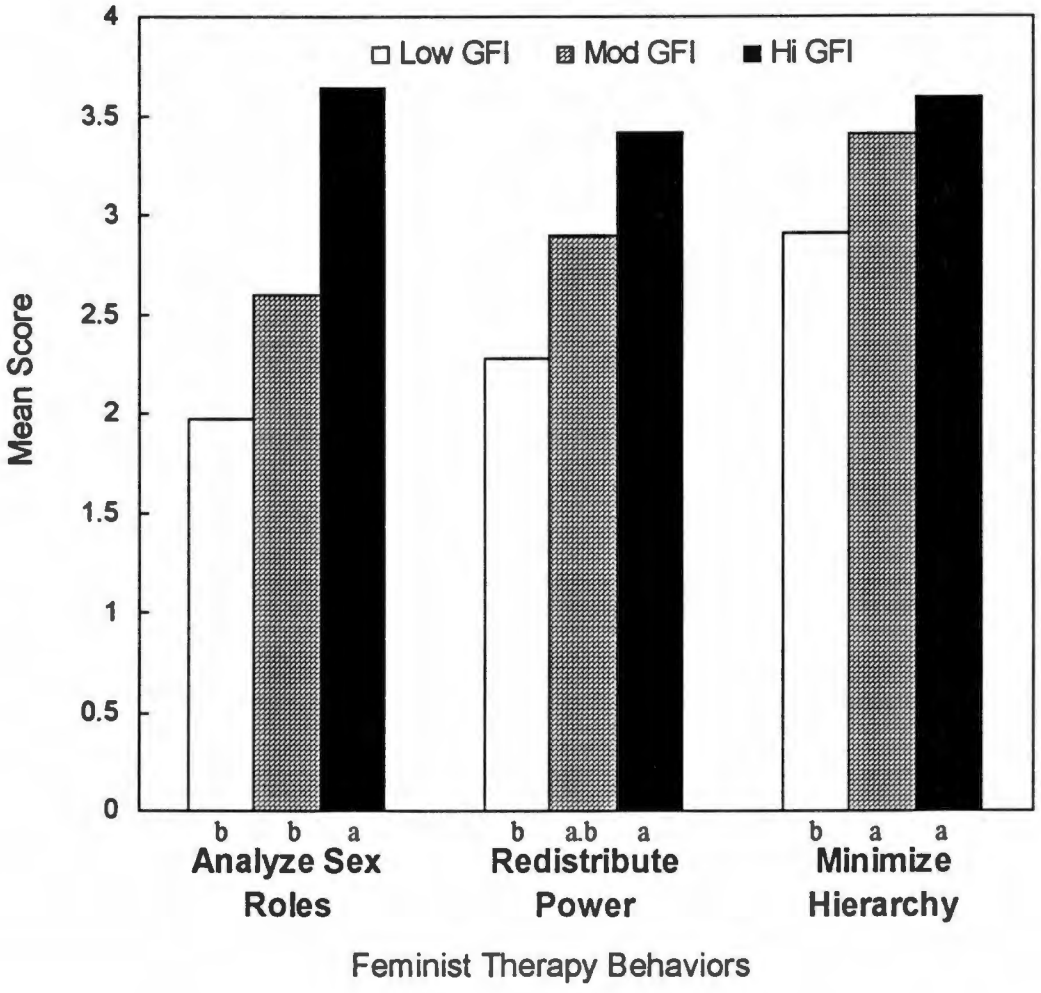

Figure 1. Feminist therapy behaviors and Global Feminist Identification (GFI).

Note: Analyses of variance indicated significant differences ($p < .05$) for the three therapy behaviors as a function of Global Feminist Identification. Common subscripts (a or b) indicate no mean difference by post hoc Bonferroni t-tests.

Table 4.

Therapists' use of feminist therapy behaviors.

Feminist Behavior Checklist Item by Subscale	Percentage of Therapists Engaging in Behavior			
	Sample (N=84)	Low GFI (n=32)	Mod GFI (n=30)	Hi GFI (n=22)
Analyzing Sex-roles				
I educated my client about the inequality of status and power between the sexes.	72	53	73	96
I raised sex-role issues whether or not they came up.	52	31	50	86
I reframed my client's definition of the problem to include the impact of socialization.	75	63	73	96
I reeducated my client about roles which are oppressive to both men and women.	64	50	63	86
Encouraging A Redistribution of Power				
I challenged my client to develop more egalitarian relationships.	85	72	90	95
I suggested alternative sex-role behavior to my client.	60	44	60	82
I directed my client to become involved in status-related activities outside the family.	56	44	57	73
I supported my client's moves to expand beyond traditional sex-role behavior.	80	69	83	91
Empowering Clients				
I underlined my client's competence.	99	97	100	100
I encouraged my client to be more assertive.	94	91	97	96
I encouraged my client to develop a social support network.	88	81	90	96
I supported my client's competence in both traditional and non-traditional roles.	91	91	90	91

Table 4 (continued).

Feminist Behavior Checklist Item by Subscale	Percentage of Therapists Engaging in Behavior			
	Sample (N=84)	Low GFI (n=32)	Mod GFI (n=30)	Hi GFI (n=22)
Focusing on Skill Training				
I educated my clients about assertive and functional ways of expressing anger.	89	84	100	82
I used role play to help clients integrate new sex-role behaviors.	36	34	23	55
I taught my client to assess and meet his/her own needs.	96	93	100	96
I taught my client to recognize and express his/her feelings.	98	94	100	100
Minimizing Hierarchy Between Therapist and Client				
I modeled both instrumental and expressive behavior.	79	63	90	86
I clearly communicated my own sex-role values.	55	41	53	77
I assumed a collaborative role with my client.	93	88	97	96
I encouraged my client to assess his/her own change and growth.	100	100	100	100

Descriptive statistics indicated that three FBC items were more regularly endorsed by therapists moderate in GFI than therapists high in GFI (see Table 4). These items included:

I educate my clients about assertive and functional ways of expressing anger.
I taught my client to assess and meet his/her own needs.
I modeled both instrumental and expressive behavior.

It appears that either these three items did not measure unique feminist behavior, or therapists high in GFI were more selective with item endorsement than therapists moderate in GFI.

Correlates of Global Feminist Identification

If Global Feminist Identification (GFI) predicts the use of certain feminist therapy behaviors, it is useful to know more about the demographic and professional variables associated with GFI. Although causal relationships cannot be established, demographic and professional variables may, in some way, influence a therapist's feminist identification and the use or non-use of feminist therapy behaviors.

Demographic Correlates

The study explored whether therapists who are members of marginalized groups themselves (e.g. women, ethnic minorities, gays and lesbians) have higher Global Feminist Identification (GFI) than therapists who are not members of marginalized groups. The study also examined whether younger therapists--who had been exposed to the women's movement of

the 1970s during their formative years--had higher GFI than older therapists. Finally, the association between GFI and income was examined in order to determine if therapists with high GFI tend to earn less money than therapists with low GFI. If feminist therapists are more concerned with client's access to treatment, class issues, and the negative consequences of working with diagnostic labels and third-party reimbursement, they may be more likely to operate within a sliding scale system and, therefore, earn less money than non-feminist therapists.

Chi square analysis indicated a significant association between gender and Global Feminist Identification (GFI). Women were more likely than men to report higher levels of GFI (chi square (2,82) = 26.14, $p < .0001$). Chi square analyses were not performed on associations between GFI and race/ethnicity, sexual orientation, age, or income due to limited variability and insufficient cell size.

Professional Correlates

The study examined the association between theoretical orientation and GFI. It was anticipated that therapists who reported a feminist theoretical orientation would have higher GFI than therapists not reporting a feminist theoretical orientation. The association between GFI and year of last degree was also examined. Therapists who received their training before the 1970s were expected to have lower GFI than therapists who received training after the 1970s. Finally, the association between GFI and receipt of formal feminist training was explored. It was anticipated that

therapists with higher GFI would be more likely to have received formal training than those therapists with lower GFI.

Therapists were asked to rank order their top two theoretical orientations from a list that included: cognitive-behavioral, eclectic, feminist, gestalt, object-relations, psychodynamic, systems, and other. Fifty percent of therapists selected psychodynamic, while 38% selected cognitive behavioral, and 33% chose eclectic. Only 17% of therapists selected feminist as the theoretical orientation that best described their work, despite the fact that 49% of the sample (41 therapists of 84) identified themselves as feminist therapists. Chi square analyses were not performed on the association between theoretical orientation and GFI due to insufficient variability, despite the fact that theoretical orientations were condensed from eight categories to five (i.e. cognitive-behavioral, eclectic, feminist, psychodynamic/object relations, and systems).

The year that therapists earned their last degree ranged from 1943 to 1997, with most (n = 26) having earned their degree in the 1980s (M = 1980; SD = 12). Data on therapists' year of last degree were collapsed into four categories by decade: 1960s and earlier, 1970s, 1980s, and 1990s. The association between GFI and therapists' year of last degree approached significance (chi square (6,78) = 12.26, p = .06). This trend suggested that therapists who obtained their degrees more recently had slightly higher levels of GFI than therapists who obtained their degrees less recently.

Therapists were asked to indicate where they had received formal feminist training, if ever. The most common area of formal feminist training was workshops (27%) followed by graduate school training (17%). A minority of the sample had received formal feminist training from post-doctoral training (4%), practica (5%), clinical internships (10%), continuing education programs (13%), or supervisors (15%). Chi square analysis indicated a significant association between GFI and formal feminist training in workshops (chi square (2,82) = 7.68, p = .02). Thus, therapists high on GFI were more likely to have received formal feminist training from workshops than therapists low on GFI. The association between GFI and the receipt of formal feminist training in graduate school was not significant. Associations between GFI and other forms of formal training were not performed due to insufficient variability and cell size.

