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FEMINIST THERAPY AS A PERSPECTIVE FOR SOCIAL WORK PRACTICE: A CASE STUDY OF A WOMAN IN SOCIAL WORK TREATMENT

A Thesis

Presented to

the Faculty of the School of Social Work

San Jose State University

In Partial Fulfillment

of the Requirements for the Degree

Master of Social Work

by

Natalie Lee Lovinfosse

December 1982

APPROVED FOR THE SCHOOL OF SOCIAL WORK

APPROVED FOR THE UNIVERSITY GRADUATE COMMITTEE

DEDICATION

This author wishes to dedicate this thesis to her advisors, Orpha Quadros and Jill Steinberg, as well as to her parents. The continuous inspiration, encouragement, and support of her advisors instilled in this author the desire, wisdom, and courage necessary to pursue this research to completion and move towards her personal and professional development as a feminist therapist in the field of social work. To her parents she wishes to express her gratitude and love for their continuous inspiration, encouragement, and support of her development as a self-actualizing and self-determining woman.

ACKNOWLEDGMENTS

I would first like to express my appreciation to the client with whom this case study is concerned. Her courage in agreeing to participate in this research in order to assist other women in their struggles towards self-actualization provided inspiration and guidance for the author's belief in the importance of this research.

I wish to thank my advisors, Orpha Quadros, Jill Steinberg, and Patricia Hogan for their support and participation in the completion of this research. I am indebted to Orpha for her patience, guidance, and wisdom that made this research possible, to Jill for her encouragement, expertise, and inspiration as a feminist therapist, and to Patricia for her support in my completion of graduate school and for filling in on my committee at the last minute.

I wish also to especially thank Vicki Lane for her personal support and encouragement that sustained me through the years of struggle involved in formulating and crystalizing my ideas.

I wish to express my gratitude to the many others who participated in so many ways in the formulation, validation, and completion of this research. Lucia Valverde's and

Ann Hudson's questions and dialogues were the initial seeds from which this research grew. John Howmiller's suggestion of an individual studies project concerning women and therapy gave me inspiration and validation as to how I could integrate my feminist values with my social work training. The support I received from my instructors Peter Lee and Antonio Soto for the inclusion of a feminist perspective in social work practice validated the professional importance of feminist therapy. Joan H. Robbins' feminist therapy seminar helped me to conceptualize and refine my understanding of this therapeutic approach. Marianne Minor's guidance in the application of a feminist therapy approach in therapy enabled me to integrate theory with practice.

Timothy Ames' and Amy Newby's years of support and inspiration enabled me to attain educational and professional self-actualization. Buzz Barnet's openness and sensitivity enabled me to better define my sense of identity as a woman.

The intense dialogues as to the effects of sex-role conditioning on women and men that I had with my mother, Natalie Wright-Lovinfosse, and my brother, Michael Lovinfosse, helped me to define and critique my ideas. Margaret Yanez's loan of her thesis as a model and guide for this research helped me organize and formulate the format and style of this research. Betty Van Arsdale's

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ABSTRACT

The focus of this research was to demonstrate the way in which feminist therapy can be applied as an effective treatment approach in social work practice. Feminist therapy is defined as an ideological approach to therapy drawing its knowledge base from many existing therapeutic principles and techniques which allow for the incorporation of certain humanistic and feminist assumptions. Inherent in these assumptions is less of a dependence on personality theory and more of a stress on a sociocultural analysis in determining the psychological effects on women of social conditioning, sex roles, and secondary status in this culture. This treatment approach emphasizes the need for social work practitioners to include a feminist analysis in the assessment and treatment process of individual casework treatment with women clients. To this end, an individual case study was performed to illustrate the application of feminist therapy assumptions and intervention strategies.

The subject of the case study was a white, married, twenty-seven-year-old female, who worked full-time as a counter clerk for a dry cleaning establishment. She had been married for seven years and had no children. She was seen by this researcher in individual and group therapy for a total of sixteen sessions at a counseling center. An

information collection guide was utilized for analysis of the content and process of sessions as related to the application of a feminist therapy approach.

Results of the case study analysis demonstrated the effectiveness of the application of a feminist therapy approach in one case illustration. Effectiveness was measured in terms of the way in which a feminist therapy approach facilitated the client's progress towards attainment of her treatment goals in the resolution of her problems. The inability to generalize the results beyond this particular case was stressed as a limitation of this study due to the use of only one subject.

FOREWORD

In the last ten years the incorporation of feminism into my awareness has had a profound impact on my consciousness and on my life. I have moved from a place of feeling powerless, helpless, and isolated as a woman, to the place of feeling in control of my destiny as a woman-person rather than as a feminine role-player. Much of my self-actualization has resulted from my identification with feminist issues and woman support networks. Throughout my undergraduate and graduate studies, my primary emphasis has been on women's issues in the behavioral sciences and social work. This emphasis originated in my own search for self in the stifling confines of the academic world's definition of humanity--The Ascent of Man. A Woman's Studies minor opened to me the seldom told story of humanity--The Ascent of Woman. I began to feel more positive about being a woman, when I started learning about who I was as a woman-person with a history and psychology of my very own. I was the subject, I was myself, I was autonomous--as opposed to "the other," who was always being compared and equated with mankind in a universe defined as male, a status and condition that I could never "reach," "achieve," or "aspire to" in a feminine role (Johnson, 1976).

My choice of the topic of feminist therapy for this study was based on my desire to combine feminism, which is so much a part of who I am and who I've become, with my professional goals as a social work practitioner. In my work with clients, I hope to support and expand the self-determination and social action aspects of the social work helping process by including a feminist orientation. To exclude this orientation from my social work practice could lead to the unintentional result of reinforcing "the debilitating effects that social structure and the traditional process of socialization have had on women" (Berlin, 1976, p. 492).

This case study provides a theoretical foundation and an opportunity for the exercise of the skills which will be necessary for practice as a feminist therapist. I hope to add to the literature which gives credibility to the therapeutic relevance and unique applicability of feminist therapy as a distinct therapeutic form. Furthermore, I hope to make clear the usefulness of this treatment modality within the field of social work practice.

CHAPTER ONE

Introduction

Women report more emotional difficulties than men and are seen for inpatient and outpatient psychotherapy more than men (Rawlings & Carter, 1977). And yet, psychology and psychotherapy, including that practiced as part of social work, is dominated by males and adheres to a standard of mental health determined by males (Thomas, 1977). Through the years, male psychologists have set about describing the true natures of women with enthusiasm and absolute certainty, basing support for their theories on "years of intensive clinical experience" (Weisstein, 1970, p. 209). This tradition was begun by Freud, whose insights on personality theory occurred during the course of his work with his female patients. A problem with insight is that it can confirm for all time the biases with which one started out (Weisstein, 1970).

The empirical research that has been done to support conceptualizations of female psychology has been found by investigators to have a biased selection of subjects (Boyd, 1978). Males were selected as subjects twice as frequently as females. Studies have indicated that the research based on males tended to be generalized to the whole population

(Boyd, 1978). An example of this situation is described by Muriel Nellis in her book The Female Fix (1980).

> An official of the Food and Drug Administration once told me, "We tried to include females in our test data on Methadone during the application period--but the damned hormone considerations just muddied up our need for quick results." (p. 25)

In her studies of contemporary clinical ideology, Phyllis Chesler (1972) found that

> Women as subjects have remained quite literally "outside" of many psychological experiments, particularly in learning or achievement: female performance proves too variable or too "minimal" to yield up the manly and publishable phenomena being sought. . . . Unfortunately, the results of just such experiments have been accepted as the standards for normal learning or "performance," standards which, by definition, women cannot achieve. (p. 66)

Two models of mental health have resulted from this psychological construction of the female "a priori"--the normative model and the androcentric model (Boyd, 1978). In the normative model a double standard of mental health is stressed. Men and women are separately encouraged to "adjust" to the behavioral norms of their gender as defined by society.[1] In the androcentric model a single standard of mental health is stressed for both sexes--the male standard.

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[1] For example, a therapist that adheres to the normative model of mental health would encourage a woman client to be passive, dependent, submissive, and emotional in order to resolve her problems successfully; whereas this same therapist would encourage a man to be aggressive, independent, dominant, and unemotional in order to resolve his problems successfully.

Within this second model, masculine associated activities and traits are viewed as superior and necessary to the development of a healthy adult, whereas feminine traits and activities are viewed as inferior and unnecessary to the healthy development of an adult (Rawlings & Carter, 1977).[2]

A third model of mental health has been proposed by feminist therapists in an attempt to remedy the male bias in the determination of the standards of mental health for women. This model of mental health consists of the "feminist ego ideal," that of androgyny (Rawlings & Carter, 1977).[3] Within this model the qualities of a healthy male and a healthy female are integrated and encouraged in both sexes so as to fulfill a person's own individual needs, yet remain aware of the needs of others, thus balancing the characteristics of being human (The Feminist Counseling Collective, 1975; Kaplan, 1976).[4]

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[2] For example, a therapist that adheres to the androcentric model of mental health would encourage both women and men to be aggressive, independent, dominant, and unemotional in order to resolve their problems successfully; at the same time, this same therapist would discourage passivity, dependence, submission, and emotionality as unnecessary hindrances to problem resolution.

[3] Ego ideal refers to societal definitions of a healthy woman, a healthy man, and a healthy adult. These ego ideals are explained in detail later. The term "feminist ego ideal" was taken from the article, "Feminist Psychotherapy," written by The Feminist Counseling Collective, 1975.

[4] For example, a therapist that adheres to the androgynous model of mental health would encourage both women and

In research done on the theory and practice of feminist therapists, the two characteristics of the therapeutic process that differentiated feminist therapy from other therapies were the presence of feminist humanism and feminist consciousness (Thomas, 1977). Humanism is the belief in the innate drives of human beings toward self-actualization, toward mastery of the environment, and toward fulfillment of one's potential. Humanism originated in the personality theories of Rogers (1954), Maslow (1951), and subsequent theorists who stressed the need for theoretical integration of the cultural milieu with the intrapsychic dynamics of individuals (Boyd, 1978). The depth and degree of a therapist's commitment to "equality between the sexes, to freedom from sex-role stereotypes, and to a person's--especially a woman's--right to self-actualization" (Thomas, 1977, p. 449) is the distinguishing factor between feminist humanism and a more global humanism as defined above.

Feminist consciousness is an understanding and awareness of how a woman's self-actualizing potential has been thwarted by the prevalence in society of stereotyped sex

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men to accept and choose from a full range of human qualities when expressing themselves in any given situation. Within this model a person would be encouraged to be passive and/or aggressive, independent and/or dependent, dominant and/or submissive, emotional and/or unemotional, depending upon his/her needs and the demands placed upon him/her in a particular problem situation.

roles and how these stereotypes contribute to her emotional and physical problems (Thomas, 1977).

Feminist therapy does not represent a particular set of therapeutic techniques. It is not based on a specific conceptual framework; rather it is an ideological approach to therapy that draws its knowledge base from many existing principles and techniques which can incorporate certain humanistic and feminist assumptions. These assumptions are derived from the humanistic and feminist consciousness explained in the preceding paragraphs. Inherent in these assumptions is less of a dependence on personality theory and more of a stress on a sociocultural analysis in assessing and helping a client with her problems.[5] Incorporation of these assumptions demands an analysis of how cultural norms and institutions participate in the creation of a person's problems and interfere in her self-actualizing potential. Theories or techniques utilized with clients must allow for the incorporation of these assumptions. Examples of such theories and techniques are: Gestalt therapy, transactional analysis, client-centered therapy, rational-emotive therapy, bioenergetics, etc.

"The difference between it and traditional therapy is that feminist therapy seeks to integrate the client's

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[5]The client will be referred to in the feminine form throughout this research.

socio-cultural and political context into the therapy" (Valverde, 1981, p. 30). "The mere act of making a personal choice can be political, if the decision involves untangling one's own desires from a web of societal 'shoulds' and 'shouldn'ts'" (Fishel, 1979, p. 80).

The humanistic assumptions as stated by Rawlings and Carter (1977) are as follows.[6]

1. The therapist maintains a belief in the equality of men and women in all areas of her life and consciously works on her increased awareness of or elimination of sex bias.[7]

2. The therapist adheres to the belief that there are no prescribed sex-role behaviors based on anatomical differences or a person's right to self-actualization; thus theories that support such premises are rejected.

3. The therapist's concerns regarding clients' dependency and independency need fulfillment in marriage, living-together arrangements, relationships, or single lifestyle choices should be the same for women and men.

4. Sex-biased testing instruments will not be used in therapy unless necessary and then only with the total

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[6] The humanistic and feminist assumptions are explained in more detail in Chapter Three of this research.

[7] The therapist will be referred to in the feminine form throughout this research.

involvement of the client in the evaluation and ownership of the results.

Feminist assumptions necessary to distinguish feminist therapy from other forms of therapy are based on the political assumptions of feminism from the women's movement that stress equal opportunity for men and women and the necessity of establishing egalitarian interaction between people. The feminist assumptions, as drawn from various sources, are as follows.

1. The primary source of women's pathology is assumed to be social, not personal; thus stress in the beginning of therapy is placed on raising clients' consciousness levels as to the realistic barriers in the social structure that block their attempts at achievement and autonomy (Feminist Counseling Collective, 1975; Rawlings & Carter, 1977; Thomas, 1977).

2. Feminist therapy assumes that women have become isolated and competitive in their relationships with other women; thus group work is stressed (The Feminist Counseling Collective, 1975; Mander & Rush, 1974; Thomas, 1977).

3. Feminist therapy assumes the client is essentially competent and has the personal power necessary to determine her own needs, values, actions, or thoughts; thus short-term therapy is stressed with an emphasis on self-help resources (Leidig, 1977; Rawlings & Carter, 1977; Thomas, 1977).

4. Based on the idea that relearning precedes behavioral change in the individual, an emphasis in therapy is placed on resocialization of sex-role conditioning through the use of action-oriented and experiential exercises (The Feminist Counseling Collective, 1975; Mander & Rush, 1974; Rawlings & Carter, 1977).

5. Feminist therapy focuses on three specific treatment areas which are related to the stereotypic roles of women in this culture as pacifiers, nurturers of others, and non-sexual beings/sex objects. These three areas are anger, self-nurturance, and sexuality (Leidig, 1977; Marshall, n.d.; Mueller, 1976; Valverde, 1981).

6. Feminist therapy makes the assumption that all therapy is value laden; thus therapists attempt to make their values explicit with their clients so as not to subtly direct and/or manipulate them (The Feminist Counseling Collective, 1975; Leidig, 1977; Rawlings & Carter, 1977).

7. Based on the assumption that inherent in the therapy situation is an unequal power relationship, feminist therapists stress egalitarian interaction in the therapeutic relationship (The Feminist Counseling Collective, 1975; Rawlings & Carter, 1977; Thomas, 1977).

8. Many but not all researchers and practitioners of feminist therapy assume that the therapist must be a woman

and a feminist (Leidig, 1977; Thomas, 1977; Rawlings & Carter, 1977).