Memorable Case Descriptions: Common Behaviors in Feminist Therapy Practice

Therapists who self-identified as feminist therapists (n = 41) completed a memorable case description in the survey. The memorable case description required therapists to provide a written account of a therapy case that, "...incorporated feminist philosophy and technique and seemed to work especially well." Therapists were asked to write about the presenting problem, goals of treatment, and what made the treatment process feminist. Questions in this section of the survey were open-ended. Most therapists responded to the

questions with phrases and short paragraphs.

According to therapists' accounts, length of treatment of the memorable cases ranged from 3 to 750 sessions (M = 102, SD = 170). The prototypical client was most often female (98%) and Caucasian (91%). She was typically heterosexual (83%), but could also be gay or bisexual (17%). Most of the clients (54%) were single or divorced, but a significant portion were married (46%). The mean age of the clients was 36 years, ranging from 13 to 65 (SD = 12).

Feminist therapy behaviors specified in the memorable case descriptions were analyzed by a combination of qualitative and quantitative methods. Each memorable case description was rated for content by two people: the author and a doctoral level psychologist who has been in independent practice for 20 years. The 16 tenets of feminist therapy generated at the first National Conference on Education and Training in Feminist Practice were used as a guideline for classifying the responses (Wyche & Rice, 1997; see Appendix A). Although these tenets are stated for specific use with with women, they were applied to all case descriptions, regardless of the gender of the client. Each memorable case description was evaluated in its entirety for the presence, or absence, of each of the 16 tenets. Thus, scores on the memorable case descriptions could range from 0 to 16. For each case, the two coders compared their ratings.

Ratings on individual tenets reached satisfactory reliability with inter-rater agreement ranging from .73 to 1.0 (M = .88; see Table 5). Inter-rater agreement was .85 or

Table 5.

Feminist therapy tenets referenced in memorable cases.

Feminist Therapy Tenet	Percent of Cases (n=41) Using Tenet	Percent of Agreement in Ratings
(#13) Feminist therapy expands girls' and women's alternatives, options, and choices across the life span.	.63	.73
(#2) Feminist therapy focuses on the cultural, social, political, economic, and historical factors of women's lives as well as intrapsychic factors across the life span.	.59	.73
(#1) Feminist therapy recognizes that being female always occurs in a cultural, social, political, economic, and historical context and affects development across the life span.	.49	.85
(#10) Feminist therapy is a collaborative process in which the therapist and client establish the goals, direction, and pace of therapy.	.39	.90
(#11) Feminist therapy helps girls and women understand how they have incorporated societal beliefs and values. The therapist works collaboratively with them to challenge and transform those constructs that are destructive to the self and helps them create their own perspectives.	.37	.80
(#4) Feminist therapy acknowledges that violence against women, overt and covert, is emotionally, physically, and spiritually damaging.	.34	.83

Table 5 (continued).

Feminist Therapy Tenet	Percent of Cases (n=41) Using Tenet	Percent of Agreement in Ratings
(#3) Feminist therapy includes an analysis of power and its relationship to the multiple ways women are oppressed; factors such as gender, race, class, ethnicity, sexual orientation, age, and ablebodiness, singly or in combination, can be the basis for oppression.	.29	.85
(#6) Feminist therapy's primary focus is on strengths rather than deficits. Therefore, women's behaviors are seen as understandable efforts to respond adaptively to oppressive occurrences.	.22	.83
(#14) Feminist therapy is a demystification process that validates and affirms the shared and diverse experiences of girls' and women's lives.	.20	.80
(#12) Feminist therapy empowers girls and women to recognize, claim, and embrace their individual and collective power as girls and women.	.20	.88
(#9) Feminist therapy strives toward an egalitarian and nonauthoritarian relationship based on mutual respect.	.12	.93
(#8) Feminist therapy is based on the constant and explicit monitoring of the power balance between therapist and client and pays attention to the potential abuse and misuse of power within the therapeutic relationship.	.05	.97

Table 5 (continued).

Feminist Therapy Tenet	Percent of Cases (n=41) Using Tenet	Percent of Agreement in Ratings
(#15) Feminist therapy involves appropriate types of self-disclosure. However, because self-disclosure may be harmful, it must be both value and theory driven and always in the client's best interest. Therapists must develop methods of continually monitoring their level of self-awareness.	.05	1.0
(#4) Feminist therapy acknowledges that misogyny exists in all women's lives and is emotionally, physically, and spiritually damaging.	.03	.97
(#7) Feminist therapy is committed to social change that supports equality for everyone.	.03	1.0
(#16) Feminist therapists are committed to continually monitoring their own biases, distortions, and limitations, especially with respect to cultural, social, political, economic, and historical aspects of girls' and women's experiences.	0.0	1.0

above for 10 of the 16 tenets. When disagreements in ratings occurred, they were discussed until an agreement was reached. Certain tenets were more susceptible to rater-disagreement, including expanding girls and women's alternatives, options, and choices across the life span (tenet 13), and focusing on the cultural, social, political, economic, and historical factors of women's lives (tenet 2), both with 73% agreement. Disagreements seemed to occur most often when a behavior qualified for more than one tenet.

Frequency counts were used to examine the behaviors feminist therapists employed. Therapists reported using an average 3.95 feminist therapy tenets in each memorable case, ranging from 0 to 10 (SD = 2.75). Only 2 of the 16 feminist therapy tenets were regularly incorporated by the majority of feminist therapists. The first--working to expand girls and women's alternatives, options, and choices (tenet 13)--was reported by sixty-three percent of the therapists. Feminist therapists incorporated this behavior by:

> Focus[ing] on autonomous functioning as [the] baseline...clearly identifying dependence on males...[and] teaching skills to modify.
>
> Brainstorming about ways to meet her needs for stimulation and fun outside the family and legitimizing them.
>
> Helping her see [that being] female does not equal [being a] subservient, passive, victim.
>
> Helping her...connect with other women in healthy, supportive ways.
>
> ...[H]elping the client to understand that, even in a traditional marriage and within a "traditional/conservative" religion, there was a possibility to choose one's destiny. Even if

> divorce was not condoned, neither was abuse and there were ways to protect oneself.
>
> Worked on being able to experience pleasure in [her] body apart from its appearance.

The second--focusing on the cultural, social, political, economic, and historical factors of women's lives (tenet 2)--was reported by fifty-nine percent of the therapists. Feminist therapists enacted this tenet by:

> Fram[ing]...fears at not being able to survive alone...as what she was taught by parents and society.
>
> Decreasing traditional sex roles and [understanding] how they shape expectations.
>
> Assisting her journey of self-discovery wherein she could feel empowered as a female in patriarchal and condescending environments at home, within marriage and in the world in general.
>
> Regular pointing out...how she internalized society's script of what she "should" be...
>
> I mentioned the women's movement she had lived through...she [was able to see] how other women had the insight to complain about a culture that had promoted her sort of dependent life style.
>
> Identified situations where she felt powerless. Recognizing early social and parental [and] church training that reinforced her powerlessness.
>
> I directly challenged prevailing norms while attempting to validate her perceptions - we spent many sessions discussing heterosexual relations, race relations, politics and culture.
>
> Client has been able to examine how roles set for her by culture, church institutions and family have contributed to symptoms of creating [an] unrealistic sense of responsibility for others at the cost of neglecting and ignoring [her] own needs and goals.

Other tenets referenced by feminist therapists included: recognizing that being female always occurs in a cultural, social, political, economic, and historical context (tenet 1; 49%); using a collaborative process to establish the goals, direction, and pace of therapy (tenet 10; 39%); helping girls and women understand how they have incorporated societal beliefs and values and helping them create their own perspectives (tenet 11; 37%); and finally, acknowledging that violence against women, overt and covert, is emotionally, physically, and spiritually damaging (tenet 4; 34%).

None of the therapists indicated that they worked to monitor their own biases, distortions, and limitations with respect to cultural, social, political, economic, and historical aspects of girls' and women's experiences (tenet 16). Only one therapist evidenced a commitment to broad social change (tenet 7; 3%), and only two indicated that they utilized self-disclosure when appropriate (tenet 15; 5%).

Semi-structured Interviews: On Being A Feminist Therapist

All nine interview participants were female. Eight were Caucasian and one was Asian. Two participants were lesbian. Eight participants were psychologists, while one participant was completing her fourth year of graduate school in clinical psychology. Of the eight psychologists, four worked in academia with teaching, supervisory, and clinical responsibilities; three worked in private practice, and one worked in an unspecified setting. The majority of

participants--five of the nine--worked primarily with women survivors of trauma (e.g. sexual abuse, domestic violence, rape, etc.). One of the participants worked predominately with women and eating disorders. Three participants did not indicate a speciality area in their clinical work. Although each of the nine interview participants indicated that she considered herself a feminist therapist in writing (i.e. on the interview-contact postcard that accompanied the survey), only one of the nine said that she publicly identified herself as a feminist therapist to clients and colleagues.

Development of Categories and Relational Schemas

Analysis of the semi-structured interviews was based on grounded theory techniques (Strauss, 1987; Strauss & Corbin, 1990) as well as general techniques used to synthesize qualitative data (Banister, Burman, Parker, Taylor, & Tindall, 1994; Dey, 1993; Ely, Anzul, Friedman, Garner, & Steinmetz, 1991; Lincoln & Guba, 1985; Weiss, 1994). Analysis of the interview data involved three general processes: (1) data were classified into categories, (2) categories were refined, and (3) patterns and connections between categories were established (Banister et al., 1994; Dey, 1993; Ely et al., 1991; Weiss, 1994; Strauss, 1987). These processes, technically labeled open coding and axial coding (Strauss & Corbin, 1990), do not occur in a linear fashion, but often occur simultaneously. The ways in which these processes were implemented in the current study are described below.

The author began by reading one of the interviews, in

its entirety, to generate an overall impression of content. Words, phrases, sentences, and paragraphs were examined and points of interest noted. These points of interest included, but were not limited to: feminist language, observations of self, expressions of humor, active versus passive stances, value judgments, theories about human development and pathology, comparisons, definitions, qualifiers, affective experiences, labels, descriptions, statements of need, personal biases, and beliefs about the connections between past experiences and current perceptions. After rereading the interview several times, the author experimented with different ways to organize these points of interest, eventually grouping them into categories. The preliminary categories that emerged from the first interview were: guiding notions, professional development, personal development, frame for therapy, and therapy behaviors/techniques. A diagram was used to illustrate the hypothetical connections between the categories (see Figure 2).

Each of the remaining interviews was then read using the same approach described above (i.e. an initial reading noting points of interest, followed by several rereadings to conceptualize categories and connections between categories). Categories from all nine interviews were eventually compared and synthesized. Three categories present in each of the nine interviews were considered primary categories and included: guiding notions about therapy, feminist therapy behaviors, and personal/professional experiences.

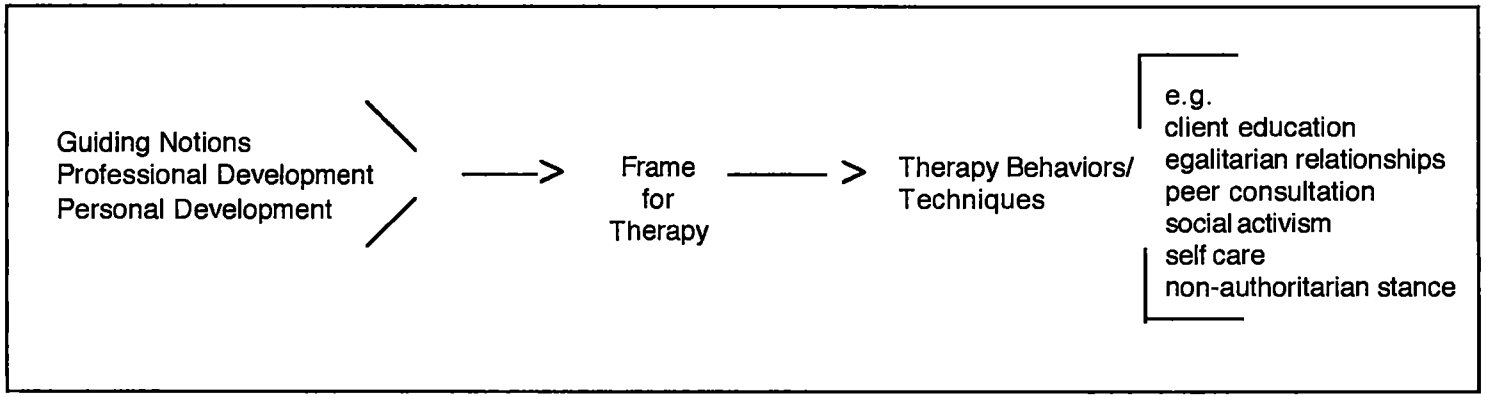

Figure 2. Initial diagram hypothesizing connections between categories.

The category guiding notions about therapy represented therapists' goals for therapy and the primary locus of their attention and investigation. Therapists articulated their guiding notions about therapy with ease. Three guiding notions emerged as central, including: (1) feminist therapy validates and legitimizes women's realities in order to help women clients take action; (2) feminist therapy emphasizes the impact of marginalization in order to challenge traditional conceptualizations that pathologize individual clients; and (3) feminist therapy empowers clients by enacting principles of egalitarianism in the client-therapist relationship. Although not every guiding notion was articulated by every therapist, the majority of therapists emphasized at least two guiding notions.

The category feminist therapy behaviors included specific techniques and stated goals of feminist therapy process. Examples, of feminist therapy behaviors included modeling competency, validating clients' perspectives, contextualizing clients' experiences within an oppressive culture, and viewing the client as the expert. Therapists provided less detail about this category than other categories.

Categories that were originally conceptualized as "personal development" and "professional development" were collapsed into a single category: personal and professional experience. This category represented defining experiences in therapists' lives that influenced their interest in feminist therapy practice. The following are examples of

personal and professional experiences that influenced feminist therapist identity development:

> Being a first-generation Chinese-American woman...I grew-up in a very traditional, conservative context. I was always very resentful of how my brother got all of the advantages I never got...it didn't make sense to me that he didn't have to do the housework...I wasn't sure that there was another way to experience the world, but I knew that I didn't like what I was experiencing. - M.

> [It was] the very beginning of the women's movement...There were eight of us who were in the [clinical psychology] program, there were four women. And there was nothing about women's issues, nothing...So we did what many people all around the country did...we just did it ourselves...we started what we called a 'feminist therapy study group'...we were looking at women's anger...at housework...women's friendships, and just some of the early kinds of things that we were intrigued with. - F.

The category originally labeled "frame for therapy" was modified after reading each of the nine interviews. "Frame for therapy" was reconceptualized as aspects of professional identity that represented "being a feminist therapist." Thus, "being a feminist therapist" was not considered a category, but the product of one's guiding notions, feminist therapy behaviors, and personal/professional experiences.

As fuller descriptions of categories emerged, an overarching schema representing the relation between primary categories was generated. This schema was a composite of the nine individual schemas and suggested that guiding notions about therapy, feminist therapy behaviors, and personal/professional experiences emerge from, and contribute to, being a feminist therapist (see Figure 3). This schema

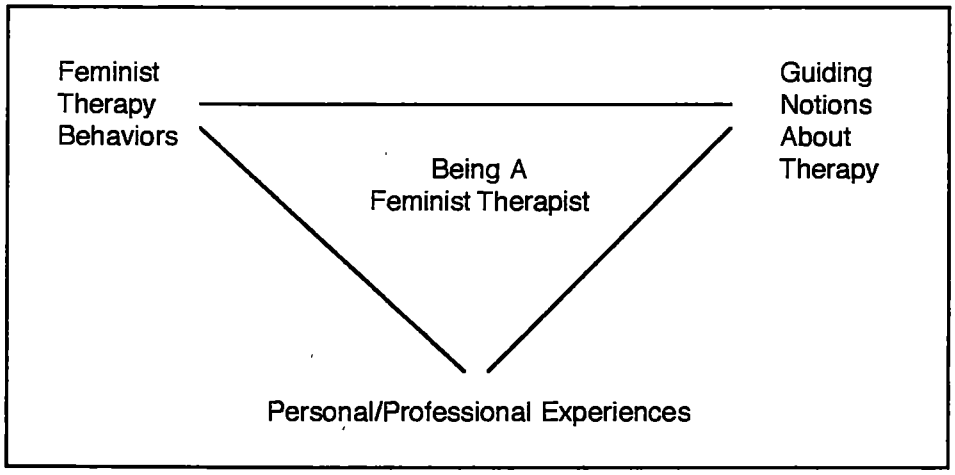

Figure 3. Diagram: On being a feminist therapist.

was similar to the internal structure of the semi-structured interview, undoubtedly due to the standardized questions asked to each participant.

Although the category personal/professional experiences provided the most rich data of any category, the depth of its content was considered beyond the parameters of the current study. Therefore, conclusions about therapists' personal and professional experiences as they related to feminist therapy practice were not established. Categories considered most central to the current study, guiding notions about therapy and feminist therapy behaviors, were explored in further detail. The relation between these two categories appeared to be parallel, although not every behavior was represented by a single guiding notion. An example of the parallel but overlapping nature of these categories is represented in Figure 4.

Finally, in order to challenge the author's assumptions and typical ways of thinking, a second reader, a licensed clinical psychologist, read each of the interviews. This second rater generated categories and connections between categories independently from the author. The two readers then discussed, compared, and evaluated their conceptualizations for accuracy. With the exception of guiding notions from two interviewees, the readers' conclusions about general impressions, specific therapy behaviors, labels for categories, and overarching conclusions were comparable. The two readers jointly refined the guiding notions wherein disagreement had occurred. This refinement