Feminist therapy can be applied to work with male and female clients by male and female therapists through the application of the humanistic and feminist assumptions necessary to distinguish feminist therapy from other forms of therapy. However, for the purposes of this research the author has chosen to concentrate on its application and historical implications for women, especially in view of the higher rates of psychiatric disturbances among women than men (Gove & Tudor, 1973). This research will describe and analyze the application of feminist therapy intervention techniques and strategies in an individual case situation.

This type of descriptive research was chosen in order to illustrate how this particular approach to understanding human behavior can be effectively applied in social work practice. It is the hope of the author that as the case study is analyzed and treatment is outlined, the social worker will have a clearer perception of the way in which the application of feminist therapy can be useful and effective in a practice situation. It is also the hope of the author that this descriptive study will "provide clues for subsequent research to pin down and generalize" (Simon, 1978, p. 45) the importance of the inclusion within social practice a specific awareness of the psychological effects

on women of social conditioning, sex roles, and secondary status. For, as Julian Simon (1978) points out in his book, Basic Research Methods in Social Science:

> Descriptive research in the form of case studies is usually the jumping-off point for the study of new areas in the social sciences. S. Freud's case history "Observation 1--Miss Anna O." and similar histories of other patients laid the foundation for modern clinical and personality psychologies. (p. 44)

Thus far, this chapter (Chapter One) has been an introductory chapter dealing with the existing differences between traditional therapeutic approaches and the feminist therapeutic approach in counseling women clients. The remainder of this thesis will be developed according to the following summary of chapter material.

The problem formulation, which outlines the normative and androcentric models of mental health and their relationship to the self-concept of women, is discussed in Chapter Two. A literature review, which focuses on five areas of significance in the development and understanding of the feminist therapy approach, is presented in Chapter Three. These five areas are as follows: (1) the double standard of mental health, (2) the androgynous model of mental health, (3) feminist therapy and the sexist bias in social work education, (4) assessing the needs of women clients, and (5) feminist therapy assumptions and intervention strategies. The problem statement and the objectives

of this research as related to therapy, women, and sexual stereotyping are described in Chapter Four. The methodology of the study is outlined in Chapter Five and includes the following: (1) study setting, (2) research design, and (3) data collection and analysis procedures. The case study is presented in Chapter Six and includes the following: (1) the presenting problem, (2) social history, (3) current life situation, (4) conceptualization of the problem, (5) treatment goals, (6) treatment process, (7) treatment outcome, and (8) values and theoretical orientation of the therapist. The case analysis, which demonstrates the application of feminist therapy assumptions and intervention strategies in an individual case situation, is presented in Chapter Seven. The author's conclusions and recommendations as to the therapeutic relevance and unique applicability of feminist therapy in social work practice are presented in Chapter Eight, which concludes this research.

CHAPTER TWO

Problem Formulation

It is generally believed that psychotherapists derive a set of values resulting from their sources of personality theories (their view of human nature), their models of psychopathology (what problems should be treated), and their models of mental health (the goals of treatment). In terms of working with women the value set of the therapist is of particular importance. Whether a therapist believes in a Freudian-derived theory of personality with a biological basis or in a sociocultural theory of personality has tremendous implications as to whether she will encourage a woman client to "adjust" to her assumed innate biological role or encourage her to develop herself to her fullest human potential. Whether a therapist adheres to the mental illness model of psychopathology, which personalizes social problems in accordance with the values and role prescription of society, or adheres to the environmental model which politicizes personal problems (so as to "enable the individual to function as a responsible actor rather than as a powerless victim") will affect the therapist's goals of treatment (Rawlings & Carter, 1977, p. 24).

The prevalence of the normative and androcentric models of mental health among clinicians in determining the mental

health of their clients has been demonstrated by the Broverman et al. (1970) studies, "Sex-role Stereotypes and Clinical Judgments of Mental Health." Within this landmark study, clinician's (clinical psychologists, psychiatrists, and social workers) conceptions of the qualities of a healthy adult were found to be the same qualities of a healthy male (aggressive, independent, dominant, unemotional, competitive, logical, ambitious, active, worldly, etc.), whereas their conceptions of the qualities of a healthy female (non-aggressive, dependent, submissive, emotional, non-competitive, illogical, passive, home-centered, etc.) were viewed as substandard to those of a healthy adult.

These attitudes exemplify the "ego ideal conflict" between womanhood and adulthood that women experience from sex-role prescription (The Feminist Counseling Collective, 1975). Broverman et al. (1970) explain:

> Acceptance of an adjustment notion of health, then, places women in the conflictual position of having to decide whether to exhibit those positive characteristics considered desirable for men and adults, and thus have their "femininity" questioned, that is, be deviant in terms of being a woman; or to behave in the prescribed feminine manner, accept second-class adult status, and possibly live a lie to boot. (p. 324)

Broverman et al. (1970) do not suggest that it is clinicians who pose this dilemma for women, but that it is their personal and professional acceptance of sex-role stereotypes prevalent in our society that continues to

perpetuate a double standard of mental health--a standard that reinforces social and intrapsychic conflict for women.

In 1974, Fabrikant et al. essentially replicated the Broverman et al. (1970) study. These researchers found that attitudes transmitted by therapists to both male and female clients had changed from those found by Broverman et al. Some of the more traditionally viewed male characteristics--animalistic, powerful, intellectual, and wise--were no longer seen as uniquely male. A number of the traditional female characteristics--dependent, passive, irrational, nurturing, manipulative, temperamental, and virtuous--were perceived as equally applicable to both sexes and/or to males. This study also found a somewhat more liberal view towards women's role options. Female clients were viewed as needing to be less dependent on their husbands financially and socially, although not sexually. Therapists were encouraging women to exercise the freedom to choose life roles other than that of marriage and family. In fact, the attitude that women cannot be completely satisfied or fulfilled in only the wife-mother role and that they need not be married to have a full life prevailed among respondents (Fabrikant et al., 1973-74).

In spite of these new attitude shifts, Fabrikant et al. (1973-74) found that male characteristics were still seen as positive and female characteristics as negative in relationship to the healthy attributes of adulthood.

> This agrees with the Broverman studies in their conclusion that women, in accepting the prevailing "feminine" view of themselves, find themselves labeled "neurotic." These females would find it very difficult to see themselves as mentally and emotionally "healthy." (p. 106)

In reviewing these two studies, Broverman et al. (1970) and Fabrikant et al. (1973-74), it appears that therapists are beginning to move away from the normative model of mental health that stressed adjustment to one's assumed innate biological role, while continuing to support the androcentric model which values male characteristics and devalues female characteristics. The fact that female characteristics continue to be viewed as substandard to adulthood continues to place women in the conflictual position of devaluing their female characteristics in their pursuit of adult status. Thus a woman who strives for the complete independence of the adult ego ideal engages in a process of devaluation of her feminine characteristics. The process of devaluation can undermine her sense of self-esteem and leave her isolated from both the female and male world.

Thus, despite the commitment of the mental health profession to self-determination and the dignity of the individual, it would seem that there is still the unexamined assumption that "humankind is still to be compared with and equated with mankind" (Johnson, 1976, p. 531). Women continue to suffer from psychological oppression in that--

in a universe defined as male, a status or condition that women can never "reach," "achieve," or "aspire to , . . . women must remain forever, in Simone de Beauvoir's terms, the 'other.' She is never the subject, never herself, never wholly autonomous" (Johnson, 1976, p. 531).

A number of studies have suggested that many of women's emotional problems are strongly associated with the socially constructed "Catch-22" double-bind between adulthood and womanhood. A few examples of these associations are shown in the following quotes:

> Recent research by Dr. Sharon Wilsnack and others indicates that many women who become alcoholic suffer painful sex-role conflicts. (Sandmaier, 1980, p. 220)

> The potential alcoholic does not consciously reject her identity as a woman; instead she consciously values traditional female roles . . . the doubts about her adequacy as a woman may stem from the existence of masculine traits in the unconscious levels of her personality. For example, a woman who is very assertive or aggressive in her personal style and whose unconscious sex-role identity is more masculine than the average woman's probably senses that she somehow does not act and feel like a "real woman." . . . She is trying, via alcohol, to feel more womanly. (Wilsnack, 1973, pp. 43, 96)

> My data show that it is the women who assume the traditional feminine role--who are housewives, who stay married to their husbands, who are not overtly aggressive, in short who "buy" the traditional norms--who respond with depression when their children leave. (Bart, 1972, p. 134)

> The women who came to the center for help with career development were not seeking psychiatric treatment. They were seeking change either because

> of the disruption caused by relocation due to their husband's job change, extended periods in the home caring for children, or a conscious reassessment of roles. As a sample of the "normal" population of educated women, it is remarkable that over one-third had symptoms of depression that were frequently as severe as those of depressed out-patients treated with pharmacotherapy. (Pincas et al., 1974, p. 193)
>
> Certain antecedents of feminine character have been overabundantly and overexclusively present in the case of the female hysteric, resulting in a dysfunctional extreme development. (Wolowitz, 1972, p. 312)
>
> In the more extreme hysterical instances the person's autonomy is severely undermined by the importance attached to emotional responses of others and the dedicated pursuit of those responses. (Wolowitz, 1972, p. 309)
>
> This paper will explore the hypothesis that phobic symptoms, particularly that of agoraphobia in women, and their associated syndrome--super-helplessness and dependency--appear related to sex role conflict . . . . Many women have been trained for adulthood as child women. Under the realistic stresses of adult life and marriage . . . the emotional stress is too great and phobia provides another solution. (Fodor, 1974, p. 133)

Women's feelings of inadequacy and self-hatred, oftentimes accompanied by self-destructive thoughts and sometimes actions, are oftentimes diagnosed and treated as

> personal failures to cope with the world. . . . Because so many therapists have not questioned the influence of stereotypes and psychological theories on therapy for women, they often do not understand fully what role a woman's environment plays in creating or intensifying problems. (Habib & Landgraf, 1977, p. 511)

The source of many problems is not necessarily a neurotic or idiosyncratic childhood or character but in the culture

and the social and economic institutions that define a woman's worth and identity.

> The origin is <u>first</u> in the culture itself--that culture which so narrowly defines the primary role for a woman as a loving wife and mother--and <u>second</u> in the social and economic institutions that block or make difficult any woman's attempt to break out of the traditional mold. According to the norms of society, learned by each young girl from the media, books, toys, her environment in general and sometimes her parents in particular, a woman's worth and identity is ultimately defined by the man she is with, by the children she produces, by the image she projects, by the ingenuity of her homemaking, and by the uncomplaining grace with which she fulfills the expectations attached to these roles. (Friedman et al., 1979, p. 4)

In addition to traditional forms of assessment and treatment, researchers emphasize the need to incorporate a mental health assessment and treatment modality that deals with the pyschological effects on women of social conditioning, sex roles, and secondary status. Within the context of this particular need, feminist therapy began to emerge in the early 1970's.

CHAPTER THREE

Literature Review

As indicated in Chapter Two, the literature review focuses on five areas of special concern:

1. The Double Standard of Mental Health
2. The Androgynous Model of Mental Health
3. Feminist Therapy and the Sexist Bias in Social Work Education
4. Assessing the Needs of Women Clients
5. Feminist Therapy Assumptions and Techniques

The Double Standard of Mental Health

> There is inherent contradiction in a health care tradition that systematically forces women into a stereotypic role that is judged by both clinicians and public opinion to be inferior to a healthy adult level of functioning. (Abernathy, 1976, p. 660)

The double standard of mental health has been studied by many researchers and found to be quite prevalent in the mental health field. In a study conducted by Neulinger (1968), psychiatrists, psychologists, and social workers were asked to rank twenty paragraphs according to how descriptive they were of a mentally healthy male and again for a mentally healthy female. Results of this study showed that there were significant differences in the mean rankings of male and female on eighteen of the twenty

paragraphs. Characteristics such as nurturance, play, succorance, deference, and abasement were rated higher for the mentally healthy female; and dominance, achievement, autonomy, and aggression were rated higher for the mentally healthy male. In interpreting his findings, Neulinger (1968) states that "the sex orientation of this society is not only shared, but also promoted by its clinical personnel" (p. 554).

The Broverman et al. study (1970), discussed in detail in the introductory chapter of this research, supports and expands upon Neulinger's (1968) findings.[8] The Broverman et al. results showed a definite bias among clinicians as to one standard of mental health for males and adults which parallels Neulinger's findings of the characteristics rated highest for the mentally healthy male. A separate standard of mental health was found by Broverman et al. for females which also parallels Neulinger's findings of the characteristics rated highest for the mentally healthy female. In addition, Broverman et al. found that the qualities of the healthy female were viewed by respondents as substandard to those of a healthy adult.

The double standard of mental health was found again in the research of Abramowitz et al. (1973). Clinicians

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[8]The Broverman et al. study and results are explained in detail in Chapter Two of this research.

were given the psychological and educational history of college students and requested to make a judgment of the mental health of the subject. The case histories were identical except for sex of the subject (identified as either Joan or John) and political orientation (left or right politically active). The results showed that the politically left female was judged as significantly more maladjusted than her male counterpart and the clinicians' verdicts for her were more severe than for the conservative youth of either sex.

The Fabrikant et al. study (1970), discussed earlier in the introductory chapter of this research, essentially replicated the Broverman et al. study (1970) and found some changing attitudes among clinicians in respect to the double standard of mental health.[9] The somewhat more liberal view expressed by clinicians in the Fabrikant et al. study towards women's role options seemed to lose some credibility when compared with other findings resulting from the same study. In spite of the new attitude shifts, Fabrikant et al. found, as did Broverman et al., that male characteristics were still seen as positive and female characteristics as negative in relationship to the healthy attributes of adulthood. The irony of these results is that, although

[9]The Fabrikant et al. study and results are explained in detail in Chapter Two of this research.

clinicians are espousing more liberal views towards a woman's role options, they continue to support the view that a woman must devalue her feminine self in order to attain status as a mentally healthy adult. The effect of the devaluation process undermines a woman's self respect, which in turn affects her level of acceptance and validation in the male and female worlds.

Another replication of the Broverman et al. study was done by Maslin and Davis (1975) with counselors-in-training rather than practicing therapists. The results showed that the female respondent's ideal healthy adult coincided with the characteristics of both the healthy female and the healthy male. The results of the male respondents showed that they viewed the healthy female as generally not having the same characteristics as the healthy male and healthy adult. In their discussion of the results, Maslin and Davis suggested that an explanation for the difference in their findings and those of earlier studies (where men and women generally agreed that male characteristics were equal to those of a healthy adult and female characteristics were substandard to those of a healthy adult) was the impact the feminist movement has had on the perceptions of women today of what constitutes a healthy female.

In an article detailing the research findings of two of his students' doctoral dissertations, Stricker (1977)

argued that there is no clear evidence of sexism in therapy. In the first one (Maxfield, 1976), the Rosenkrantz Stereotype Questionnaire was given to 250 members of the American Psychological Association's (APA) Division of Psychotherapy. Stricker reported that the male and female therapists responded the same on the Stereotypic Questionnaire, showing no "qualitative" differences in the means for healthy males and females (Foxley, 1979).

In the second doctoral dissertation study (Oppendisano-Reich, 1976) mental health professionals were asked to make diagnostic and prognostic judgments on a series of vignettes of patients who differed in their symptoms, social class, race, and sex. The results showed many differences based on symptoms, some based on class, and no main effects of race or sex. Some interactions involving sex were found:

1. Females were considered less mentally ill than males by the social workers and psychologists but not by the psychiatrists.