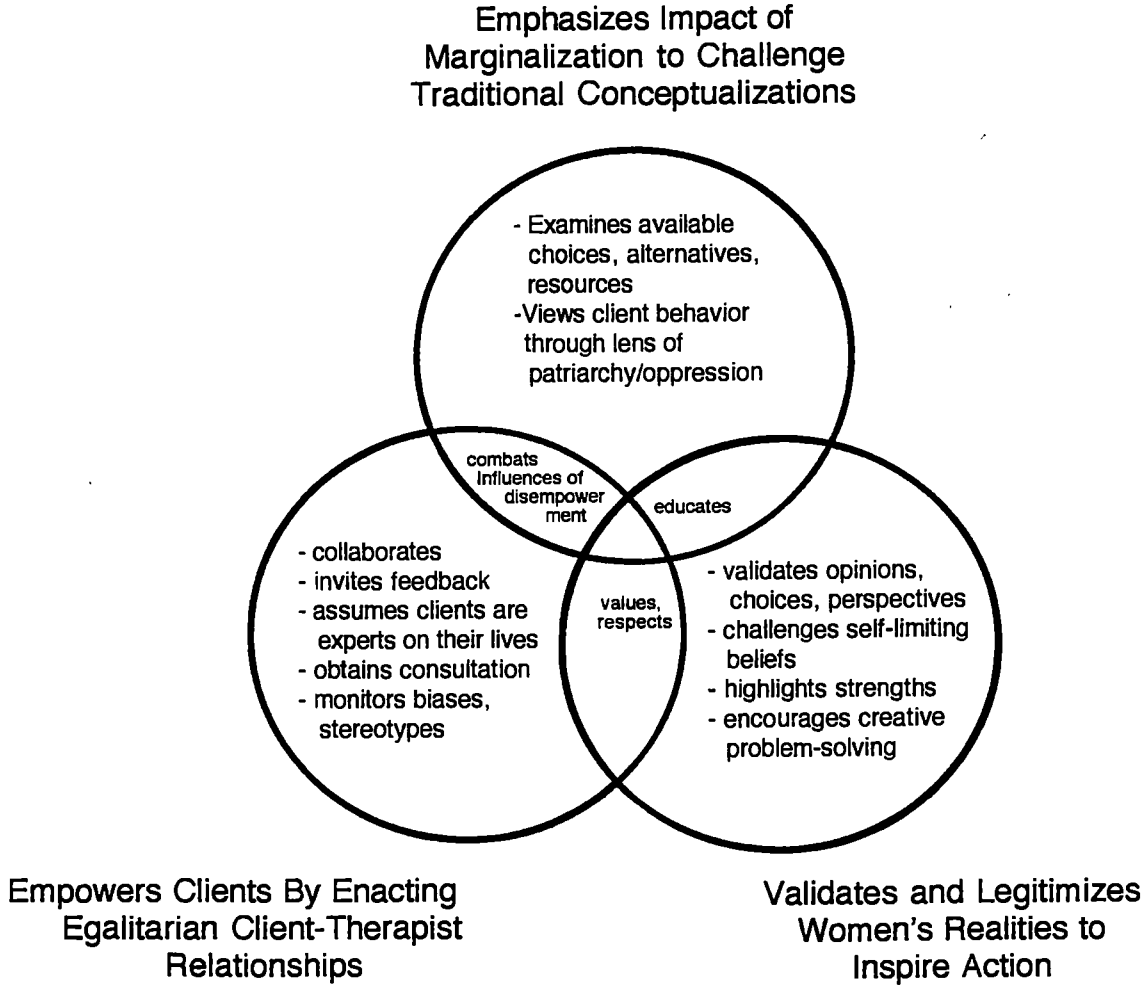

Figure 4. Connection between three guiding notions and feminist therapy behaviors.

did not change the constellation of the categories, nor their relation to one another.

It is important to note that the process of qualitative data analysis is always influenced by the subjectivity of the people conducting the analysis. The literature on qualitative analysis suggests, in fact, that the most important tool for extracting meaning from interview data is the researcher herself; emotional, subjective, and intuitive reactions are not only tolerated within qualitative analysis, but they are considered essential to the process (Ely et al., 1991; Lincoln & Guba, 1985). Thus, although the two readers used their personal and professional value systems in constructing meaning from the interviews, such personal perspectives of any given phenomenon are considered valuable as long as conclusions are qualified by the researcher's goals and intent.

Guiding Notions and Feminist Therapy Behaviors: Connections

Interview participants emphasized three guiding notions about feminist therapy that included validating and legitimizing women's realities in order to help women clients take action; emphasizing the impact of marginalization in order to challenge traditional conceptualizations; and empowering clients by enacting principles of egalitarianism. Corresponding to each guiding notion was a set of feminist therapy behaviors, the details of which are reviewed below.

Guiding Notion #1. The first guiding notion emphasized by the interviewees was that feminist therapy validates and legitimizes women's realities in order to help women clients

take action. By feeling supported in their opinions, choices, and viewpoints, women clients can be empowered to become proactive agents in their own lives. Interviewees stated that feminist therapists value client perspectives and help clients develop a sense of agency by challenging traditional gender-roles and encouraging creative problem-solving. Feminist therapists also educate clients and emphasize client strengths. Interviewees reported incorporating this guiding notion in a variety of ways:

> [I take] whatever necessary steps that would be empowering...like assertiveness training...[to] help her become more able to have her own opinions... - D.
>
> Not buying into the idea that just because they're female they can't do [the things that men can do]... - S.
>
> I model 'taking charge of things' for them... - S.
>
> I challenge them about the [limiting] things that they say about themselves...I try to make them think in a different way... - S.
>
> [I] free them up in their mind, first of all, and then they can begin to get more creative in their life and think about doing things they hadn't done before. -S.
>
> I'm there to validate her inner voice...I assume she has the answer. It's just a manner of creating enough safety for her to hear her inner voice...I believe that resilience is in all of us, it's a potential that we're born with...But it takes a certain environment for that resilience to blossom... - M.
>
> I try to create a sanctuary...for her to explore and do her own research into her life and her possibilities and where she wants to be. - M.
>
> [I] focus on the core issues for a woman, her sense of not having options, her inability to see her own strengths...her isolation... - M.

> Women need an opportunity to become consciousized...they need an opportunity to be able to recognize that there are alternatives... - M.
>
> I [am] mirroring where she is, giving her words, giving her an opportunity to be heard, validated... - M.
>
> I don't...assume anybody's thought patterns are 'irrational!' - M.
>
> [I] educate women...how to be proactive in gaining respect and equality in all the areas in their lives...[I teach them] different ways that they can communicate to others in a way that will get them what they need... - E.
>
> I offer...different kinds of readings... - E.
>
> [I help them] get educated about their goal and the facts... - E.
>
> I try to help them become empowered...to not have [people in powerful positions] use their authority in an abusive way. - E.

Guiding Notion #2: The second guiding notion generated by interviewees was that feminist therapy emphasizes the impact of marginalization in order to challenge traditional conceptualizations that pathologize individual clients. Those who are disempowered and discriminated against have fewer viable choices, alternatives, and resources as compared to those who are privileged. Interviewees suggested that feminist therapists highlight the role of sexism and patriarchy in the development of client difficulties. Feminist therapists use their knowledge about the effects of cultural disempowerment as a foundation for much of what they do with their clients. The degree to which feminist therapists convey their knowledge about disempowerment to

clients is unclear. Interviewees reported they challenge traditional conceptualizations in multiple ways:

> I look at everything that I'm doing [in] therapy through...a lens that says women are discriminated against...[I look at] what's happened [to them] in terms of patriarchy and sexism... - N.

> I see violence against women...[as] a pay-off for men...they benefit. I see many women as being real warriors and they become adaptive and they've done the best they can to deal with the situation. - N.

> Traditional theories, both in normal development and in psychopathology, have tended to locate the source of personality and behavior in the individual...[suggesting that] people walk around with their personalities in-tact, and it really distorts and denies how influenced we all are...by the world that surrounds us, by how supportive that world is, by the specific aspects of ourselves that get supported and those that don't...You have to take seriously...[how the]exploitations of the use of power has been a central cause of people's psychopathology. - F.

> [I] Attune...[to] the role of power and power differences...how disempowered [clients] may be in their current daily lives. - F.

> [I] understand that there are a lot of differences in the way men and women are both raised and treated in this society... - D.

> [I am] clued-into what it's like to be a woman and ...really understand how unempowered women feel... - S.

> Not assuming that the way that people deal with things happens in a vacuum. - T.

> Women have minority status...I want to look at the people I'm supervising and the people that I'm seeing with those kind of glasses. Minority...doesn't have to do with numbers. It has to do with position. And in terms of position, women typically have the lower position. - L.

> I...recognize the circumstances that [women] are in take away their power. So I want to say to them,

"Well, it's not necessarily your fault." - L.

[As a woman] your reactions are looked at negatively, your contributions are less valued...[you are] not encouraged as much...not expected to perform as much...[and your] opinions are discredited. - L.

I see a woman's life in context...it's impossible for me to separate her life from the social milieu and the political milieu. - M.

The person that you are looking at is the product of a multivariate analysis...the person is a combination or overlap of all the circles, gender, SES, race, ethnicity, ableism, sexual orientation, religious orientation...I seek to have an understanding of each of those components of somebody's identity... - M.

Guiding Notion #3: The third guiding notion emphasized by interviewees was that feminist therapy empowers clients by enacting principles of egalitarianism in the client-therapist relationship. The framework within which these behaviors occur was emphasized:

It's an approach and an attitude and a value system, [it is] more than a set of techniques... - B.

It absolutely runs through the work that I do and the way that I talk to [people]...it's part of who I am. There's no way to separate it out. - F.

Therapists enact egalitarianism by assuming a collaborative stance and by respecting and valuing client perceptions. Therapists empower clients by applying power analyses to the therapy relationship and by examining their own biases and stereotypes. Interviewees reported facilitating client empowerment by:

[Recognizing that] although I have more training in mental health than they do, that doesn't necessarily mean my opinions are always right. - B.

I don't do most of the things that tend to exacerbate the power difference between clients and therapists...like not answering [personal] questions, like having them using a title to call me and I call them by their first name, like never self-disclosing... - F.

...You have to talk to [clients] and you have to get consultation...you have to watch yourself, watch your own vulnerabilities. - F.

It is always a question of degree and at every step of the way there are technical issues that you have to be mindful of...self disclosure can be undisciplined focus on one's self and it can also lead into boundary violations... - F.

I see power as responsibility...[and] power differentials as additional responsibility. - M.

I'm very much a companion and a partner in her journey and I am both intellectually and emotionally present with her. - M.

I'm not going to lead her, [but] I'm not a blank slate. - M.

When I ask a question, I really don't anticipate knowing what the woman is going to say. - M.

You want [the client] to be empowered and get out of therapy. - D.

I...get myself into a "coach" position as fast as I can...you know, I'm [not] God. - D.

[I help them] decide [if] they want to stay in that world and try to adapt to it in a more healthy manner, or...put themselves in another context... - E.

I'm striving for a give and take of thoughts about what goals should be, how we should proceed, whether this is working or not, whether I'm doing something that bothers the client. I always invite people to give me feedback about that. - B.

[I'm] trying not to impose traditional values on clients about sex roles, not buying into our society's compulsory heterosexuality...recognizing that clients have the right to define for

> themselves what their sexuality is and what that means in their lives, what sorts of relationships they want to have. - B.

> [I] help clients have an experience of relating with me that can be a model of the way they can relate to other people...I want to emphasize that yes, it is possible to speak-up for yourself and be collaborative with someone...[in] authority... - B.

> Feminist are committed to having some sort-of availability to clients with lower incomes, whether it's through a sliding scale or doing some pro-bono work...[they are] concerned about the client's ability to access services... - B.

> Each [client] needs to determine for themselves what's going to be the most helpful. - B.

> I know that I have some authority...but I still think that there is a collaborative relationship...I don't like being called "doctor"...I don't think I need that authority. - L.

> When you offer your feedback as a therapist, just owning that as your own viewpoint...[so that clients] can disagree with your opinion. - T.

Remaining Issues

Although the interview data generated comprehensive findings regarding feminist therapy practice, several issues were not represented by the primary categories but are useful in considering the practice of feminist therapy. First, almost all of the interviewees indicated ambivalence about using the label feminist therapist. Therapists discussed the inherent risks of publicly identifying themselves or their practice as feminist in a world generally unsympathetic to feminist perspectives:

> I don't always call it that because the word 'feminist' gets some people's backs up, and I don't think that's necessary. - F.

> I just tell them how to be feminist without labeling it that! - S.

> I would never go out and say I'm a feminist therapist...the label 'feminist therapist' has probably picked-up a meaning that it wasn't intended to have...I think it's become increasingly associated with gay issues. What I'm proud of is being a "good clinical psychologist"...that's the label that I'm proud of and that's the one I carry. - D.

> I feel like I can utilize this perspective without labeling it! I think that people think feminist therapy must mean that you are trying to make your clients into little activists or that it's only for women... - T.

Second, in contrast to what the feminist therapy literature promotes, only one therapist indicated she regularly engaged in social activism (e.g. the participation in efforts to change laws, influence public policy, and improve the status of disempowered people). The majority of therapists indicated they had been more socially active when they were younger, or that social activism simply was not something they on which they focused. Therapists commented on their lack of social activism:

> I'm not...much of an activist. I used to be more of an activist when I was younger. - B.

> With all of this mess of managed care, I have found myself being politically active...[but] not necessarily [participating in] feminist activism. - S.

> [I] fight battles with colleagues behind closed doors...I think my political activism, if anything, has become more intense, because the battles are less visible. - M.

Third, therapists seemed unsure about how to promote social activism among their clients. Although most

therapists thought participating in social activism could be useful for clients, they felt uncomfortable about suggesting or encouraging social activism:

> I support their need to do something to try to fix things, but...I'm not particularly in their face about it... - F.

> I don't actively encourage in the sense of being directive...If somebody expresses an interest I would certainly support it. - B.

> I would probably not bring that up. I think that would need entirely to come from the person. - D.

> If that's what they chose to do...If they ask for that yes, as far as my bringing that up, no. - S.

Although the majority of feminist therapists stated they help clients counter the effects of marginalization, some feminist therapists failed to encourage or promote change beyond the individual level. Rather than helping clients learn how to challenge elements of the oppressive culture within which they live, some feminist therapists focused exclusively on individual adjustment:

> For me, that's what feminism is about...women being all that they can be in whatever area they choose to be themselves, whether it's being a Mom at home, or whether it's being a corporate executive... - S.

> I would not say that [working to change the culture] is particularly common...but I don't necessarily think that I do that right...I tend to be a person who focuses on the individual level more than the society level... - L.

Fourth, although most therapists stated that they viewed individual suffering in the context of a culture that promotes gender bias and patriarchy, one therapist actively disagreed with that conceptualization. Despite the fact that

she self-identified as a feminist therapist, this therapist emphasized interpersonal relationships over systemic oppression:

> A lot of people focus on the role of women in society as an oppressed minority group and see that as the core theme that a feminist therapist should be focusing on. But I have to honestly say that in my experience, that isn't the core with most people...with half my clients the core is that they were sexually abused as kids. And you could say that that's because women are oppressed in this society or it's because men think that they have the right to abuse all females...but to me that's kind-of simplistic. To me, it's that someone in their lives crossed their boundaries and really harmed them. - B.

Fifth, only two interviewees discussed the applicability of feminist therapy when working with issues presented by clients of racial and ethnic diversity. The majority of interviewees neglected to mention the centrality of diversity-awareness and appeared to focus the majority of their clinical and research efforts on Caucasian women. Although the feminist therapy literature has promoted increased attention to issues of diversity, one therapist commented on the ways in which feminist therapy is incomplete:

> ...Within the feminist movement, there has not been a real place for women of color...[I have been] reading a lot of cultural psychology literature. I think I've attempted to blend the two...It's not that feminism is wrong, but it [needs to] be supplemented. - M.

Finally, none of the participants spontaneously described the role of therapist self-care as being an important component of feminist therapy practice. When asked

directly, five of the participants indicated they engage in moderate amounts of self-care (e.g. peer consultation, personal therapy, exercise, vacations, etc.), although four of the self-identified therapists indicated that they did not proactively pursue self-care at all.

CHAPTER 4

DISCUSSION

Three distinct measures--a semi-structured interview, a memorable case description, and a feminist therapy behavior checklist--were used to assess feminist therapy practice. Results indicated that feminist therapy is ~~comprised~~ composed of/comprises certain therapist behaviors, although not all therapy behaviors promoted by the feminist therapy literature were evidenced. Results also indicated that feminist identification appeared to predict the self-reported use of feminist therapy behaviors.

Through semi-structured interviews, self-identified feminist therapists articulated the specific objectives of feminist therapy practice. Three guiding notions of therapy emerged as central, including: validating and legitimizing women's realities in order to help women clients take action; emphasizing the impact of marginalization in order to challenge traditional conceptualizations of pathology; and empowering clients by enacting principles of egalitarianism in the client-therapist relationship. Specific behaviors corresponding to these guiding notions were elaborated. Examples of feminist therapy behaviors included helping women voice their perspectives, encouraging creative problem-solving, examining client behavior within the context of patriarchy, and assuming that clients are the experts on their lives.

Memorable case descriptions also assessed the objectives

that comprise feminist therapy practice. Using 16 tenets of feminist therapy (Wyche & Rice, 1997) for classification, memorable case descriptions indicated that the majority of self-identified feminist therapists work to expand women's alternatives, options, and choices. The majority of therapists also focused on the cultural, social, political, economic, and historical factors influencing women's lives. At least one-third of self-identified feminist therapists indicated they: recognized being female always occurs in a cultural, social, political, economic, and historical context; used a collaborative process to establish the goals, direction, and pace of therapy; helped girls and women understand how they have incorporated societal beliefs and values in order to help them create their own perspectives; and acknowledged that violence against women, overt and covert, is emotionally, physically, and spiritually damaging.

Several objectives considered primary in the feminist therapy literature were <u>not</u> consistently referenced by feminist therapists in the current study. First, in both the semi-structured interviews and the memorable case descriptions, almost none of the self-identified feminist therapists emphasized the importance of striving to create broad social change. Therapists did not typically report participating in social activism, nor did they promote social activism among their clients. Although most therapists indicated they would support clients engaging in social activism if the clients initiated interest, none felt comfortable directly suggesting or encouraging social

activism as a component of treatment.

Unfortunately, previous authors have noted similar findings (Enns, 1993; Morrow & Hawxhurst, 1998). Some have speculated that a lack of social activism among therapists is an inevitable consequence of attempting to "professionalize" feminism (Morrow & Hawxhurst, 1998). Others suggest a lack of social activism may occur as a result of the paradoxical tension that exists between attending to the needs of an individual client versus encouraging activism that benefits the group, but may compromise the needs of the client (Parvin & Biaggio, 1991).

To acknowledge the influences of oppression on clients' experiences is an essential component of feminist therapy, but alone is insufficient. For therapy to be feminist, it must explore ways to help clients challenge the influences of oppression. Inherent in conceptualizing clients' struggles as rooted in context is a commitment to change that context. Without engaging in efforts to change the culture, change within the individual is never complete. Membership to a marginalized group will always limit a person's choices and render them with fewer resources and less individual and collective power.

Second, self-identified feminist therapists in the semi-structured interviews and memorable case descriptions reported attending primarily to the effects of gender-bias, sexism, and patriarchy. Therapists did not typically emphasize the bias and discrimination that occur as a result of other sources of oppression, such as racism, classism, or

homophobia. Although feminist therapy is supposedly a viable form of treatment for all clients, therapists in this sample applied the principles of feminist therapy almost exclusively to female clients--and to Caucasian females clients at that! According to Brown (1994b), in order for feminist therapy to embody a truly "anti-oppression" stance it must not assume the primacy of gender oppression over other forms of oppression that influence clients' lives. Thus, feminist therapists may need to further educate themselves about multi-cultural perspectives as they strive to make their services accessible to a wide range of clients.

Third, although self-identified feminist therapists in the semi-structured interviews and memorable case descriptions emphasized the importance of egalitarian client-therapist relationships, they did not reference certain elements that are essential to creating such a relationship. For instance, few therapists stated they actively monitor their own biases and stereotypes or utilize self-disclosure. Although these behaviors may be so subtly interwoven in the process of therapy that therapists did not think to specify them as independent entities, monitoring biases and self-disclosing are critical feminist therapy techniques that may be generally underused.

Finally, few therapists indicated they proactively pursue self-care. In fact, several therapists in the semi-structured interviews indicated they neglect self-care almost completely. This, despite the fact that therapist self-care is a major component of the Feminist Therapy Institute code

of ethics (Feminist Therapy Institute, 1987). Therapist self-care is not only critical for therapist health and empowerment--especially as females now constitute the majority of therapist positions in the field--but is also essential to modeling, an essential tool for client education. Assisting therapists in developing self-care abilities may need to assume priority status in professional education and development initiatives.