2. The male professionals preferred treating female psychotics rather than male psychotics.

3. Neurotic females were judged by psychiatrists as less likely to improve than neurotic males (Foxley, 1979).

Although these studies cited by Stricker (1977) have importance in questioning the validity of the claim that

there exists a double standard of mental health, Stricker himself makes some of the same mistakes in his research that he criticizes other authors for. For example:

> not presenting the data in "sufficient detail to allow for adequate evaluation and critique," and not seeming to apply the same standards of research methodology to the two doctoral dissertaion studies as he does to the other studies he reviews. (Foxley, 1979, p. 30)

It would also seem important to question the results that Oppendisano-Reich (1976) found as to the effects of sex of client on therapist-client interactions. What sexist attitudes might be involved in the finding that male professionals prefer treating female psychotics rather than male psychotics? Are the sex biases inherent in the double standard of mental health involved in the finding that neurotic females were judged by psychiatrists as less likely to improve than neurotic males? These questions and others seem important to pursue before accepting the validity of Stricker's arguments that there is no clear evidence of sexism in therapy.

The following description of a survey authorized by the APA contradicts some of Stricker's students' research findings with APA respondents, which again questions the validity of Stricker's argument. A survey in 1975 was conducted by the APA's Task Force on Sex Bias and Sex-Role Stereotyping and given to 2,000 female psychologists. The survey consisted of an open-ended questionnaire regarding actual

circumstances and incidents which the respondents felt demonstrated sexism in psychotherapy with women.[10] The Task Force found it difficult to generalize the results because only 16 percent of the respondents returned the questionnaire, but the Task Force did identify five areas of sexist behavior exhibited by psychotherapists, as common concern among respondents. According to Foxley (1979):

> 1. Fostering traditional sex roles, primarily by emphasizing the role of wife and mother and de-emphasizing the rewards from a career.
> 2. Having lower expectations for female clients and devaluing them, as shown through demeaning comments and the encouragement of dependency and passivity.
> 3. Using psychoanalytic concepts, e.g., penis envy, in a sexist way.
> 4. Viewing women as sex objects.
> 5. Sexually exploiting female clients. (p. 30)

Although none of these studies contained enough evidence to prove widespread sexist practice in therapy,

> it is the cumulative data provided by all the studies combined, as imperfect as they may be, which is alarming. Granted, this area of research is still in its infancy, and better designed studies need to be carried out with larger samples. But therapists, like everyone else, have been reared and educated in a society which has encouraged and perpetuated stereotyped roles for men and women. That mental health professionals have escaped this indoctrination of sexist attitudes is not likely. That their own attitudes and values affect their professional work with clients is likely. (Foxley, 1979, p. 31)

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[10] Webster's New Collegiate Dictionary (1975) provided the following definition of sexism: "prejudice or discrimination based on sex: especially discrimination against women--sexist."

The fact that the APA authorized Brodsky et al. in 1978 to develop "Guidelines for Therapy with Women" for use in training and in continuing professional practice as a result of the 1975 survey cited earlier in this section seems to indicate a recognition of sexist practices with women and a need for consciousness raising in work with women clients. At the same time the disclaimer printed in the footnote section of the article outlining the "Guidelines" seems to indicate a reticence on the part of many clinicians to universally validate this need:

> This paper was authorized by the Board of Professional Affairs (BPA) of the American Psychological Association (APA) but does not necessarily reflect the views of the BPA or APA in general (Task Force on Sex Bias and Sex Role Stereotyping in Psychotherapeutic Practice, 1978). (p. 1122)

The Androgynous Model of Mental Health

Dissatisfaction with and questions about the prevalent usage of the normative and androcentric models of mental health in establishing treatment goals has led to the development of the _androgynous_ model upon which feminist therapy bases its treatment goals. The term androgynous, which literally means both female and male in one, or hermaphroditic, was first defined by Rossi (1964) in much broader terms:

> A socially androgynous conception of the roles of men and women, in which they are equal and similar in such spheres as intellectual, artistic, political,

> and occupational interests and participation, complementary only in those spheres dictated by physiological differences between the sexes. (Foxley, 1979, p. 155)

The ideal that a single person embodies both the characteristics ascribed to the feminine ego ideal and to the masculine ego ideal has been expressed by others through the years. Although the specific descriptive term "androgynous individual" was not generally used by theorists through the years, emphasis on the integration of complementary polarities of human characteristics within an individual person for psychological health was antecedent to the androgynous conception of mental health.

Rogers' (1951) flexible individual embodies the traits of an androgynous individual. Rogers' self theory provides a framework for understanding the influence of sex role stereotypes on mental health. Accurate perception and subsequent integration of social expectations with personal values are essential to adaptive behavior, according to self theory. Rogerian theory states that flexible individuals who can find a variety of ways to integrate personal needs and social demands are least likely to experience psychological conflicts between personal goals and social norms (Foxley, 1979).

Jung (1953) emphasized the need for integration of the "anima" (female) and "animus" (male) that reside in each person. Describing the "anima" and "animus" in terms of the

Chinese principles of "yin" and "yang," he held that the "yin" is the aspect of life that is receptive, yielding, withdrawing, and inwardly turned and that the "yang" is the aspect of life that is outgoing, aggressive, heroic, and unfeeling (Hodges, 1975).

Maslow's (1954) self-actualized person is one who has succeeded in developing his or her basic, healthy inner natures to their fullest expression. Maslow asserts that all individuals have two core tendencies: (1) survival tendency which ensures the maintenance of life (deprivation motivation), and (2) actualizing tendency which leads to the enhancement of life (growth motivation). When all the needs associated with survival are satisfied, those associated with actualization become important. The distinguishing features Maslow found common to all the actualized persons he studied were independent of sexual identity, for he found the same characteristics in both the men and the women (Maddi, 1976). A few of these characteristics are the following:

1. Realistic orientation, accepting themselves, others, and the natural world for what they are.

2. Fresh rather than stereotyped appreciation of people and things.

3. Creative, resisting conformity to the culture by transcending it.

4. Emotionally self-sufficient, striving for autonomy (Foxley, 1979).

Parsons and Bales (1955) associated masculinity with an "instrumental" orientation where there is a cognitive focus on getting the job done or the problem solved. They associated femininity with an "expressive" orientation where there is an affective concern for the welfare of others and the harmony of the group (Bem, 1975).

Bakan (1966) stressed the need for the successful integration of "communion" and "agency" within an individual. "Communion" is an individual's concern for the relationship between oneself and others, while "agency" is an individual's concern for oneself as an individual person. He argues that the major task of life is to strike a compromise between these two antagonistic forces. The most successful kind of compromise, according to Bakan, is that in which both forces are represented as much as possible in living. The psychological growth that results from the integration of "agency" and "communion" parallels Angyal's (1965) definition of simultaneous "differentiation" and "integration." "Differentiation" involves a sense of one's own individuality and an appreciation of the different aspects of oneself and one's changeability. "Integration" involves a sense of common cause with other individuals and a recognition of how all the parts are organized together,

as well as how there is a thread of continuity that persists through the change (Maddi, 1976).

In attempting to conceptualize "trait constellations" in different terms than the masculine-feminine dichotomy which perpetuates the old "set," (Block (1973) employs Bakan's (1966) concepts of "agency and communion"; "agency" manifests itself in self-protection, self-assertion, and self-expansion, whereas "communion" manifests itself in the being at one with other organisms. Androgyny, from Block's perspective, requires the balancing and integration of "agency and communion." By utilizing Loevinger's (1966) "Milestones of Ego Development," Block (1973) traces

> the development of sex role definition, embedding it in the larger context of ego and cognitive development and relating it to the forces for socialization that derive from parents and culture. (p. 64)

She found that the task of integrating "agency and communion" is different for men and women. Men tend to have a more developed sense of "agency" than "communion"; thus they must learn to temper self-assertion, self-interest, and self-extension by the considerations of mutuality, interdependence, and joint welfare. Women tend to have a more developed sense of "communion" than "agency"; thus they need to learn to temper the concern for harmonious functioning of the group, the submersion of self, and the importance of consensus in order to include aspects of

agentic-self-assertion and self-expression. Block asserts that the integration of "agency and communion" is essential for personal integration and self-actualization.

More recently, psychologists have advocated psychological androgyny as a more practical and human standard of psychological health. In the eight years since Bem introduced the Bem Sex Role Inventory (1975), the study of psychological androgyny has increased from a few scattered studies on the detrimental effects of sex-typing to a conception of mental health that is constantly being refined, critiqued, and measured.

Citing studies on the detrimental effects of sex-typed behavior, several researchers (Bem, 1975; Foxley, 1979; Kaplan, 1979; Rawlings & Carter, 1977) emphasize the fact that high femininity in females has been correlated with high anxiety, low self-esteem, and low social acceptance. These same researchers point out that high masculinity in adult males has been correlated with high anxiety, high neuroticism, and low self-acceptance.

It appears that individuals who possess a high degree of both masculine and feminine characteristics may be better adjusted than those who do not. Hammer (1964) and Helson (1966) found that greater creativity in both sexes depends on a balance of masculine and feminine traits (Foxley, 1979; Rawlings & Carter, 1977). Maccoby (1966) found that

greater intellectual development has been correlated with cross sex-typing--i.e., with femininity in boys and masculinity in girls (Foxley, 1979; Rawlings & Carter, 1977). Block (1973) found that greater maturity as measured by Kolhberg's Moral Judgment Test was "accompanied by more androgynous, less sex typed definitions of self" for both sexes; and women who scored high levels of ego maturity using the Loevinger Sentence Completion method were found to have a better balance of agentic and communion concerns (p. 64).

In a series of studies Bem (1975) found that androgynous individuals demonstrated more flexible and adaptive behaviors in the instrumental and expressive domains, thus enabling them to function effectively in whatever life situations they might experience. Spence and Helmreich (1978) found androgynous individuals displayed more self-esteem, social competence, and achievement motivation than non-androgynous persons (Foxley, 1979; Rawlings & Carter, 1977).

As mentioned earlier, the study of psychological androgyny as a viable model of mental health began with Bem's (1975) development and testing of the Bem Sex-Role Inventory in 1974. The inventory was a paper-and-pencil instrument which enabled researchers to distinguish androgynous individuals from those with more sex-typed self-

concepts. The major hypothesis of Bem's work was: "Feminine and masculine qualities can exist in the same individual, promoting flexible behavior adaptive to situations rather than stereotyped expectations" (p. 49). Utilizing the inventory, Bem empirically tested this hypothesis in a set of unique experiments in cross-sex behavior, independence and nurturance. Her results supported earlier researchers' findings on the detrimental effects of sex-typing that can result in personal problems and poor psychological adjustment, as well as the reported advantages of androgynous behavior.

The feminine male did well only in the expressive domain, and the masculine male did well only in the instrumental domain. The masculine males were less responsive in all of the diverse situations designed to evoke their more tender emotions; thus their partners in the interaction received less emotional sustenance than they would have otherwise. The feminine women did not do well in either the instrumental or the expressive domains except in situations where the experimenter's instruction left no room for initiative or improvisation--in other words, when there was virtually no ambiguity about what a subject ought to do if he or she wished to be responsive. Bem's (1975) discussion on the findings of the feminine women's behavior is as follows:

> What this pattern suggests to me is that the major effect of femininity in women--untempered by a sufficient level of masculinity--may not be to inhibit instrumental or masculine behaviors per se, but to inhibit any behavior at all in a situation where the "appropriate" behavior is left ambiguous or unspecified. (p. 59)

These findings are consistent with earlier studies on the detrimental effects of sex-typed behavior where femininity in females is associated with high anxiety and poor social adjustment.

Bem's results on androgynous men and women, as well as masculine women, indicated that all three function effectively in both the instrumental and expressive domains--i.e., stand firm in opinions when necessary, show affection and warmth toward kittens and babies, and listen sympathetically to someone in distress.

The similarity of response between the sex-reversed (masculine women) and androgynous women differed significantly from the results for men. Bem (1974) suggests that "growing up female in our society may be sufficient to give virtually all women at least an adequate threshold of emotional responsiveness" (p. 59). In reference to these particular results, Bem also suggests:

> That which differentiates women from one another is not the domain of expressiveness or communion, but whether their sense of instrumentality or agency has been sufficiently nourished as well. (p. 59)

Following Bem's beginning formulations of an androgynous model of mental health, several researchers have further critiqued and refined the androgynous model. Some researchers criticize the term androgyny due to the emphasis it places on polarity combined instead of polarity transcended. Hefner et al. (1974) present a model of sex role transcendence where individual emotional and behavioral choice is based on a full range of possible human characteristics, which are appropriate and adaptive to specific situations for a particular individual. They emphasize sex role development rather than a balancing of human characteristics, as the process necessary to achieving sex role transcendence. Three stages of sex role development are outlined in this model: (1) undifferentiated conception of sex roles, (2) overdifferentiated or polarized conception of sex roles, and (3) flexible, dynamic approach to human roles that transcends sex-role constraints. Hefner et al. stress that an individual need not go through the second stage before she or he can transcend it. Rather, individuals may have different paths that lead to a transcendent view of sex roles. Often a person may make a "quantum leap" between stages as a result of the resolution of a crisis

> which produces both a lack of fit with stage two conceptions and the awareness of stage three that leaves behind the defensive need to cling to the pole to which one has been assigned. (Foxley, 1979, p. 157)

White (1979) stresses the need to look at the developmental stages of adulthood versus the masculine and feminine sex roles when formulating a theory of androgyny. In critiquing the recent trends in studies on sex role identity and androgyny, White points out the lack of emphasis on developmental differences which may prevail among adults of different ages. The fact that researchers typically use subjects within the 18-22 age group, an age period where achieving a sense of sexual identity is an important and overriding task, may account for the rigidity of sex role differentiation among subjects. White stresses the idea that susceptibility to or reliance on stereotypes may be a developmental characteristic and that individuals at higher developmental levels may be less subject to stereotypic thinking. She developed a scale that measured skills and competencies in Bakan's (1966) agentic and communal domain in an attempt to emphasize coping as a relevant dimension of developmental maturity, as opposed to the age bound ego defenses that masculine and feminine stereotypes may represent. Results of her studies did not seem to indicate whether age or developmental level influence androgyny in women. However, these were the initial findings and much of the analysis is still ongoing.

Kaplan (1979) discusses logical inconsistencies between Bem's (1974) theoretical and empirical definitions of

androgyny where a person can be high in both masculine and feminine traits but may express this androgynous nature in a dysfunctional blend. Using case illustrations to illustrate her viewpoint, Kaplan goes on to develop a model of androgyny that contains two stages of an androgynous state. In the initial, dualistic stage the masculine and feminine behavior traits remain independent of the other with the individual alternating between the two. In the hybrid stage, on the other hand, the masculine and feminine traits come to co-exist, to be tempered one by the other, to unite in the formation of truly integrated characteristics. This blend and integration of the hybrid stage enables an individual to be flexible, situationally appropriate, and effective in her behavior. Kaplan emphasizes the difficulty in recognizing or assessing the presence of hybrid characteristics due to therapists and clients having been thoroughly schooled in bi-polar notions of self. In dealing with the conflicting strains of the polarities of masculinity and femininity, Kaplan states that it is the process by which we strive for integration rather than the end point itself that needs careful consideration.