Regarding self-identity, therapists in the semi-structured interviews indicated they were ambivalent about using the term feminist therapist publicly with colleagues and clients. Therapists suggested their ambivalence is based on fears of negative evaluation and professional rejection. The current backlash against pro-feminist ideology and activism (Faludi, 1991) undoubtedly influences the freedom with which therapists identify themselves as feminist. "Femi-natzi" has become a popular derogatory term to describe feminists, and postfeminist rhetoric suggesting women have attained equal status--and should therefore abandon feminist pursuits--is plentiful.

The literature suggests therapists' fears are not unfounded. A recent study concluded that although certain positive attributes are considered "typical" of feminists--such as being serious, intelligent, and productive--negative attributes such as being angry, tense, egotistical, opinionated, stubborn, aggressive, and dominant are also considered "typical" (Twenge & Zucker, 1999). This same study found that feminists are much more likely to be

stereotyped as lesbian than the average woman. Thus, the possibility of negative evaluation and stereotyped judgments toward those who publicly identify as feminist therapists appears to be significant. The consequences of such evaluations on hiring, promotion, and referral practices are unknown, but one suspects they are not positive. Of additional concern is that feminist therapists may be losing the power associated with the act of naming. If therapists who privately identify as feminist therapists do not appropriate the term publicly, they are essentially allowing others to define its meaning. As Morris (1997) states, "Those who name some phenomenon thereby claim it in the sense that they determine how it shall be known" (p. 64-65).

This connection between self-labeling and therapy behavior was explored in the current study with the feminist therapy behavior checklist (FBC). In general, feminist identification predicted the use of feminist therapy behaviors. Based on self-report, therapists with higher feminist identification were more likely to use feminist therapy behaviors than therapists with lower feminist identification. This finding has been previously reported by other researchers (Chaney & Piercy, 1988; Juntunen et al., 1994; Dankoski et al., 1998; Black & Piercy, 1991).

Feminist identification also appeared to predict the use of specific types of feminist therapy behavior. Therapists with higher feminist identification were more likely to analyze sex-roles, encourage a redistribution of power, and work to minimize hierarchy in the client-therapist

relationship than therapists with lower feminist identification. Feminist identification did not predict the use of two types of feminist therapy behavior, however, including empowering clients and skill training. The most plausible explanation for these findings is that the items comprising these subscales were endorsed by the majority of therapists, regardless of feminist identification. This lack of variation in the endorsement of some feminist therapy behaviors between feminist and non-feminist therapists has been found in previous studies; most therapists, regardless of feminist identity, endorse most feminist therapy behaviors (Chaney & Piercy, 1988; Dankoski et al., 1998; Juntunen et al., 1994).

One hypothesis for this finding is that feminists are taking credit for "good therapy behaviors" that have been valued and practiced by clinicians all along. A second hypothesis is that feminists have succeeded in transforming typical traditional therapy practices such that feminist approaches are now considered "good therapy". A third possibility suggests a combination of the two: maybe "feminist-like" behaviors have been valued by some therapists all along, but feminists have been the ones to identify, label, and promote them as both useful and necessary.

Feminist identification was associated with gender, with women more likely to report higher feminist identification then men. Associations between feminist identification and age, income, race/ethnicity, and sexual orientation were not established. Few therapists have ever received formal

training in feminist therapy. Although feminist identification was associated with having received feminist training in workshops (i.e. therapists with higher feminist identification were more likely to have received formal feminist training from workshops than therapists with lower feminist identification), it is probable that therapists who report an interest in feminism self-select their attendance at workshops on feminist therapy. Feminist identification was not significantly associated with having received feminist training in graduate school. Associations between feminist identification and having received feminist training in supervision, post-doctoral study, practica, continuing education, and internship were not established.

A lack of exposure to feminist therapy training is problematic since it appears that levels of sexism in diagnosis are higher for therapists who do not receive gender coursework from a feminist perspective (Leslie & Clossick, 1996). Even small scale training efforts are better than none. Gray, Alterman and Litman (1988) demonstrated the impact of a 30-hour training program in feminist therapy on the attitudes of mental health professionals. Results indicated that, compared to controls, participants exhibited a significant increase in awareness of feminist issues, such as "sexism is a problem," "psychotherapy is political," and "women's empowerment is important." Thus, the argument for increased training in feminist approaches to psychotherapy is supported.

Feminist identification was moderately associated with

the year therapists received their last degree. Therapists who received their degrees more recently had slightly higher feminist identification than therapists who had received their degrees less recently. Although this trend may indicate differences in feminist training across generations, it is more likely the result of other factors, including greater numbers of women students entering graduate school, greater numbers of women obtaining faculty positions, and the more wide-spread availability of feminist-informed literature. This trend may also simply mirror an increasing acceptance of feminist ideas--as evidenced, for example, by increasing numbers of women's studies programs and women's athletic teams--that ultimately impact individual conceptualizations of identity. Associations between feminist identification and theoretical orientation were not established.

Limitations of the Study

A low survey return rate and small sample size undoubtedly influenced the results of the current study. With little variability in demographic representation or in the range of therapist behaviors, some questions were simply impossible to assess (e.g. associations between feminist identification and race/ethnicity). Even when the assessment of feminist therapy behavior was successful, effect sizes were consistently small. Variability within the sample may have been limited due to the method of assessment (i.e. a mailed survey), since it is likely that most respondents were

at least partially sympathetic to feminist perspectives.

In this study, feminist identification was represented by participants' self-report to questions regarding personal identity, professional identity, and professional behavior. Although measuring therapists' self-identification was essential to the study, future studies may want to measure additional aspects of feminist identification. For example, research has shown that there are distinct perspectives toward feminism, including: a radical/anti-racist position; a liberal position; a humanist position; a conservative position with some anti-feminist elements; and a postfeminist position (Snelling, 1999). Research has also demonstrated that feminists can be in one--or more--of four stages of feminist therapy identity development (Whipple, 1996). These stages include: (1) having a personal sense of identity as a feminist; (2) awareness of the existence of sexism in therapy; (3) integration of feminist values into therapy theory and practice, and (4) consolidation of personal and professional identity. Exploring the connection between feminist therapy behaviors and variations in feminist perspectives or stages of development may be useful.

Although the Feminist Behavior Checklist used in the current study was based on the established Feminist Family Therapy Behavior Checklist (Chaney & Piercy, 1988), its validity is questionable. The modifications made to the original checklist for use in the current study were based on empirically valid modifications by Juntunen et al. (1994), but were not exact with regard to the wording of specific

items or the overall reduction of items. Thus, the modifications used in the current study may be one reason why the the two subscales of feminist therapy behavior, empowering clients and skill training, were not associated with feminist identification.

Two sections of the survey that assessed feminist therapy behavior, the feminist behavior checklist and the memorable case description, were based on retrospective, self-report. Although these techniques are commonly used in psychology research, the data they produced may have been skewed on account of social desirability. For example, when completing the feminist therapy behavior checklist, who would not want to remember him or herself as a therapist who did not, "encourage my client to assess his/her own change and growth," whether or not that behavior actually took place in the therapy?

The memorable case descriptions required therapists to provide written accounts of a case and to generate--from memory--the elements that made the therapy feminist. Just because a therapist did not mention a feminist therapy behavior in the written account, does not mean that the behavior never occurred. Thus, the memorable case descriptions may not have been a thorough measure of feminist therapy behavior. The format of the written summary may have been too brief, and ultimately too superficial, to capture the subtle elements and nuances of feminist therapy practice.

The 16 tenets of feminist therapy developed at the first National Conference on Education and Training in Feminist

Practice (Worell & Johnson, 1997; Wyche & Rice, 1997) that were used to categorize feminist behaviors in the memorable case descriptions did not seem to represent distinct behaviors. Using this method of categorization with the memorable cases proved somewhat difficult as several of the tenets (e.g. tenets 1 and 2, and tenets 11, 12, 13) were often represented by the same behavior.

Conclusion

Feminist therapists indicated they validate women's realities in order to help women clients take action. Feminist therapists also emphasize the impact of marginalization in order to challenge traditional conceptualizations of pathology, and empower clients by enacting principles of egalitarianism in the client-therapist relationship. Feminist therapists reported working to expand clients' alternatives, choices, and options, and reported focusing on the cultural, social, political, economic, and historical factors that affect clients' lives. Therapists with high levels of feminist identification consistently endorsed feminist therapy behaviors such as analyzing sex-roles, encouraging a redistribution of power, and minimizing hierarchy in the client-therapist relationship. The majority of therapists regardless of feminist identification, however, reported using feminist therapy behaviors.

Most feminist therapists were not social activists, nor did they promote social activism among their clients. Few feminist therapists highlighted the importance of attending

to issues of diversity unless they themselves were a part of another marginalized group (i.e. unless they were lesbian or an ethnic minority). Few therapists acknowledged the importance of continually challenging their own biases or self-disclosing with clients. None of the therapists indicated they prioritize therapist self-care.

The most perplexing issue to emerge from the current study concerns the degree to which feminist therapy is really feminist, and thus qualitatively different from "good" non-feminist therapy. Self-identified feminist therapists were, on the whole, extremely concerned about women. They were well-intentioned and evidenced sensitivity to the issues women face. However, some behaviors labeled feminist did not appear especially unique. For instance, validating clients perspectives, examining the role of socialization, and inviting client feedback--while valuable therapist behaviors--are not exclusively feminist.

Even therapy behaviors labeled feminist in standardized scales may not be significantly different from non-feminist therapy behaviors. In Chaney and Piercy's (1988) Feminist Family Therapy Behavior Checklist, the subscale therapist empowers female clients (modified for this study to be empowering clients) targets behaviors such as enhancing the self-esteem of female clients, underlining female clients' competence, and helping female clients negotiate for their own personal time. It seems reasonable to assume that most therapists strive to increase their clients' self-esteem, competence, and ability to negotiate for personal time,

regardless of the client's gender. Although these behaviors are positive and worthwhile, are they feminist simply because they are aimed at women?