> Before one can be tempered by the other, preliminary work may be needed to bring these traits to the fore, beyond the point where they are so tentative, so vulnerable, that their expression feels threatened by its co-existence with another. (p. 229)

Following the need for preliminary work, Kaplan goes on to stress the difficulty therapists may experience in the integration process. There may exist a continuous back and forth interplay of characteristics--i.e., independence/ dependence, anger/passivity, etc., that may frustrate the therapist and urge her to push the client in a direction that may inhibit integration. Because of the therapist's own indoctrination into bi-polar notions of self and struggles toward integration, Kaplan stresses the importance of self-awareness and constant exploration with other therapists of "one's self in relation to the model of androgyny on the one hand, and to the cultural constraints that impinge upon us, on the other" (p. 229).

In 1979, Downing developed and tested a hybrid scoring system in an attempt to bridge the gap between the theory of the psychologically healthy aspects of the androgynous person, as researched by Bem (1974), and the reality of the integration process in androgynous persons, as researched by Kaplan (1979). Using this hybrid approach to scoring, she found fewer individuals who are considered truly androgynous and a greater percentage who merely possess masculine and feminine traits. In her conclusions Downing states that the best measurement of androgyny has yet to be formulated, especially in terms of assessing the integration process of masculine and feminine characteristics.

Moving from empirical research to a social analysis and therapeutic application of the concept of androgyny, several authors (Kaplan, 1976; Kenworthy, 1979; Marecek, 1979) speak to the social changes in our culture that necessitate the development of an androgynous identity, especially for women. They also outline some of the difficulties and consequences for women in the integration process that leads to attaining the androgynous ideal.

Through an analysis of the social changes that have occurred in the past few decades, Marecek (1979) emphasized the fact that highly differentiated sex role orientations are less suited to current conditions than are androgynous orientations, especially for women. Social change in life spans and life cycles, labor force participation, and marriage, divorce, and childbearing all have implications as to the desirability of developing an androgynous identity for positive mental health. For example, the rising rates of marital dissolution and single lifestyle choices require women to develop competencies in both masculine and feminine spheres of behavior. The advent of birth control and legalization of abortion allows women to control the number of children they want to raise, which may push them to look for additional sources of life satisfaction outside traditional realms. The longer life span of women and the decline of extended family networks results in a need for women to increase their independent living skills.

While acknowledging the advantages of incorporating an androgynous model of mental health into psychotherapeutic practice, Kenworthy (1979) discussed the marketing problems inherent in selling androgyny in "Peoria." "Peoria" represents the quintessential small town in the U.S., where sex roles permeate the basis of existence--the myths upon which "Peoria" is built. She emphasized the fact that the model of androgyny is merely an

> interesting exercise in intellectual dexterity unless eventually it becomes useful in Peoria, . . . or any setting where traditional gender roles have only begun to be questioned by a few inhabitants. (p. 232)

To espouse a belief that women and men embody both masculinity and femininity is to overturn one of the informing myths on which "Peoria" is built. In view of this reality, Kenworthy stressed the need for therapists to be aware of the potential costs to women who make non-traditional choices in moving towards androgyny. "The emerging androgynous woman may be regarded as an anomaly within her own culture, however admirable she is in the therapist's ideal world" (p. 237). The woman who begins in adulthood to develop her capacity for self-reliance, analysis, assertiveness, and many other latent traits may also begin to yearn for more complex activities than those of marriage and raising children. For a woman to question the value of her marriage may result in a great threat to "Peoria"--

a divorce. An androgynous woman may experience smaller payoffs than an androgynous man, for he may be seen as "humane," whereas she may be viewed as a "castrating female." Kenworthy cites research that supports the fact that feminine competent women are preferred by employers and coworkers over nonfeminine competent women.

Androgyny is not a key to social recognition or the good life for many women, for they are still underpaid and undervalued by society. Kenworthy summarizes her research with the fact that androgyny is not the remedy for sexism and clinicians must not fail to assist women in coping with and surmounting the real problems that they encounter in a sexist society.

Although not a remedy for sexism, the androgynous model of mental health does attempt to remedy the deficiencies in the sex-role socialization process that is a by-product of a sexist society. The core of many of the problematic issues women clients bring into therapy revolves around deficiencies in their upbringing due to sex-role socialization patterns. Understanding that her problems may arise from her socialization process as a woman, "a client can be helped to broaden her sense of what is appropriate and acceptable for her, enlarging the scope of her self-definition" (Kaplan, 1976, p. 3555).

Kaplan (1976) stressed that it is not sex-typed traits themselves that are pathological, but rather overly sex-typed reactions and/or the absence of responses that are assigned to the opposite sex that results in pathology.

Utilizing the androgynous model of mental health that requires that behaviors at both extremes be brought to a more reasonable, modulated, middle ground, Kaplan indicated certain psychotherapeutic methods for attaining this goal by means of a therapy of resocialization. She developed guidelines for working with the two traits that appear with the greatest frequency as problematic for women: "aggression, which in women is rather consistently suppressed; and dependency, which in women tends to be encouraged" (p. 356).

Women clients have a wide range of styles by which they express their rage: depression, indirect rage, deception, and indirect manipulation. Common to all of these expressions of anger is the underlying fact that women do not accept the validity of their feelings and as a result cannot express them effectively. Women's anger does not count in our culture. Women are uncertain of their right to be angry and often experience a conflict between anger clearly expressed and their self-images as women.

Applying an androgynous model of mental health demands that a therapist draw attention to any suggestions of unrecognized anger in a client, encouraging her to examine

these feelings. Once a client recognizes her anger, the therapist then works to help her learn a behaviorally successful and appropriate expression of her feelings through such techniques as: behavioral rehearsal, role-play, or predicting potential stumbling blocks to her expression. Therapists need to be sensitive to any indication of anger between herself and her client and push for a direct and honest expression of these feelings with her client. "It is meaningless for a therapist to verbalize acceptance of a woman's anger 'on the outside' if she cannot demonstrate that acceptance when the anger is directed at her" (Kaplan, 1976, p. 357). Although not always the problem, anger is viewed by the androgynous model of mental health as a major potential mental health hazard for women.

"As women are taught to inhibit their anger, so are they trained to express their dependency" (Kaplan, 1976, p. 359). Women's reliance on others for approval, acceptance, and guidance severely inhibits their ability to trust their own judgment and evaluative skills as self-reliant and independent persons. According to Kaplan, establishing self-reliance and independence of thought are two of the more critical goals if one is to approach an androgynous state of mental health. Kaplan emphasizes the single most important tool the therapist can use in helping clients establish self-reliance and independent judgments--herself.

The way in which the therapist handles dependency issues between herself and her client in their relationship will teach a client the skills of self-reliance or encourage continued dependency. The therapist must encourage the client to evaluate her own behavior rather than depending on other's opinions, including the therapist's. Kaplan acknowledges the therapist's need to express opinions and share reactive feelings towards the client's behavior, but not until the client has already done so and in a way that encourages the client to question the therapist's authority and rely on her own opinions. Kaplan warns against a therapist getting too intimate or personal with a client, for this could unwittingly encourage a client to pattern herself after the personality or lifestyle of the therapist. As an agent of resocialization, the therapist helps the client grow in self-reliance through allowing her to experience her own process of trial and error. A therapist "is caring and warm, yet avoids creating an overinvolved, entangling relationship that could diminish the client's own initiative and sense of her own power" (p. 360).

Kaplan points out that anger and dependency are primary concerns for women clients and there are numerous other problem areas to which the perspective of an androgynous model of mental health could be applied. In each area a therapist should examine the literature for indications of

deficiencies in women's upbringing. She then can consider ways to modulate the two extremes in sex-typed behavior which Kaplan points out as pathological: overly sex-typed reactions and/or the absence of responses that are assigned to the opposite sex.

Feminist Therapy and the Sexist Bias in Social Work Education

> The critique of society from a feminist viewpoint has placed particular emphasis on the psychological oppression of women, pointing to the damage they have suffered in regard to self-concept, identity formation, intellectual development and aspirations, and overall emotional well-being as a result of the socialization they have undergone and the socio-political status assigned them. (Thomas, 1977, p. 447)

In the early 1970s, many in the mental health field began to respond to the criticisms leveled by feminists. Researchers and practitioners began to develop and publish new models for working with women in therapy at about the same time that feminists were developing alternatives to therapy, such as consciousness-raising groups, self-help counseling, assertiveness training groups, battered women's shelters, career counseling, and rape crisis hotlines and counseling centers, as well as calling for a new psychology of women to be developed by and for women.

Feminist therapy was developed out of the responses of the mental health field to feminist criticism and the feminist search for alternatives to the traditional therapy

that seemed to reinforce oppressive conditions for women (Thomas, 1977). "Studies of social workers, psychiatrists and counselors demonstrate the influence of sex bias in their diagnostic evaluations, criteria of mental health, and attitudes toward women" (Kravetz, 1976, p. 424). In view of these facts, Kravetz identifies very basic problems for women in her observations that "stereo-typical views of female development, anti-women bias in personality theories, and traditional set role standards pervade the theoretical framework for much social work knowledge" (p. 424).

> Theoretical background must influence the way in which problems are perceived, the strategies by which they are addressed, and treatment goals, as well as the policies promulgated by agencies and clinics. Will a clinic, for example, see the value of a women's consciousness-raising group or of a women's therapy group? Will administrators allocate funds to employ a woman therapist or social worker who has a "feminist orientation"? It was not professional social work agencies or mental health clinics that pioneered the establishment of wife abuse centers and rape crisis centers. These are examples of social needs of women to which the established mental health system has not been responsive. (Donadello, 1980, pp. 202-203)

Human personality and behavior theories utilized extensively in social work education and training contain many sexist biases. Today, few social work practitioners define themselves as strict adherents of Freudian theory; still, some of his personality theories and therapeutic concepts are still widely used to explain people's problems. Psychologists, psychiatrists, and social workers--even when

they negate or ridicule parts of Freud's theories--have themselves gone through a training program permeated with Freudian myths about women (Friedman, 1979).

> Sigmund Freud's theories of personality development have had widespread influence on mental health practice and contribute greatly to its sexist nature. The concept of penis envy neatly divides the sexes and defines the "masculine" and "feminine" traits and attributes ascribed to masculinity and femininity.[11] It also underpins the notion of women's inferiority and provides a reason for their oppression. A woman's effort to become self-actualizing is explained by Freud as her desire to compensate for her lack of a penis. To him, all that was good, creative, productive, and assertive was masculine; the opposite of those traits he identified as feminine. Freud's theories have become powerful and invidious influences because of the degree to which they have been borrowed, assimilated, and incorporated by influential theoreticians. (Donadello, 1980, p. 209)

The double standard of mental health uncovered in the studies cited earlier in this chapter by sex-role researchers may not be based on the theory of penis envy, but the implications are the same for women.

The ideas of Freud which include, for example, such concepts as defense mechanisms and conscious and unconscious drives are still widely used to explain people's problems and especially their refusal to recognize their problems. Any statement the client makes can be twisted

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[11] Penis envy: Because she does not have a penis, the female child considers herself defective and is therefore naturally envious of the male.

into evidence for the therapist's ideas about one's state of emotional health. No matter how the client denies that these defense mechanisms are not operating, the therapist can argue that the client is unconsciously making use of them and that she is unaware of the forces operating within herself. Freudian interpretations can be a closed system where the therapist is seldom, if ever, wrong and the client's own feelings are seldom, if ever, valid. Misuse of this power by a therapist can result in a client questioning the validity of any of the feelings she experiences (Friedman et al., 1979). The following examples exemplify some of the ways in which direct practitioners can misuse Freudian conceptualization when they are unaware of their own biases and values:

> Repression. When your therapist says you are "repressing," this means he/she thinks you are forcing an anxious, distressing, or threatening thought out of your mind. For example, if a woman tells her therapist she enjoys being with women more often than with men, he may counter with the observation that she's repressing a memory of a bad experience she once had with a man, a father perhaps. He may ask her to dig up some childhood experience to prove his label. His assumption may be that it is "abnormal" to enjoy being with women more than men; and he can use the terminology of defense mechanisms to obscure his personal bias. (Friedman et al., 1979, p. 40)

> Projection. This means that someone, some situation (even your therapist) is making you so anxious that the only way of dealing with the difficulty is by evading personal responsibility for your actions and transferring that responsibility for your actions to something or someone else. Say, for

> example, that a woman believes her boss is discriminating against her because she's a woman. As a result, she is very frustrated and begins to hate her boss, and other men at work. A therapist may explain this by saying she really hates herself because she can't function as well as she should and needs to blame someone else for her failure. (Friedman et al., 1979, p. 41)
>
> Fixation. This means remaining at a certain stage of development instead of progressing to a subsequent stage. Suppose a woman gets a job in a male-dominated field and she constantly finds herself in conflict with her employers and colleagues. The therapist may interpret her rebellion as fixation: during the Oedipal phase of psycho-sexual development (when, according to Freud, girls compete in fantasy with their mothers for the sexual love of their fathers), she became angry with her father for rejecting her. In her adult life, the therapist may explain, she is fixated at this stage of angry rebellion against men. The therapist, using the concept of fixation, might not see alternative explanations of anger--that the woman is justifiably angry with the discriminatory treatment she receives from some men at work. (Friedman, 1979, p. 43).

Emphasis on such concepts as defense mechanisms, psycho-sexual stages of development, and conscious and unconscious drives are still very much a part of social work education and training, yet little if any stress or education is available in terms of a sociocultural analysis of potential social workers' sexist biases and values (Donadello, 1980; Schwartz, 1973; Wesley, 1975).

Erik Erikson, another important theorist in the field of social work education and training, theorizes that "woman's somatic design harbours an 'inner space' designed to bear the offspring of chosen men, and with it a biological,

psychological and ethical commitment to take care of human infancy" (1964, p. 582).

> Because he is a contemporary and because his theories depart somewhat from Freud's, Erikson's formulations of personality theory enjoy a broad and prominent place in the mental health field, and for these reasons they are probably more disastrous than Freud's. He offers the mental health practitioner such currently useful dogma as the notion that "when the role of career wife is pursued within a family, a girl's identification with her mother and a boy's with his father may be impeded." (Donadello, 1980, p. 209)

In his book, Childhood and society, Erikson (1963) devotes one-third of his book to youth and the evolution of identity. What he really describes is the male identity crisis. Seventeen pages are devoted to the adolescent development of a "Protestant, Anglo-Saxon white collar" boy, while one paragraph is devoted to female adolescent development. The rest of the book is devoted to showing how national character influences the male adolescent identity (Schwartz, 1973). The problem in utilizing a theorist such as Erikson is that potential social workers learn little, if anything, about the female adolescent search for identity as well as receiving a series of subtle messages indicating its unimportance in their training.