The current study suggests that a therapist's intention defines a behavior as feminist. Engaging in behaviors with the primary purpose of improving the status of women, on individual and collective levels, is what seems to distinguish feminist therapy behavior from "good" non-feminist therapy behavior. Essential to this intention, however, is its public pronouncement. In order to retain the political spirit of feminism, therapists must--without hesitation--define themselves publicly as feminists. By sharing one's goal of improving the status of women with both clients and colleagues, a therapist advocates for systemic change. Without this public pronouncement, the enactment of feminist therapy behaviors may be compromised. If therapists do not identify themselves as feminists, are they in a position to be true activists? If therapists do not identify themselves as feminists, are they able to uphold their ethical guidelines to self-disclose, foster egalitarian relationships, and empower clients to have choice as "consumers" of therapy?

Of additional consideration is the increasing application of feminist therapy theory to all marginalized people. As feminist theory has become less focused on women exclusively, its political emphasis may have become diluted. If feminist therapy is primarily an "anti-oppression" force rather than an "anti-patriarchy" force, it may inevitably

cross-over the line into humanism, where every person is considered equal in their striving to create meaning and purpose in life. In order to foster the empowerment of women, feminist efforts may need to reclaim gender-based oppression as their primary, or exclusive, focus.

Ultimately, the current study leads one to reexamine the fundamental compatibility of feminism and psychotherapy. Can a political philosophy designed to target systemic oppression subsist within a practice that focuses primarily on "individual functioning" and "individual treatment?" Some authors, indeed, have suggested that feminist therapy may be oxymoronic (Brown, 1994b; Perkins, 1991). Although the solution to this puzzle is uncertain, there is no reason for feminists therapists to abandon their work--yet; only to continue questioning their ability to embody and promote feminist ideology through a system that is counter-designed.

Part of the answer will lie in future studies that further explore not only the specific behaviors that comprise feminist therapy practice, but <u>how feminist therapists understand these behaviors to be feminist</u> and <u>how clients' goals for therapy are transformed as a consequence</u>. The most meaningful studies will be observational in nature. Future studies may, for example, videotape feminist therapy sessions and ask therapists to review the tapes, explaining which statements or techniques were feminist and why. Additionally, some form of client assessment may be needed to assess whether or not feminist therapy successfully transmits feminist messages to clients. The power of feminist therapy

is in its ability to help clients develop a new understanding of themselves in relation to the culture. Thus, it is important that clients be able to articulate this understanding.

Promising results are also likely to emerge from studies that explore the paradoxes of feminist therapy. Parvin and Biaggio (1991) have identified five paradoxes, including: (1) meeting the needs of the individual client vs. compromising the needs of the individual client for activist pursuits that benefit the group; (2) seeing therapy as a place where clients have the freedom to create their own sense of meaning vs. therapy as a place where meaning is created through a feminist lens with the help of the therapist; (3) determining what counts as a client's "choice" vs. a "politically correct" choice; (4) maintaining appropriate boundaries vs. "joining" with the client; and (5) viewing women as a single entity vs. recognizing issues of diversity. Exploring the ways that feminist therapists contend with these paradoxes may illuminate the pieces of feminism that are compatible, and those that are incompatible, with psychotherapy.

Despite all that is unknown about the future of feminist therapy, feminist philosophy remains essential to the study of human development and health. Regardless of whether or not feminist approaches are ever fully integrated into psychotherapy practice, they will always be useful for evaluating psychotherapy process. As Brown and Brodsky (1992) state:

> We will always be a voice for the least powerful and most oppressed in our cultures: we will always

be a source of irritation to whatever complacencies about their good intentions that our colleagues may develop about their work with women and members of other disenfranchised and at-risk groups. We will continually challenge mainstream theories and practices to be more inclusive of human diversity, more questioning of their assumptions, more willing to scrutinize their need to be paternalistic with functioning adult clients. We will continue to remind all therapists that gender is an important and highly meaningful category of analyses whose power cannot be denied or minimized at any state of the therapeutic endeavor. We believe that it is this focus, this process of feminist therapy, that presages what our contributions will be in years to come." (p. 56).

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APPENDICES

APPENDIX A

TENETS OF FEMINIST THERAPY

Tenets of Feminist Therapy
(Wyche & Rice, 1997)

1. Feminist therapy recognizes that being female always occurs in a cultural, social, political, economic, and historical context and affects development across the life span.

2. Feminist therapy focuses on the cultural, social, political, economic, and historical factors of women's lives as well as intrapsychic factors across the life span.

3. Feminist therapy includes an analysis of power and its relationship to the multiple ways women are oppressed; factors such as gender, race, class, ethnicity, sexual orientation, age, and ablebodiness, singly or in combination, can be the basis for oppression.

4. Feminist therapy acknowledges that violence against women, overt and covert, is emotionally, physically, and spiritually damaging.

5. Feminist therapy acknowledges that misogyny exists in all women' lives and is emotionally, physically, and spiritually damaging.

6. Feminist therapy's primary focus is on strengths rather than deficits. Therefore, women's behaviors are seen as understandable efforts to respond adaptively to oppressive occurrences.

7. Feminist therapy is committed to social change that supports equality for everyone.

8. Feminist therapy is based on the constant and explicit monitoring of the power balance between therapist and client and pays attention to the potential abuse and misuse of power within the therapeutic relationship.

9. Feminist therapy strives toward an egalitarian and nonauthoritarian relationship based on mutual respect.

10. Feminist therapy is a collaborative process in which the therapist and client establish the goals, direction, and pace of therapy.

11. Feminist therapy helps girls and women understand how they have incorporated societal beliefs and values. The therapist works collaboratively with them to challenge and transform those constructs that are destructive to the self and helps them create their own perspectives.

12. Feminist therapy empowers girls and women to recognize, claim, and embrace their individual and collective power as girls and women.

13. Feminist therapy expands girls and women's alternatives, options, and choices across the life span.

14. Feminist therapy is a demystification process that validates and affirms the shared and diverse experiences of girls' and women's lives.

15. Feminist therapy involves appropriate types of self-disclosure. However, because self-disclosure may be harmful, it must be both value and theory driven and always in the client's best interest. Therapists must develop methods of continually monitoring their level of self-awareness.

16. Feminist therapists are committed to continually monitoring their own biases, distortions, and limitations, especially with respect to cultural, social, political, economic, and historical aspects of girls' and women's experiences.

APPENDIX B

FEMINIST THERAPY CODE OF ETHICS

Feminist Therapy Code of Ethics

(Feminist Therapy Institute, 1987)

I. Cultural Diversities and Oppressions

(1) A feminist therapist increases her accessibility to and for a wide range of clients from her own and other identifies groups through flexible delivery of services. When appropriate, the feminist therapist assists clients in accessing other services.

(2) A feminist therapist is aware of the meaning and impact of her own ethnic and cultural background, gender, class, and sexual orientation, and actively attempts to become knowledgeable about alternatives from sources other than her clients. The therapist's goal is to uncover and respect cultural and experiential differences.

(3) A feminist therapist evaluates her ongoing interactions with her clientele for any evidence of the therapist's biases or discriminatory attitudes and practices. The feminist therapist accepts responsibility for taking action to confront and change any interfering or oppressing biases she has.

II Power Differentials

(1) A feminist therapist acknowledges the inherent power differentials between client and therapist, and models effective use of personal power. In using the power differential to the benefit of the client, she does not take control of power which rightfully belongs to her client.

(2) A feminist therapist discloses information to the client which facilitates the therapeutic process. The therapist is responsible for using self-disclosure with purpose and discretion in the interests of the client.

(3) A feminist therapist negotiates and renegotiates formal and/or informal contacts with clients in an ongoing mutual process.

(4) A feminist therapist educates her clients regarding their rights as consumers of therapy, including procedures for resolving differences and filing grievances.

III. Overlapping Relationships

(1) A feminist therapist recognizes the complexity and conflicting priorities inherent in multiple or overlapping relationships. The therapist accepts responsibility for monitoring such relationships to prevent potential abuse of or harm to the client.

(2) A feminist therapist is actively involved in her community. As a result, she is especially sensitive about confidentiality. Recognizing that her client's concerns and general well-being are primary, she self-monitors both

public and private statements and comments.
(3) A feminist therapist does not engage in sexual intimacies nor any overtly or covertly sexualized behaviors with a client or former client.

IV. Therapist Accountability
(1) A feminist therapist works only with those issues and clients within the realm of her competencies.
(2) A feminist therapist recognizes her personal and professional needs, and utilizes ongoing self-evaluation, peer support, consultation, supervision, continuing education, and/or personal therapy to evaluate, maintain, and improve her work with clients, her competencies, and her emotional well-being.
(3) A feminist therapist continually reevaluates her training, theoretical background, and research to include developments in feminist knowledge. She integrates feminism into psychological theory, receives ongoing therapy training, and acknowledges the limits of her competencies.
(4) A feminist therapist engages in self-care activities in an ongoing manner. She acknowledges her own vulnerabilities and seeks to care for herself outside of the therapy setting. She models for the ability and willingness to self-nurture in appropriate and self-empowering ways.

V. Social Change
(1) A feminist therapist actively questions other therapeutic practices in her community that appear abusive to clients or therapists, and when possible, intervenes as early as appropriate or feasible, or assists clients in intervening when it is facilitative to their growth.
(2) A feminist therapist seeks multiple avenues for impacting change, including public education and advocacy within professional organizations, lobbying for legislative actions, and other appropriate activities.

APPENDIX C

SURVEY

Dear Colleague,

I am a doctoral student in clinical psychology at The University of Tennessee and am inviting you to complete the attached questionnaire. The purpose of the questionnaire is to 1) determine the beliefs and behaviors of feminist and non feminist therapists, and 2) understand the ways in which feminist therapy is implemented by practitioners who identify themselves as feminist therapists.