In respect to sex role norms for family members on which caseworkers base their diagnosis of problems, social work education and training emphasizes "the anxiety provoking implications of more flexible sex roles rather than the

self-actualizing potential that less defined sex roles can provide" (Schwartz, 1973, p. 67). For example, Nathan Ackerman (1958), a pioneer in family therapy, depicts the father as "a man of vigor, strength and courage, the unchallenged leader and governor of the family" (p. 179). His thoughts on the modern woman state that "woman's aggressiveness and mastery are only a facade. Her facade of self-sufficiency and strength represents an effort at compensation, an effort to console herself for her inability to depend safely on a man" (p. 179). In spite of its sexist implications, Ackerman's book is still viewed as a classic in the field of family therapy and used as a text in social work classes. Granted Ackerman's theories may contain some useful and valid insights for family therapists, but the use of his theories without a critique of the sexist implications for women and men continues to support a double standard of mental health and an adjustment theory to preconceived sex role stereotypes. The following statement seems to give some indication of the underlying basis of much of Ackerman's theories:

> In an effectively functioning, well-organized social system, the task of adjustment requires that people conform on a selective and flexible basis to the mores of their community. In order to integrate themselves with the group, they must identify with the dominant ethics of family and society. (p. 334)

In Schwartz'z (1973) review of the family therapy literature in social work education and practice, she emphasizes the fact that there exists an unconscious ambivalence and confusion as to the issue of male dominance in the family. At the same time she states that there is little, if any, education on the effects of this assumption of male dominance in the family on the mental health of women and the changing roles of men and women in present day society:

> What I have tried to do here is make manifest what has been mainly latent; that is, demonstrate that writers, practitioners, and teachers have points of view often unthinkingly assumed about male-female dominance and that these points of view influence their diagnosis and treatment plans. (p. 69)

Assessing the Needs of Women Clients

Social work has historically stressed the influence of a person's situation gestalt on her personal or familial problems. In the earliest history of social work in the United States, social change was the main focus in work with oppressed populations, specifically in the settlement houses. But, as the direction in social work shifted from its original social action emphasis to an individualized psychosocial emphasis under the influence of Freudian psychoanalytic theory, the belief in adjustment rather than change seemed to be emphasized. Thus women's assessment and intervention needs came to be based on assisting her

to adjust and adapt to what was considered "natural" for her--the stereotypical role of wife, mother, and homemaker (Berlin, 1976). Through the years the personal experience, practice wisdom, and research findings of many social work professionals combined with the influence of the women's movement has begun

> to provide a clear view of the debilitating effects that social structure and the traditional process of socialization have had on women. This new awareness generates pressure to do something different, particularly to be more effective in counseling women clients. The question for social workers in direct practice with women is how to apply the conviction that cultural conditioning accounts for the dilemmas of many women clients. (Berlin, 1976, p. 492)
>
> Could it be that women have been mistakenly labeled "neurotic-depressive" because they are often adapting unsuccessfully to the passive-submissive, isolated existence of wife and housekeeper in modern suburbia? Could it be that as individuals they are not suited to such a role, but rather may be conforming to societal expectations with resultant energy loss, low self-esteem, and often a great deal of repressed anger and guilt which has caused them to become depressed. (Habib & Landgraf, 1977, p. 511)

Throughout the writer's review of research literature, a general theme was reiterated: that assessment of women's problems must include an emphasis on the ways in which the ego ideals of a healthy female have not prepared women for the attainment of the ego ideals of a healthy adult (Berlin, 1976; The Feminist Counseling Collective, 1975; Thomas, 1977). It was also stressed that whether a woman attempts to maintain the passive, submissive, and dependent ego-ideal of the healthy woman or attempts to

attain the assertive, action-oriented, or independent ego-ideal of a healthy adult, she will experience many debilitating and conflictual personal crises.

This "ego-ideal conflict" was first recognized in the landmark study of Broverman et al. (1970), "Sex-Role Stereotypes and Clinical Judgments of Mental Health," and substantiated in later studies.[12]

> This dual standard creates an excruciating Catch-22 situation for a woman, for if she behaves like a healthy adult, she is considered neurotic and even deviant as a woman, but if she conforms to prescribed female behavior, she is deemed an unhealthy and immature adult. In short, whether she behaves "just like a man" or "just like a woman," she is judged emotionally unbalanced. (Sandmaier, 1980, p. 220)

Because many social workers have not questioned the influence of stereotypes in the assessment needs of women, they often do not understand fully what role a woman's environment plays in creating or intensifying problems. Women's feelings of inadequacy and self-hatred, oftentimes accompanied by self-destructive thoughts and sometimes actions, are oftentimes diagnosed and treated as "personal failures to cope with the world." Yet in reality these "personal failures to cope with the world" are frequently the result of a lack of necessary skills to negotiate the

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[12] See Chapter Two of this research for a detailed description of the Broverman et al. study.

adult or male world or of the continual presence of an ego-ideal conflict. Thus, "personal failures to cope with the world" can be reassessed as a socially constructed no-win situation for women, for "attempts to achieve either of the ego ideals can be accomplished only at the expense of the other, and thus at the expense of our self-respect" (The Feminist Counseling Collective, 1975, p. 56). There were numerous examples in the literature that spoke to this special problem.

Oftentimes women who are struggling to make a life for themselves have had minimal experiences in autonomous functioning (Habib & Landgraf, 1977). They have spent many years of isolation within the nuclear family, maintaining the healthy female ideal of passivity, submissiveness, and dependency. This ego-ideal has been constructed and nurtured by the socially sanctioned feminine role model that identifies a woman's worth and identity by the man she is with, by the children she produces, by the image she projects, by the ingenuity of her homemaking, and by the uncomplaining grace with which she fulfills the expectations attached to these roles (Berlin, 1976). The vulnerable state that a woman finds herself in when she divorces, separates, becomes widowed, or when her children leave home can lead to a state of "frantic, disheveled disorientation" that may precipitate hospitalization. This

state of disorientation and isolation encourages some women to turn to their ex-husbands for legal and financial advice on divorce proceedings. This behavior results in her feeling inadequate and powerless when she ends up cheated and denied due financial property settlements. When women with these types of problems become involved in a women's self-help and support group, they soon become self-sufficient and begin networking with other women and community resources (Habib & Landgraf, 1977).

Abused and battered women are confronted by hostile family members, judges, and the police when they try to deal with their men. They are made to feel that it is their role and their responsibility to reform their husbands by being obedient and staying with the family. They are told to stop setting their husbands up through their harrassment and vindictive behavior, oftentimes the only skills they have of maintaining some control in a powerless situation.

> This experience induces them to doubt their self-worth, and their doubts are reinforced by a society that is inclined to blame the victim. Because they are often ill-equipped to manage a household independently, they are apt to hold on to the abusive relationship, hoping that it will improve. (Habib & Landgraf, 1977, p. 511)

The coping mechanisms these women know of pleading, crying, praying, harrassing, and enduring only worsen or maintain their already destructive interactions with their husbands. And yet these are the only skills they have

learned from their early childhood poverty, parental neglect or abuse, lack of educational and occupational opportunities, early marriages followed quickly by childbearing, and their parental role models of abusive and submissive husband and wife relationships. Once these types of women become involved in assertiveness training that stresses education in socialization conflicts, behavioral modeling, and behavioral rehearsal, they become more aware of their abilities to be self-sufficient and make choices to better their situation (Boulette, 1977).

For many women the attempts to maintain the female ego-ideal have left them isolated and lonely within the nuclear family. Spanish-speaking women experiencing delusional and hallucinatory behavior were found to be spending up to ten hours per day isolated in their homes. These non-English speaking women had compliantly and submissively followed their husbands to live in totally English-speaking neighborhoods, and instead of receiving validation for doing so, they ended up isolated and eventually delusional. Many of these women's debilitating delusional or psychosomatic complaints, for which they were hospitalized and given diagnoses of depressive neurosis, schizophrenia, hysterical neurosis, and involutional depression, seemed to fulfill a personal need to be recognized. Becoming sick seemed to be the only socially

sanctioned behavior that enabled them to be self-centered and validated as a person separate from their roles as wife and mother. Once they became active participants in a Spanish-speaking women's group that stressed education in socialization conflicts, the need for parenting skills, social activities, and community resources, their health returned and stabilized (Hynes & Werbin, 1977).

Women who are struggling between the adult ego-ideal and the female ego-ideal will oftentimes find their conflict centers around independency and dependency needs. Some will strive for the complete independence of the adult ego-ideal, and in doing so will find themselves frustrated in attempting to meet their dependency needs to be loved and cared for by others. Other women will strive for the dependent ego-ideal of femininity, and in doing so will continually feel inadequate as a woman and a person. This type of woman can never quite fulfill the submissive, obedient, and never-angry ideal of femininity, yet is terrified that she can't make it on her own either. When her bottled up rage and conflict finally explodes and she leaves her husband or he leaves her, she panics and feels that no man will ever want her again (The Feminist Counseling Collective, 1975).

There are women who become so caught between the conflictual roles of adult and woman that their anger becomes immobilizing to them and they feel unable to actualize

either or both parts of themselves. This situation oftentimes ends in deep depression, guilt, immense feelings of conflictual inadequacy, and clinical assessments of a borderline personality (The Feminist Counseling Collective, 1975).

This double-bind situation can be attributed to the systematic undermining of women's capabilities, opportunities, and self-perceptions through the socially sanctioned healthy model of femininity.

> By promoting unhealthy behaviors in them, society limits the roles that women can assume, devalues what they are, and then punishes them if they fail to take charge of their lives and affairs when the circumstances so demand. (Berlin, 1976, p. 492)

From the literature reviewed in this section there emerges a clear view of the importance of the process chosen by the therapist in assessing the needs of women clients. "The debilitating effects that social structure and the traditional process of socialization have had on women" results in: isolation, lack of development of necessary skills to negotiate the world, devaluation of important female skills, a double-bind conflict between healthy woman and healthy adult, socially deviant labels attached to women who step out of traditional roles--"castrating female," "opinionated bitch," or "aggressive woman," and the lack of appropriate role models (Brockway, 1976, p. 498). This type of assessment process goes beyond

the personal and situational variables contributing to a woman's problems. It includes an assessment of the social system in which such a situation is encouraged to develop and ways in which sociopolitical systems continue to perpetuate a personal dilemma for women. This view calls for a return to the original emphasis of social work, that of a need for social change in order to help women solve their problems. This social change must include the encouragement of the development of a new ego-ideal for women and men--an androgynous ideal that integrates the healthy qualities of the female ideal and the adult ideal. Clients can then learn to fulfill their own individual needs, yet remain aware of the needs of those they love.

Feminist Therapy Assumptions and Intervention Strategies

In terms of its assumptions and intervention strategies, feminist therapy addresses the issue of unconscious assumptions about women's and men's roles that are inherent in theories of human behavior, models of mental health, models of psychopathology, and the therapeutic relationship. It assumes that women and men by nature may be different from one another, but does not speculate upon what those differences are since behaviors are heavily influenced by culture.

> Therefore, feminist therapy allows clients to determine their own destinies without the construction of culturally prescribed sex-role stereotypes based

> upon assumed biological differences. It attempts to facilitate equality (in personal power) between females and males . . . and incorporates the political values and philosophy of feminism from the women's movement in its therapeutic values and strategies. (Rawlings & Carter, 1977, p. 28)

As indicated in Chapter One of this research, there are certain feminist and humanistic assumptions that are at the core of feminist therapy. This section will enlarge upon these assumptions in respect to how a therapist can incorporate them in her work with clients.

Humanism is the belief in the innate drives of human beings toward self-actualization, toward mastery of the environment, and toward fulfillment of one's potential. Humanism originated in the personality theories of Rogers (1954), Maslow (1951), and subsequent theorists who stressed the need for theoretical integration of the cultural milieu with the intrapsychic dynamics of individuals (Boyd, 1978). The depth and degree of a therapist's commitment to "equality between the sexes, to freedom from sex-role stereotypes, and to a person's--especially a woman's--right to self-actualization" is the distinguishing factor between feminist humanism and a more global humanism as defined above (Thomas, 1977, p. 449). The humanistic assumptions upon which feminist therapy is based will be discussed in the following:

1. The therapist maintains a belief in the equality of men and women in all areas of her life and consciously

works on her self-awareness and elimination of sex bias. To increase her consciousness in this area, the therapist should participate in workshops and consultations with feminist therapists; read women's literature; periodically participate in values clarification workshops; and participate in women's and men's consciousness raising and support groups (Rawlings & Carter, 1977).

2. The therapist adheres to the belief that there are no prescribed sex-role behaviors based on anatomical differences or a person's right to self-actualization; thus theories that support such premises are rejected. Therapeutic concepts based on such theories need to be extensively critiqued for sexist implications when used in therapy. Education in theories of human behavior (views of human nature), models of psychopathology (what problems should be treated), and models of mental health (the goals of treatment) that are written by and about women is a necessary prerequisite for working with women in a competent manner. Alternative sexual lifestyles--i.e., lesbians--are accepted as perfectly healthy. Problems that arise for clients involved in these lifestyles are dealt with as reactions to external social pressures to conform, as opposed to problems related to individual pathology. Sex-role reversals of heterosexual couples are dealt with as healthy adjustments to individual needs, not as pathological

problems. Women are expected and encouraged to be as autonomous and assertive as men, and men are expected and encouraged to be as expressive and tender as women (Leidig, 1977; Rawlings & Carter, 1977; Thomas, 1977).

3. Therapist's concerns regarding clients' dependency and independency need fulfillment in marriage, living together arrangements, relationships, or single lifestyle choices should be the same for women and men. Because of the cultural expectation that women be dependent, many therapists assume therapy has a good outcome when their female clients marry. Feminist therapists attempt to explore with the client, whether male or female, their needs in terms of independence and dependence regardless of the client's choice to be in a relationship or remain single. The important issue is that clients separate their individual needs for independence and dependence from culturally conditioned definitions of independent manhood and dependent womanhood, thus integrating these needs within their own person so as to balance the characteristics of being human. Clients can then become centered within themselves and can fulfill their own individual needs, yet remain aware of the needs of those they love. This self-acceptance of the full range of independent and dependent needs enables a client to enter a relationship or single lifestyle from the perspective of a conscious choice rather than a desperate

need (The Feminist Therapy Counseling Collective, 1975; Rawlings & Carter, 1977).

4. Sex-biased testing instruments will not be used in therapy unless necessary, and then only with the total involvement of the client in the evaluation and ownership of the results.

> Testing puts the therapist in an expert position with the client. Having a client spend long hours taking tests and then giving her an evasive interpretation under the assumption that the therapist knows more about the client than she knows about herself are both means by which therapists mystify women clients and gain power over them. (Rawlings & Carter, 1977, p. 61)

Many feminist therapists reject the clinical use of tests altogether due to the existing sex bias in the established criteria for interpretation. Since such criteria or normative data reflect the status quo, interpretations based on normative data are, by definition, sexist. But other feminist therapists are not in complete agreement, arguing that there are a few well-defined occasions when testing could be used. For example, testing might be used at the request of the client for her direct benefit. In this situation, though, the therapist must fully educate the client regarding the limitations of and inherent biases in the tests. The client should also be totally involved in the evaluation and ownership of the results. "The use of diagnostic categories, like testing, is a complex issue

on which feminist therapists are not in agreement" (Rawlings & Carter, 1977, p. 62).

Feminist assumptions necessary to distinguish feminist therapy from other forms of therapy are based on the political assumptions of feminism stemming from the women's movement. These stress equal opportunity for men and women and the necessity of establishing egalitarian interaction between people. The <u>feminist assumptions</u> upon which feminist therapy is based will be discussed in the following:

1. <u>The primary source of women's pathology is assumed to be social, not personal; thus in the beginning of therapy stress is placed on raising clients' consciousness levels as to the realistic barriers in the social structure that block their attempts at achievement and autonomy</u> (The Feminist Counseling Collective, 1975; Rawlings & Carter, 1977; Thomas, 1977). While feminist therapists would not totally deny the possible existence of personal inner conflicts which may have made the client more vulnerable to sociocultural pressures, there would also be a strong commitment toward sharing with the client facts concerning realistic societal barriers. Consciousness-raising helps women to sort out for themselves whether their behavior is determined by others' expectations, needs, and demands or by their own expectations, needs, and demands. Consciousness-raising can occur in individual therapy or in a group.

The consciousness-raising group is designed to provide a safe forum where women can explore the ways in which they live their lives. A consciousness-raising group follows a group process such as that seen in traditional therapy groups. This includes working through such phases as opening up, sharing, analyzing, and abstracting. Group leadership is shared in that each member is expected to lead one weekly discussion. Some groups have an official leader who organizes selected topics and structured exercises, and assists group members in leading their particular discussion. Other groups have no official leader; members decide as a group the topics for discussion and equally share in the preparation and leadership responsibilities each week. The groups usually consist of eight to ten members who contract to meet weekly for two-and-one-half hours for ten weeks. The shared leadership responsibilities, regardless of whether there is an official leader or not, encourage the women to depend on themselves as competent adults and to recognize their right to personal power (Rush, 1973; Thomas, 1977; Valverde, 1981).

> Through the use of selected topics and structured exercises, the women will have the opportunity to heighten their awareness of the condition of women in a male-dominated world in general. This will help them to re-examine those attitudes, assumptions and beliefs they hold which are incongruent with their true feelings and which may be contributing to their present stress. (Valverde, 1981, p. 38)

2. <u>Feminist therapy assumes that women have become isolated and competitive in their relationships with other women; thus group work is stressed</u>. It is an assumption of feminist therapy that it is preferable to move a woman, as soon as possible, from individual therapy to a group. The group provides her with a supportive atmosphere in which she can explore with other women the roles she plays in the political, economic, social, and personal context of her life. By establishing a common bond with other women, clients can begin to formulate an ego-ideal of womanhood and adulthood that is comfortable to their individual person, while receiving support and validation for doing so by others involved in the same task (The Feminist Counseling Collective, 1975; Mander & Rush, 1974; Thomas, 1977).

3. <u>Feminist therapy assumes the client is essentially competent and has the personal power necessary to determine her own needs, values, actions, or thoughts; thus short-term therapy is stressed with an emphasis on self-help resources</u>. The client is discouraged from depending on the therapist as the source of strength, nurturance, and knowledge. Instead, the therapist helps a woman reclaim her own individual strength to be assertive, strong, and self-nurturing as well as yielding, vulnerable, and other-nurturing.

A most important and integral part of feminist therapy that helps women reclaim their competency and personal power

to determine their own needs, values, actions, and thoughts is assertiveness training. Assertiveness training teaches women ways to communicate that are neither hostile nor submissive.

> Assertive behavior is that type of interpersonal behavior in which a person stands up for her legitimate rights in such a way that the rights of others are not violated. Assertive behavior is an honest, direct, and appropriate expression of one's feelings, beliefs, and opinions. It communicates respect for the other person, although not necessarily for that person's behavior. (Jackubowski-Spector, 1973, p. 75)

The four stages in assertiveness training seem to consist of the following (Bloom et al., 1975; Butler, 1976; Rawlings & Carter, 1977):

a. Help clients distinguish among assertive, aggressive and nonassertive behaviors within themselves and others.

b. Help clients identify and emotionally accept their basic interpersonal rights, and to develop a belief system which will support their behavior. This process is necessary so as to provide members with the emotional strength they will need to counteract negative reactions to their newly learned behavior.

c. Help clients reduce psychological obstacles to assertive behavior, such as anxieties and fears about hurting the feelings of others, being embarrassed, disliked, or retaliated against, and fear of expressing anger.

d. Help clients rehearse assertive skills with each other in the group setting through the use of role play so as to help them build confidence in their newly learned skills and prepare them for use outside the group.

4. Based on the idea that relearning precedes behavioral change in the individual, feminist therapy assumes the emphasis in therapy should be placed on resocialization of sex-role conditioning through the use of action-oriented and experiential exercises (The Feminist Counseling Collective, 1975; Mander & Rush, 1974; Rawlings & Carter, 1977). Since many of the dilemmas women clients face are strongly related to the debilitating effects of cultural conditioning, it is important for them to actively experience the trying on of new behaviors. In this way they can determine for themselves the ego-ideal of womanhood and adulthood that fits for them individually or experience psychological and interpersonal obstacles they wish to overcome.

> Consciousness raising teaches women how to think clearly about their lives. Assertiveness training teaches women how to articulate their thoughts and feelings and how to advocate for their rights. However, even though a woman learns to communicate congruently, frequently her body language does not support her words. Although speaking assertively, the woman may still be indicating passivity through her posture, her downcast eyes, her inaudible voice, or other postures and movements. (Valverde, 1981, p. 41)

It is important for a feminist therapist to stress body awareness as she attempts to help women clients reclaim

their inherent competency and personal power. Body movement therapists believe learning takes place throughout the entire nervous system, not just in the brain. Anger, frustration, and self-competence are experienced throughout the body. For example, suppressed rage may be felt as chronic stomach pains. Stress may be experienced as lower back pain and so forth. Body awareness exercises where breathing, body movements, and verbalizations are used to release chronic muscular tension can also release pent up anger, grief, or other emotions. By getting in touch with the feelings that may be associated with muscular tension, "and learning to express these emotions through the body, women can strive for greater congruence between feelings and interactions" (Valverde, 1981, p. 41). Body awareness comes from movement, not just thinking; it is a continuous process of learning to re-integrate feelings with actions. When one is in touch with body patterns and attitudes, she then has the choice to make changes (Rush, 1973).

Body awareness techniques help women clients to re-integrate their feelings with their newly learned behavior and consciousness. It helps them to get in touch with psychological blocks and obstacles, as well as body patterns and attitudes. Examples of some action-oriented and experiential techniques and exercises are the following:

a. Rational-emotive techniques, where clients observe, understand, and persistently challenge irrational beliefs and perfectionistic "shoulds, oughts, and musts" (Ellis, 1973, p. 200).

b. Gestalt techniques, where clients can attempt to resolve their internal conflicts in emotionally accepting newly learned behaviors.

c. Transactional analysis techniques, where clients can gain an awareness and understanding of the societal, familial, and individual "messages" they have received throughout their lives. These "messages" participate in the formation of individual "life scripts" and can interfere or enhance human transactions.

d. Systematic desensitization, where a client is helped to reduce anxiety by using relaxation techniques when presented with an anxiety-producing situation.

e. Role play, where a client recreates or creates an interpersonal situation in therapy and acts it out by trying on new and old behaviors. She practices behaviors in order to prepare for using them in her world, as well as to gain an awareness of how the old and the new feel when compared and observed by herself and others.

f. Relaxation and stress-reduction techniques, where a client can learn to depend on herself for mental and spiritual well-being rather than drugs, alcohol, doctors, and/or intimate others.

5. <u>Feminist therapy focuses on three specific treatment areas which are related to the stereotypic roles of women in this culture as nurturers of others, non-sexual beings/sex objects, and pacifiers. These three areas are self-nurturance, sexuality, and anger</u>. First, it is assumed that women have traditionally nurtured and served everyone but themselves. Thus there is a strong emphasis on <u>self-nurturance</u> in feminist therapy. Second, it is assumed that women have experienced years of medical and sexual misinformation, patriarchal gynecologists, objectification of women's bodies by a sexist society, and stereotypic mythology of lesbianism as a sickness. Thus there is a strong emphasis in feminist therapy on the positive nature of <u>sexuality</u> and body image. Third, it is assumed that women have been socialized to avoid the expression of anger, and have learned to fear their expression of it because of male economic or assaultive retaliation. Thus there is a strong emphasis in feminist therapy on the discovery, validation, and expression of <u>anger</u> (Leidig, 1977; Marshall, n.d.; Mueller, 1976; Valverde, 1981).

> A woman in our society is denied the forthright expression of her healthy anger. Anger, for women, appears unseemly, aesthetically displeasing and against the sweet, smiling, pliant feminine image. A woman fears her own anger--she, the great conciliator, the steadier of rocked boats, moves out of her fear to quiet not only other's anger but also her own. Small wonder that when the vacuum-sealed lid bursts off, the angry woman seems either like a

> "freaked-out nut" or a "bitch on wheels." Her frenzy is intensified by the shakiness of her commitment to her own anger. What if she's really wrong? What if the other person is right? Or worse (and this seems to be her greatest fear), if the other person retorts back with "You're crazy, I don't know what you're so mad about." (Leidig, 1977, p. 12)

6. Feminist therapy makes the assumption that all therapy is value laden. Many studies dealing with psychotherapy have confirmed the knowledge that clients have integrated many of their own therapist's values, even though they were never directly stated (Leidig, 1977; Rawlings & Carter, 1977). Therefore, the feminist therapist attempts to make her values explicit with her client, so as not to subtly direct and/or manipulate a woman client (The Feminist Counseling Collective, 1975; Thomas, 1977).

7. Based on the assumption that inherent in the therapy situation is an unequal power relationship, feminist therapists stress egalitarian interaction in the therapeutic relationship. Therapists attempt to equalize the power in the therapist-client relationship by establishing contracts with clients, sharing personal values and feelings with clients, demystifying the therapist role and therapeutic process with clients, and modeling a new ego-ideal of strength and vulnerability for their clients (Feminist Therapy Counseling Collective, 1975; Leidig, 1977; Thomas, 1977).

8. Many but not all researchers and practitioners of feminist therapy assume that the therapist must be a woman and a feminist (Leidig, 1977; Rawlings & Carter, 1977; Thomas, 1977). Leidig (1977) and Odell (1978) express feelings that male clinicians who are committed to combating sexism can be most effective with male clients, in that they can provide excellent role-modeling. Odell goes on to state that

> if a man is working at becoming a feminist therapist, why should a woman be his guinea pig? . . . until the horrors of patriarchy are eradicated, men should not try to learn from women clients how women feel. (p. 100)

She states that men should work actively to change the patriarchal system of "rape and woman abuse" and to form their own political perspectives.

Leidig states that certain stereotypic and predictable group processes take place in feminist training groups of women and men, no matter how liberal, sensitive, and committed to feminism the male clinician may be. Men tend to end up teaching and women listening, which makes training of feminist therapists in mixed groups difficult, if not impossible.

Chesler (1972) states that it is the male therapist who should pay the woman client, because he presumably would be learning to relate to women in a non-sexist way and may in fact be enjoying a psychological "service" from his female client--

> namely being able to feel superior to, or in control of his own forbidden longings for dependence, emotionality, etc.--longings he has been trained to project onto women as a caste: projections which he can experience most safely with a woman who is a patient--rather than with a wife or a girlfriend or mother. (Chesler, 1972, p. 108)

The Feminist Counseling Collective believes that women who are struggling with the constraints of stereotyped behavior benefit most by having another woman as their therapist.

> Only another woman can truly understand another woman's conflicted and painful experience as second-class citizens. Another woman as therapist can model both strength and vulnerability, resolving the conflict between adulthood and womanhood. (Feminist Counseling Collective, 1975, p. 60)

Thomas (1977) found that most of the feminist therapists she interviewed felt that their feminist beliefs had an impact on their therapeutic orientation and vice versa.

> In short, a meshing took place whereby feminism and therapy no longer existed as discrete parts of the individual's life but became integrated into feminist therapy. (p. 449)

The feminist therapists interviewed by Thomas (1977) stated that they had not become feminists through a school or from any one leader,

> but that they embraced feminism because its message had relevance for them, because it reduced their feelings of isolation and provided them with support and a sense of identification with other women, and, perhaps most important, because incorporating feminism into their awareness had a profound impact not only on their consciousness but also on their lives. (p. 448)

Sprei-Ott's (1976) study shows that the majority of feminists feel that separatism is necessary. But she does conclude with the statement that with proper training men can be considered feminist therapists and do have a place in the women's movement. However, she also states that that place should be defined by women.

> By excluding men, she [Sprei-Ott] feels, we are not giving credit to those men who are aware enough to realize that in order to work effectively with women, they need to examine their own stereotypes, raise their consciousness, and study the psychology of women as they would study any other population before attempting to do therapy with them. (Odell, 1978, p. 99)

Rawlings and Carter (1977) state that nonsexist and feminist men who are knowledgeable about women's problems are qualified to treat women. "Indeed, they would be more appropriate than a female therapist who is sexist in her approach to therapy" (p. 71). They qualify this statement with the fact that having a professional degree is not a sufficient qualification nor is believing that women and men should be equal. They state that a therapist's skill, expertise, and commitment to the principles of feminism in her personal as well as her professional life is necessary for qualification as a feminist therapist. They also state that a therapist, regardless of sex, is not qualified to treat women unless she/he has participated in a consciousness-raising group. In addition, Rawlings and Carter identify specific situations when it would be <u>preferable</u>

for men not to treat women. Further, they feel there are certain situations when men <u>should not</u> treat women at all. These situations are outlined below:

> a. It would be <u>best</u> if men did not do therapy with women in the crisis of divorce. To ease her feelings of loss she may replace her husbnad with a new man, her therapist. The comfort she may experience from her replacement may prevent her from feeling motivated to move ahead psychologically and become a strong, autonomous, adult person.
>
> b. It would be <u>best</u> if men did not do therapy with extremely dependent, inhibited women who equate femininity with passivity and docility. These women would profit more from a female therapist who can model assertiveness and strength in the context of positive feminine qualities.
>
> c. A man <u>should not</u> do therapy with an all-female group. Such a situation would be counter-productive to the goals of feminist therapy.
>
> d. Men <u>should not</u> do therapy with women who are hostile to men. . . . Such women are not likely to have much trust in the male therapists at the beginning of therapy, when the work is most difficult.
>
> e. Men <u>should not</u> do therapy with women who relate to men primarily in a seductive manner. For those women, seeing a male therapist would contribute no new learning to their methods of coping. A female therapist can provide such women with a model of a nurturant, but strong female from whom they can learn more adaptive coping mechanisms. (pp. 71-74)

CHAPTER FOUR

Problem Statement and Objectives of the Study

Women in large numbers continually present themselves to mental health treatment settings for help with emotional problems. Through the years, treatment models utilized by social work practitioners tend to reflect the cultural biases of the therapist in regard to sexual stereotyping. Women's feelings of inadequacy and self-hatred, frequently accompanied by self-destructive thoughts and sometimes actions, are often diagnosed and treated as "personal failures to cope with the world" (Habib & Landgraf, 1977, p. 511). Oftentimes a social worker may not fully understand what role a woman's environment plays in creating or intensifying problems, because she may not have questioned the influence of stereotypes and psychological theories on the lives of women. The source of many problems is not necessarily a neurotic or idiosyncratic childhood or character but the culture and the social and economic institutions that define a woman's worth and identity (Friedman et al., 1979).