The questionnaire does not contain any questions or markings that would identify you as a respondent, and thus, your anonymity is assured. Your return of the questionnaire will constitute your informed consent to participate in this study.

I know that your time is valuable and limited. Therefore, I have designed this project so that your participation really will make a difference. **For each completed questionnaire returned, a $5 donation* will be made to the Knoxville Women's Center**, an organization that assists women in achieving economic self-sufficiency through skill training, interview preparation, and the provision of a suitable wardrobe for the workplace. The Knoxville Women's center seeks to build self-esteem and job-readiness for women of all socioeconomic levels.

Included with this questionnaire is a postcard that invites you to participate in a structured interview on the topic of feminist therapy. If you are interested or willing to be interviewed, please return the completed postcard. A consent form will be mailed to you promptly.

If you have any questions about this research, either now or later, please contact:

Kayce L. Meginnis
Department of Psychology
227 Austin Peay Building
University of Tennessee
Knoxville, TN 37996

Thank you for your time.

* Sponsored by Goody's Family ClothingTM

Degree:
___ Masters
___ Doctoral

What's your major field?:
___ Clinical Psychology
___ Counseling Psychology
___ Marriage & Family Therapy
___ Social Work
___ Other

Gender:
___ F
___ M

Age:
___ 34 and under
___ 35 - 44
___ 45 - 54
___ 55 - 64
___ 65 and over

Race/Ethnicity:
___ Asian American
___ Black/African American
___ Chicano/Latino/Hispanic
___ Multi-ethnic
___ Native American
___ White/European American

Marital/Relationship Status:
___ Single
___ Committed (non-married relationship)
___ Married
___ Divorced

Sexual Orientation:
___ Heterosexual
___ Homosexual (Gay/Lesbian)
___ Bisexual

Are you ABPP certified?
___ Yes
___ No
___ Don't know

Primary Work Setting (Check Only <u>One</u>):
___ College Counseling Center
___ CMHC
___ Hospital
___ Private Practice
___ University
___ Other

Average Annual Individual Income:
___ 19,000 and under
___ 20,000 - 34,000
___ 35,000 - 49,000
___ 50,000 - 64,000
___ 65,000 - 79,000
___ 80,000 - 94,000
___ 95,000 and over

<u>Rank order the top 2</u> theoretical orientations that best describe your clinical work:
___ Cognitive-Behavioral
___ Eclectic
___ Feminist
___ Gestalt
___ Object-Relations
___ Psychodynamic
___ Systems
___ Other _____

Have you ever received any formal feminist training? If so, where? (Check all that apply)
___ clinical internship
___ continuing education program
___ graduate school
___ post-doctoral training
___ practicum
___ supervision
___ workshop/seminar
___ other

In my practice I treat (check one):
___ exclusively women
___ more women than men
___ equal numbers of men and women
___ more men than women
___ exclusively men

In my practice I treat (check one):
___ exclusively individuals
___ more individuals than groups/families
___ equal numbers of individuals and groups/families
___ more groups/families than individuals
___ exclusively groups/families

In my practice I treat (check one):
___ exclusively Caucasian clients
___ more Caucasian clients than Ethnic Minority clients
___ equal numbers of Caucasian and Ethnic Minority clients
___ more Ethnic Minority clients than Caucasian clients
___ exclusively Ethnic Minority clients

In my practice I treat (check one):
___ exclusively heterosexual clients
___ more heterosexual clients than gay/lesbian clients
___ equal numbers of heterosexual and gay/lesbian clients
___ more gay/lesbian clients than heterosexual clients
___ exclusively gay/lesbian clients

How many clients do you see on average per week?

_____

When did you complete your last degree?

_____

1. To what extent are you a feminist in your personal life?

Not At All Very Much

1	2	3	4	5

2. Please describe "feminism" and explain why you circled the number you did.

3. How often do you incorporate feminist techniques into your clinical practice?

Never Occasionally Always

1	2	3	4	5

4. In your professional practice, do you consider yourself a feminist therapist?

Not At All Very Much

1	2	3	4	5

5. Please describe "feminist therapist" and explain why you circled the number that you did.

6. Thinking of your own therapy clients, choose the most memorable case that you think incorporated "feminist" philosophy and technique and that seemed to work especially well. In reference to your work with this client, please describe the following information. (If you do not consider yourself a feminist therapist in any way, please skip to page 7.)

A. Client's:age _____

gender _____

sexual orientation _____

race/ethnicity_____

marital status _____

approximate # of sessions seen _____

B. Presenting Problem

C. Explain the goals of treatment:
- how were they chosen?
- how were they informed by feminist theory/technique?
- what progress was made?

D. In your mind, what techniques or processes made this treatment "feminist"?

Thinking of your own therapy clients, choose one client (for those of you who answered the previous question, please keep the same client in mind) and indicate whether or not you engaged in this behavior with the client at least once during his/her treatment:

1. I educated my client about the inequality of status and power between the sexes.....N Y

2. I challenged my client to develop more egalitarian relationships.....N Y

3. I underlined my client's competence.....N Y

4. I educated my clients about assertive and functional ways of expressing anger.....N Y

5. I modeled both instrumental and expressive behavior.....N Y

6. I raised sex-role issues whether or not they came up.....N Y

7. I suggested alternative sex-role behaviors to my client.....N Y

8. I encouraged my client to be more assertive.....N Y

9. I used role play to help clients integrate new sex-role behaviors.....N Y

10. I clearly communicated my own sex-role values.....N Y

11. I reframed my client's definition of the problem to include the impact of socialization.....N Y

12. I directed my client to become involved in status-related activities outside the family.....N Y

13. I encouraged my client to develop a social support network.....N Y

14. I taught my client to assess and meet his/her own needs.....N Y

15. I assumed a collaborative role with my client.....N Y

16. I reeducated my client about roles which are oppressive to both men and women.....N Y

17. I supported my client's moves to expand beyond traditional sex-role behavior.....N Y

18. I supported my client's competence in both traditional and non-traditional roles.....N Y

19. I taught my client to recognize and express his/her feelings...N Y

20. I encouraged my client to assess his/her own change and growth.....N Y

Thank you for participating.

APPENDIX D

FEMINIST FAMILY THERAPY BEHAVIOR CHECKLIST: SCALE DEVELOPMENT

The Feminist Family Therapy Behavior Checklist (FFTBC: Chaney & Piercy, 1988) was designed to be an observational instrument that assesses the use of feminist family therapy techniques. In constructing the FFTBC, a list of 62 feminist family therapy techniques was generated from the feminist therapy literature, as well as from feminist therapists themselves. Thirty-nine items were deemed by two of three raters as being "feminist family therapy techniques" and were included in the checklist.

The participants in the standardization study of the FFTBC were family therapists (N = 60) who worked either in training institutions or private practice settings. The therapists agreed to be observed either live (n = 12) or by videotape (n = 48) by one of two raters while they conducted a 50-minute family therapy session. Therapists were rated on the degree to which they used feminist therapy techniques and behaviors using the 39-item list.

Several measures of reliability were conducted on the FFTBC. Test-retest reliability revealed 98.9% agreement between raters' initial ratings and their ratings two weeks later on 10 sessions. Adjusted for chance, Kappa indicated a 92.5% rate of agreement. Inter-rater reliability was also assessed on 10 sessions and revealed an agreement rate of 98.7%, 92.1% after adjusting for chance. To ensure that ratings for live and taped sessions were comparable, 8 live sessions were also taped. A 99.7% agreement on live versus taped sessions was found which was 98.4% after being adjusted for chance.

Content validity was determined by the initial three raters who had to reach majority agreement for each item in order for it to be included on the final checklist. Construct validity was measured by comparing the scale to several "theoretically derived hypotheses" regarding the behavior of feminist therapists. Criterion-related validity was determined by a final expert rater who had not been exposed to the 39-item list, who was asked to categorize whether or not feminist techniques were being utilized in certain sessions. FFTBC cores from the three sessions that the expert rater found to be feminist were compared with scores from two sessions the rater found to be non-feminist; They were significantly different ($t = 2.64$, $df = 3$, $p < .05$).

APPENDIX E

CONSENT TO PARTICIPATE IN SEMI-STRUCTURED INTERVIEW

Consent to Participate

The purpose of the interview is to gain a better understanding of feminist therapy theory and practice. You will be asked to talk about your own personal vision of feminist therapy; how you incorporate this vision into your clinical practice, and the philosophy or mission behind your work. The interview will last approximately 30 minutes.

Each interview will be tape-recorded and transcribed. Identifying data (e.g. names, dates, locations, university affiliations) will be removed from the typed transcriptions. Your identity will be kept confidential as well as the identities of any persons discussed.

We will commence with the interview upon the completion and return of this consent form. All consent forms will be stored at the University of Tennessee for three years past the completion date of the project.

Your participation in this interview is strictly voluntary and you may decline or withdraw from the interview at any time. If you have any questions about this research, either now or later, please contact me, Kayce L. Meginnis, at:

227 Austin Peay
Department of Psychology
University of Tennessee
Knoxville, TN 37996
(423)974-2161

I have read and understood the explanation of this interview and have had my questions about it answered satisfactorily. I voluntarily agree to participate.

_____ _____

Name Date

_____

Signature

VITA

Kayce Lane Meginnis-Payne was born in Athens, Georgia on January 19, 1970. She attended public schools in Chapel Hill, North Carolina. Kayce graduated summa cum laude from the University of North Carolina at Chapel Hill where she received a Bachelor of Arts degree in Psychology and a certificate in Women's Studies. Recruited by the program Teach For America, Kayce taught third grade in inner-city Houston, Texas for two years. In the fall of 1994, she entered the doctoral program in Clinical Psychology at the University of Tennessee, Knoxville. Kayce completed her predoctoral internship at Eastern Virginia Medical School in Norfolk, Virginia.