In addition to traditional forms of assessment and treatment, researchers emphasize the need to incorporate a mental health assessment and treatment modality that deals

with the psychological effects on women of social conditioning, sex roles, and secondary status. Within the context of this particular need, feminist therapy emerged as an ideological approach to therapy drawing its knowledge base from many existing therapeutic principles and techniques which allow for the incorporation of certain humanistic and feminist assumptions, as outlined in Chapter Three of this research. Inherent in these assumptions is less of a dependence on personality theory and more of a stress on a sociocultural analysis in assessing and helping a client with her emotional problems. Incorporation of these assumptions demands a sociocultural as well as political analysis of the way in which cultural norms and institutions participate in the creation of women's problems and interfere with women's capacity for self-determination. A client's personal choice can be political, if the decision involves untangling one's own desires from a web of societal shoulds and shouldn'ts.

The objective of this research is to demonstrate the way in which feminist therapy can be an effective treatment approach for use in social work practice. To this end, a descriptive case study approach will be used. This type of descriptive research was chosen in order to illustrate how this particular approach to understanding human behavior can be effectively applied in an individual case situation.

In the case analysis this author will attempt to analyze both the beneficial aspects and the possible difficulties in the application of a feminist therapy approach in social work practice.

The client chosen for the case study was seen in individual and group sessions by this author from February, 1981 to May, 1981. The therapy sessions took place at the Family Counseling Center, located in a large metropolitan city (population approximately 650,000) in California.

It is the hope of the author that as the case study is analyzed and treatment is outlined, the reader will have a clearer perception of the way in which the application of feminist therapy can be useful and effective in an individual case situation.

It is anticipated that this descriptive research will provide a foundation for the author's professional development in the area of direct practice from a feminist therapy perspective. In addition, it is also the hope of the author that this study may provide questions for subsequent research to investigate and generalize as to the importance of the inclusion of this perspective within the possible approaches to treatment in social work practice.

CHAPTER FIVE

Methodology

The Study Setting

In order to ensure confidentiality, the name and location of the treatment center as well as the names of the client and her intimate others have been changed.

The Family Counseling Center, located in a California metropolitan city with a population of approximately 650,000, serves about 200 clients a year. The clientele served consists of adults, adolescents, children, and families. There are five counseling programs that specialize in specific areas of needs: Senior Citizens Outreach, Women's Drug Abuse, Domestic Violence, Play Therapy, and General Counseling. The staff of all these programs combined includes a director and the following staff members:

1. four workers holding the license LCSW;
2. two workers holding the degree MSW;
3. two workers holding the license MFCC;
4. three community workers;
5. six interns from various counseling disciplines.

A psychologist and psychiatrist are on call to the agency for referrals and consultations for clients whose problems appear to be beyond the expertise of the staff--i.e., psychosis or medication.

The agency-wide workload is somewhat non-hierarchical, with all the staff sharing in general administrative responsibilities and intake evaluations. Co-ordinators of each program equally share with their staff the administrative, outreach, and caseload responsibilities of each program's operation. Each program is responsible for outreach efforts to generate its own clientele, as well as a certain percentage of its own funding. All program co-ordinators attend bi-weekly meetings with the director to discuss agency-wide issues. Individual programs are responsible for arranging and attending staff meetings and in-service training specific to their particular program.

The center is partially financed through The United Way and private donations which supplement individual programs' funding efforts and allow for a sliding scale that is conducive to middle and low-income clients. A community board, made up of various community leaders, oversees agency operations in terms of fiscal and program decisions and recommendations.

This author worked as an intern 16 hours per week in the General Counseling Program and 8 hours per week in the Women's Drug Abuse Program.

The General Counseling Program offered services to those clients whose presenting problems did not fit into the other specialized programs within the agency. The therapists

in this particular program used various theoretical approaches when counseling clients--i.e., social systems theory, learning theory, ego psychology, structural family therapy, and communications theory.

The Women's Drug Abuse Program offered services to women with alcohol and drug abuse problems. This program adhered to a feminist therapy approach and stressed the utilization of transactional analysis, Gestalt therapy, assertiveness training, consciousness raising, relaxation training, and women's support groups.

This author's supervisor in the General Counseling Program was an invaluable resource in the application of the feminist therapy approach, for, although not a feminist therapist herself, her ideological approach and her assessment and intervention strategies were similar to that of a feminist therapist. This author's supervisor within the Women's Drug Abuse Counseling Program was also an invaluable resource in that she was a feminist therapist. As co-ordinator of the women's program, she integrated a feminist therapy approach in the staff training and program operations as well as in the treatment model and treatment goals of each case. She supplied much of the guidance and support for this author's application of the feminist therapy approach.

Research Design

The study design consists of a case study of a descriptive nature. Simon (1978) describes this type of study design in his book, Basic Research Methods in Social Science:

> Descriptive research in the form of case studies is usually the jumping-off point for the study of new areas in the social sciences . . . to provide clues for subsequent research to pin down and generalize. (pp. 44-45)

Data Collection and Analysis Procedures

This author used no special criteria for choice of a subject for this research, other than that which was necessary for obtaining enough material to effectively perform a case study in the application of a feminist therapy approach. These criteria consisted of the following:

1. no psychotic pathology;
2. commitment to attend at least six individual sessions;
3. agreement to join a women's support group;
4. agreement to taping of sessions;
5. agreement to participating in the case study;
6. agreement to weekly attendance of individual and group sessions.

The subject chosen, a 27-year-old white female, was seen individually by this author in the General Counseling Program for six individual sessions of sixty minutes each.

After her third individual session this client also joined a women's support group offered by the same program and co-led by this author. She continued attending both individual and group sessions for three weeks and then ended individual sessions, while continuing to utilize the group for support and problem solving for a remaining seven weeks.

The decision to terminate individual sessions was initiated by this client and agreed to by this therapist. The original six-week contract of individual sessions that had been agreed to had ended, and upon evaluation by both client and therapist it was decided that the client could benefit more by participation in the women's support group.

Altogether this client attended sixteen sessions, with the six individual sessions beginning in February, 1981 and continuing uninterrupted to March, 1981. The ten group sessions began in March, 1981 and continued uninterrupted until May, 1981, when the group officially ended.

An information collection guide is utilized in order to describe the case. Interviews are analyzed for content and process in the following areas: (1) presenting problem, (2) social history, (3) current life situation, (4) conceptualization of the problem, (5) treatment goals, (6) treatment process, (7) treatment outcome, and (8) values and theoretical orientation of the therapist. Individual sessions

were recorded on tape and in writing by this author, and group sessions were recorded in writing by this author.

The limitations of this study design are obvious. As a single case example, it is not intended to be considered representative of all women clients or of all feminist therapists.

CHAPTER SIX

Case Study: Dianna Sands

This chapter will present the case study basic to this research. It begins with an introductory section that will outline the case selection process, methods of recording, confidentiality safeguards, and demographic characteristics of the client. The following areas will then be discussed: presenting problem, social history, current life situation, conceptualization of the problem, treatment goals, treatment process, treatment outcome, and values and theoretical orientation of the therapist relevant to this case.

Introduction

This case was selected by this therapist from the Family Counseling Center's waiting list of clients because of the client's request for an evening appointment. Having an evening appointment open at the time requested by the client, this therapist scheduled an intake interview with her. During the intake interview the client seemed to be a potential candidate for this study because of a lack of evidence of psychotic pathology and a possible commitment to regular attendance at five more individual sessions. Following the intake interview, the second and third sessions were used to ascertain the client's continuing commitment

to regular attendance of individual sessions and an initial agreement to participate in ten group sessions. The second and third sessions were also used to evaluate the psychodynamics of the client to make certain that she did not exhibit psychotic pathology and to establish a relationship of trust which would enable her to participate in the research without feeling fearful or threatened. This study was explained to the client in the third session, with the option of participating as a subject. Upon agreement to participate, the client signed a consent form that gave this therapist permission to tape the remaining individual sessions and to use all individual and group session material in this research.

The names of people, places, and employers are disguised in order to maintain confidentiality. However, other pertinent information such as occupational titles, recreational interests, family composition, problem areas, and ages remain the same.

The client chosen for this study was Dianna Sands, a white female, age twenty-seven, who works full-time as a counter clerk for a dry cleaning establishment. She has been married for seven years to Jon Sands. Dianna's husband is unemployed and has continual problems with drug abuse. Neither Dianna nor Jon have any children.

Presenting Problem

In January of 1981, Dianna telephoned the Family Counseling Center on the advice of a friend to seek help with her marital relationship. She indicated to the intake worker that her husband's drug addiction was interfering in their relationship and she wanted to talk with a counselor about how to deal with the problem.

She was first seen by this therapist in February of 1981 and elaborated on the original problem statement. Her husband's drug addiction had continually interfered with their seven-year marital relationship in terms of legal, financial, residential, and emotional problems. She expressed a desire to remain strong in her decision to divorce her husband and not to give him "one more chance," as she had done numerous times.[13] At that time, she had not yet spoken with her husband about her decision to separate and seemed to want help in doing so. She had asked her husband to attend couple's therapy with her, but he refused.

Social History

Dianna's family of origin consisted of her biological parents, an older brother and older sister, as well as a younger brother and younger sister, Dianna being in the

[13]All quotations in this chapter are the client's own words.

middle of the five children. She was raised in a working class suburban neighborhood close to her present home. Her mother worked at home as a mother and a wife, while her father owned and ran a dry cleaning business. The children had little knowledge or involvement in their father's life outside the home and did not discover his role as an active community organizational developer until reaching early adulthood. He never talked about his work or displayed his exemplary community leadership qualities in the home. Dianna remembers him as always being too tired to interact with his children, except for yelling at them. His main recreational activities were playing cards regularly with friends, drinking, and attending functions at the Elks Club and Moose Lodge with his wife. He died in 1980 of cancer after years of being ill with the disease.

Dianna's mother's life seemed to center around her role as primary caretaker of the children's and her husband's needs. She had little time to pursue other interests that were not related to her role as wife and mother.

Dianna and her siblings were all involved in their teens and adulthood with drug and/or "fast" crowds of friends. Whereas school was viewed as "boring," "big flashes" such as "choppers," "bikers," drugs, rock music, and fancy cars seemed to provide an excitement that attracted each of them to engage in "rowdy" lifestyles as teenagers and adults.

There appears to have been much chaos in the family interactions where the primary emotion displayed was anger, its expression seeming to take the form of physical and/or verbal fighting or namecalling among family members. Dianna remembers, as a child and as an adult, throwing things, kicking walls, and getting into fist fights with her siblings and friends. This behavior seemed to be modeled by her father, who was continually telling the children to "shut-up and go to their rooms" and hitting them with the belt when they did not obey. He also appears to have been extremely derogatory in his remarks to the children, as well as to his wife, calling them "stupid" or "idiotic." As the children got older, they learned to fight back, recognizing that their father seldom carried through with his threats of restrictions.

Dianna's mother counteracted her husband's behavior by taking on the role of comforter and pacifier with the children when their father expressed his anger towards them. She would tell them that their father was just in a bad mood and he wasn't really mad at them and modeled a passive acceptance of his degrading remarks towards her. In her teens, Dianna remembers "standing up" to her father in defense of her mother and ending up verbally fighting with him over his verbal abuse of her mother. Although Dianna was the only child in the family to take on the role of her

mother's advocate, the aggressive behavior she learned was shared by all her siblings.

The family message in respect to expressions of emotional vulnerability was "keep your chin up--be tough" and "don't allow yourself to get into your feelings or express weakness." As an adult, Dianna still feels an impatience with other's expressions of "emotional weakness."

Current Life Situation

After finishing high school Dianna left home to live with a man she had met in her senior year. This man was a drug abuser and a "jerk" who expected Dianna to take care of his every need as well as accept his verbal abuse. After three years with him she grew frustrated and tired of his unappreciative and derogatory treatment of her and left the relationship. Upon her departure she "got a panicky feeling at being alone." Shortly thereafter she met Jon and within a few months decided to marry him. She related to this therapist that "I didn't realize at the time, but after I'd really thought about it, I realized that rather than waiting and doing things for myself, I was willing to settle for anybody rather than be alone." For although Jon was less verbally abusive towards her and seemed to have a pleasant personality, he still expected her to take care of his every need and was also a heavy drug abuser.

In the area of employment, Dianna pursued various clerical jobs, usually quitting after a year or two because of boredom. She enjoys her present job of counter work at the cleaners due to the variety of job responsibilities and customer contact. She is also applying for work as an airline stewardess, being attracted to the adventure and travel aspects of that kind of career.

Up to one year ago her relationships and friendships revolved around a drug culture and a "loose fast crowd." Her attraction to those types of people seemed to result from her search for "excitement," yet resulted in her becoming a caretaker of the heavy drug users she dated and lived with. The few men she dated who were quiet, "straight" types soon became boring and uninteresting to her.

Her present relationship with Jon has been chaotic and stressful, full of many legal problems, housing evictions, financial problems, and emotional highs and lows. Through the seven years of their marriage, Dianna seems to have been the primary caretaker of their joint relationship responsibilities. She financially supported them due to Jon's inability to hold down a job and was the one who found a new living situation when they were evicted for heavy drug traffic and parties. She also was the one to bail Jon out when he was arrested or received fines for his drug abuse.

Although Dianna used drugs ("speed" and marijuana) herself, she did not seem to experience the problems with addiction or inadequate social and occupational functioning that was typical of her husband.

Dianna's and Jon's relationship seemed to work well when he wasn't "loaded." During those rare times they enjoyed each other's companionship, were able to resolve conflicts successfully, and could communicate in a caring and loving way. Over the passing years, these positive aspects of the relationship became less prevalent, as Jon's addiction increased.

The communication style that evolved was that of Dianna holding her resentments until a time when Jon wasn't "loaded" and then confronting him with her anger. Although Jon was better able to respond when he was "clean," Dianna's build-up of resentments kept her so angry that she became "hysterical," and both would end up namecalling and arguing without any resolution of their conflicts occurring. After a fight, she recalls feeling more resentment and frustration as well as much guilt for "dumping her angry feelings on Jon."

In 1977 she attended Al-Anon regularly for two years because of her dissatisfaction and frustration with her

relationship.[14] Although she found it to be helpful in learning new behavior patterns, she quit attending due to her feeling that she was the only one working on the relationship, with Jon continuing to be irresponsible and abusive with drugs. After a year of not attending meetings she found herself "backsliding into old habits" as Jon's caretaker and again began to attend regularly. She feels that Al-Anon has been an immense help in that it provided not only an outlet for her frustrations of living with a chemically dependent person but a support network for problem solving as well.

In the past year Dianna has experienced some changes that have affected her relationship with Jon to the point that she is seriously considering a divorce.

Five months before she began her sessions with this therapist, her father and Jon's mother died of long-term illnesses. Dianna and Jon were also evicted from their apartment at about the same time as the deaths occurred. Not having the financial means to rent another place and needing space from each other, they each went to live separately with their remaining parent. Shortly after the move and at about the time of Dianna's first individual session with this therapist, Jon was arrested on drug

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[14] Al-Anon is an auxiliary self-help group of Alcoholics Anonymous. Its purpose is to help family member of alcoholics to improve their own emotional health and spiritual growth as well as provide a more wholesome environment for the whole family, including the alcoholic.

charges and was incarcerated for six months. When Jon left his father to go to jail, his father needed someone to care for him because of his arthritic disability. Dianna's mother invited him to stay with them, in spite of Dianna's desire to continue in her separate living arrangements from Jon and his father. This living situation has resulted in the continuing presence of Jon, who is allotted work furlough time to care for his father, and an added responsibility for Dianna as caretaker of her father-in-law when Jon is not around. The freedom and independence she felt while living separately from Jon and continues to feel while he is in jail has been a strong motive in her consideration of divorcing Jon when he gets out.

Another development in the past year that has affected Dianna's feelings towards her marriage has been her effort to move away from the drug crowd with which she and Jon socialized. She has begun to recognize how her relationship with Jon interferes with her socializing attempts. Jon's inconsistent behavior of disappearing for two to three days at a time and his erratic pattern of drug abuse has created difficulties for Dianna in her attempts to establish new friendships. Many times she has had to cancel invitations or make up stories to cover for Jon. Eventually she gave up these efforts and because of her refusal to honestly divulge Jon's problem and be viewed as a masochistic wife,

she ended her efforts to establish new friends. At present she has no close friends other than her family. She states that it is easier to call on them for friendship because they already know and accept her relationship with Jon.

Most of Dianna's time is spent working with little or no time for recreation. She spends much of her time attending Al-Anon and working the Al-Anon program at home, maintaining her job, caretaking for Jon and his father, learning holistic health methods, completing a homestudy course in accounting, and organizing her career plans. She expresses an overwhelming desire to get her life together as fast as possible because she has wasted so many years. In fact, her relating style matches this highspeed drive, for she talks very fast, moving quickly and in an organized way from topic to topic, while experiencing an uneasiness with silences and emotional expressions of vulnerability.

Conceptualization of the Problem

Dianna's presenting problem was to seek help in solidifying her decision to divorce her husband and obtain support in confronting him and carrying through on this decision. However, she and this therapist recognized in the second session that the problem centered more on her need to individuate from Jon and to establish herself as her own separate person. In discussing her decision to divorce and

her years of "giving him one more chance," she got in touch with her feelings of emptiness at the thought of not having Jon in her life. Thus both client and therapist began to conceive of the treatment problem in terms of trying to understand and deal with the causes and effects of those feelings of emptiness.

The underlying causes and contributing factors of the problem--i.e., her "empty" feeling--seemed to fall into three overlapping areas: behavioral learning, socialization, and environmental factors. This author defines behavioral learning as the factors involved in the client's upbringing that influenced her personality development and her development of interpersonal relationship skills. Socialization factors are defined as the ways in which the client has been socialized into the feminine ego ideal and how this socialization process contributes to the problem. Environmental factors are defined as those conditions present in the client's current life situation which may precipitate and/or aggravate the problem.

The feelings of emptiness which Dianna experienced at the thought of divorcing her husband seemed to be related to her lack of knowledge and training in the skills of self-actualization. She had consistently exhibited many of the ego-strengths of a self-actualized person (Maslow, 1954): economic independence, motivation for self-growth,

utilization of self-help community resources, pursuit of challenging job opportunities, insight into her self-defeating role of caretaker, responsible handling of her life, ability to articulate her thoughts and feelings, sensitivity to the needs of others, and desire to abandon the drug culture. In spite of these personality strengths, there seemed to be many blocks that prevented her from utilizing these strengths in her own interests. This inability to move toward greater self-actualization seemed to be related to the role constraints of her feminine socialization process as well as to the environmental conditions of her more recent life situation.

Her enmeshment in the role of caretaker of her husband parallels the modeling her mother provided as a selfless caretaker and nurturer of others for which women in general in this culture have been socialized and validated. In addition to this modeling, the continual denigration of her mother by her father modeled for Dianna the fact that women in this culture are not held in high esteem even when adhering to the feminine ego ideal. The role she took on as advocate for her mother enabled her to counteract this message to some degree. She was able to maintain some feelings of high self-esteem in her ability to control and negate her father's attempt to undermine his wife's self-esteem. Unfortunately, although this situation placed her

in a position of some status and personal power, she was still dependent on the caretaking role as central to her feelings of positive self-esteem. Her feelings of emptiness at the thought of divorcing Jon as well as her fear of success in her career planning may have been caused by her lack of experience in being responsible only to herself.

In her family of origin this client also learned the two extremes of stereotypical communication styles of males and females in this culture. Her development of an aggressive and hostile communication style seemed related to the behavior modeled by her father and her adaptation of this behavior to her role as her mother's protector. On the other hand, the passive and submissive style she had learned seemed related to the behavior modeled by her mother and the role constraints of feminine socialization that discouraged aggressive expression in women.

Although this client's life situation seemed somewhat determined by behavioral learning and feminine socialization factors, the environmental conditions present in her current life situation seemed to aggravate the problem. It appeared that Jon's years of dependence on drugs and her commitment to the relationship made it difficult for her to ignore his need to depend on her highly developed ego strengths. His periods of "cleaning up" and portraying an ideal spouse continually rekindled Dianna's hopes of making

the relationship work. The recent death of Jon's mother and his current incarceration left his father without the necessary care he required due to his disability. Dianna's mother's insistence on "taking care of family," at a time when Dianna was attempting to pull back some from Jon, placed her again in a position of caretaking and further enmeshment in Jon's life.

In summary, this client seemed to have learned overly sex-typed reactions of male and female behavior that are representative of extreme ends of the spectrum in stereotypical behavior (Kaplan, 1976). Additionally, the role constraints of her feminine socialization encouraged development of a caretaker role and application of her ego strengths and aggressive traits to an implementation of that role. The combination of these factors placed her in a continually frustrating place in attempting to set limits on her caretaking role and in self-actualizing her own self. Her aggressive and hostile behavior towards her husband left her feeling guilt-ridden and empty. Yet her passive behavior of caretaking left her feeling resentful and angry. There appeared to be a need for an integration of these extremes in behavior towards a more androgynous ideal, so as to enable the client to self-determine her own ego-ideal--one that was comfortable for her specific lifestyle.

An additional factor considered in helping this client integrate her extremes in behavior was the effect on her behavioral development of her family's intolerant attitudes towards expressions of emotionally vulnerable feelings. The client's difficulties in expressing vulnerable emotions could have participated in her development of the two extremes in sex-typed behavior. Consideration of the relationship of these factors in the client's development resulted from this author's research into aggressive and passive behavior. Neither behavior allows for genuine expression of vulnerable feelings. These feelings seem to get repressed and denied to such an extent that communication attempts result in domination and submission (Bloom et al., 1975).

Treatment Goals

Based on the conception of the problem, the basic treatment goal with this client was to help her recognize and apply her ego strengths to the fulfillment of her own needs, separate from those of her husband. This basic goal involved several interim stages.

First, in order to begin this process, it was necessary to help the client accept and affirm the strengths she already possessed in terms of self-actualizing skills. She had already done much work in attempting to resolve the problem; thus the task of this therapist was seen as

validating and building on this previous work. To that end, it was necessary to help her recognize the gains she had made as well as fill in the gaps that seemed to be preventing her from moving beyond her caretaker role.

The second stage in the process of treatment was to establish a treatment contract that consisted of mutually agreed upon goals and behavioral objectives. This therapist and client identified three areas that seemed to need work: assertiveness skills, awareness of learned behavior and feminine socialization processes, and increased contact with other women engaged in strengthening their sense of self.

The process of attaining these goals, mutually agreed upon by both parties, consisted of several intervention strategies. First there was a need to concentrate on the teaching of assertiveness skills and strategies. A part of the assertiveness training was helping the client to recognize the extremes in aggressive and passive behavior she had learned in order to assist in the integration process of a more satisfying and validating communication style.

Secondly, there was a need to help the client gain an awareness of learned behavior and feminine socialization processes that may have been interfering in her attempts at individuation. Once an awareness was established of these participating factors in her problem, it was hoped that the

effects of other's expectations upon her would be neutralized, allowing her to choose alternative behaviors that were more representative of how she wanted to behave.

Thirdly, participation in group would enable the client to attain support and confirmation of her reality as a woman and gain an awareness of feminine socialization processes that interfered in her individuation attempts. The opportunity to give valuable feedback and support to other group members in their similar struggles would enable her to recognize her own strengths. Another benefit of the group would be to discourage the establishment of a dependency between herself and this therapist, a dependency that would have again reinforced her need to depend on others for a sense of her own identity.

Treatment Process

The treatment process was approached by this therapist from a feminist perspective, and an attempt was made to integrate the ideologies and strategies of feminist therapy throughout the ongoing treatment. This approach was explained to the client in the first and second session, and she agreed to learn about and examine feminine socialization processes that may have participated in her inability to feel self-worth outside of her role as caretaker.

The client's uneasiness with silences and emotional expressions of vulnerability were to continue throughout

most of the sessions except at times when the therapist used intervention techniques that encouraged emotional expression. The client spoke very fast, moving quickly and coherently from topic to topic. It was difficult for her to express sadness or depression in any but a superficial way. This difficulty seemed related to her desire to "report in" to this therapist in order to receive support and validation for her attempts to use the new skills she was learning. Her need to express pent-up anger and resentment also seemed to add to her difficulties in expressing sadness and depression. This situation was made more complicated by the therapist's lack of skill in working with a highly verbal client who gave the therapist little time to assess the ongoing process and intervene when appropriate.

Individual treatment. During the first session (intake interview) the client seemed unsure of her desire for individual therapy, stating that she was satisfied with her life except for her relationship with her husband. She elaborated on how her husband's drug addiction had continually interfered with their seven-year marital relationship in terms of legal, financial, residential, and emotional problems. She expressed a desire to remain strong in her decision to divorce her husband and not to give him "one more chance," as she had done numerous times. She seemed to have an awareness of how her "mothering" role had been

part of the problems with her husband but felt at that time a divorce was the only solution. She had not yet spoken with her husband about her decision of divorce and requested help in doing so and following through with her decision. Couple's therapy was suggested to facilitate the process, but her husband had already refused this option. Thus this therapist agreed to help her examine her decision of divorce and help her move towards confrontation and action.

By the second session Dianna's resolve to divorce her husband had weakened, and she expressed her feeling that her life would be empty without him. This change in her decision seemed to result from his recent incarceration and her feelings of emptiness in his absence. Although she wanted to get out of the relationship, she felt a lack of direction without it. Thus client and therapist contracted to work for four more sessions to help her explore her feelings of emptiness. It was agreed to discuss ways she could raise her own self-esteem to assist her in individuating some from her dependence on the relationship as her only source of validation. She agreed to consider joining the women's support group co-led by this therapist. The women's group was suggested as an aid in helping her to learn to center on her relationship with herself as an individual woman instead of on her relationship with others as a wife, mother, and/or daughter. A treatment contract was verbally

decided upon that contained three goals mutually agreed upon by both the client and therapist. These goals towards which individual sessions would be geared consisted of: assertiveness training, discussion of learned behavior and feminine socialization processes, and consideration of the client joining the women's support group co-led by this therapist. Behavioral objectives necessary to attain these goals would be identified on an ongoing basis throughout sessions.

During the third session Dianna discussed her ambivalence about her need for individual therapy. This feeling seemed related to her continuing ambivalence about staying with her husband, whose attitudes seemed to be becoming more positive towards the relationship and staying off drugs. She was experiencing a feeling of being in "limbo" while waiting for her husband to get out of jail. This process of "being on hold" seemed to make it difficult for her to separate her own problems from her husband's problems. When the therapist pointed out ways she was still caretaking for her husband, the client became defensive and related ways in which she was refusing to do so. Once these behaviors were validated, the client relaxed and initiated a questioning of her continual adherence to a caretaking role. This questioning led to a discussion of the behavior she had observed in her mother and father while living with them as a child.

Her descriptions of her father's derogatory behavior included an emotionless rendition of his death and her difficulty in grieving because of a need to "stay strong."

This therapist was supportive of the client's strength and ability to control her emotional life so as not to allow herself to feel overwhelmed. She explored with the client ways in which this strength might also interfere with the attainment of intimate and equal relationships with others as opposed to the "mothering" types of relationships she continually found herself in. It was also suggested that individual therapy was a place where she could learn to express her vulnerable feelings in a confidential and supportive atmosphere. In response to this suggestion, Dianna strongly expressed her "impatience with emotional people" and then recognized her history of relationships with emotionally crippled people. Both therapist and client questioned her attraction to those persons as related to an undeveloped part of herself. At that point the therapist felt frustrated and puzzled as to how to break through the lack of emotional expression in this discussion. She expressed these helpless and puzzled feelings to the client, which resulted in Dianna letting down her "everything's fine" facade with many tears and expressions of sadness. She talked of the unhappiness and sadness she felt in her life and connected her learned family message to "keep your

chin up and hold onto your vulnerable feelings" as a primary motivator in her need to "stay strong and invincible."

This session seemed to help Dianna separate her own problems from those of her husband. Her facade of invincible emotional strength prevented her from getting nurturance and validation from her own self and others. She began to recognize ways she could utilize therapy to understand herself and gain insight into the learned behavior and feminine role constraints that had denied her access to self-nurturance. At this point the client also announced her decision to join the women's group to help in this process.

In the fourth session there was a noticeable change in Dianna's attitude toward her caretaking role. This change seemed to be related to her experience in the first meeting of the women's group where she felt that "everybody's at the exact same point as myself--a critical point where we're ready to change things in our lives." She expressed much anger at "being used and unappreciated" while fulfilling a role for which this culture socializes and validates women.

> I'm tired of getting stuck with stuff that's not my responsibility. I'm tired of shit like that. I used to just let it slide off my back, but now it's really standing out in my mind how in group we talked about getting strokes for things--well, I never get none of that--I give it to myself--but negative,

> negative from everybody else! And Jon, he's not getting the usual responses from me. I'm tired of going--oh poor somebody else!!

She expressed her growing awareness of her husband's selfish and unappreciative attitudes towards her caring gestures. "It's like it's starting to hit home; he isn't anything but a selfish jerk." The commonalities she experienced in this area with all of the women in the group seemed to allow her to focus on her own need for "strokes" and her anger at not receiving them. This demand for self-nurturance was in sharp contrast to her confused feelings of emptiness and resentment which she expressed in previous sessions.

Her angry expression in regard to a particular situation involving Jon's "selfish" demands provided an opportunity for exploration of their communication style via a role play. It was to be a trial run of an upcoming confrontation via the telephone. As the exercise progressed, Dianna and the therapist became aware of some of the obstacles in her communication problems with Jon. Her use of "You" blaming statements such as "You make me so mad because you don't care if we get the bills paid or not" resulted in her husband becoming defensive and closed off to validating her feelings. He would counterattack with his own "You" blaming statements and eventual namecalling and fighting would ensue between the two. Her absence of "I" statements such as "I feel angry and upset when the bills

don't get paid" prevented her from expressing vulnerable feelings. This absence of genuine expression seemed to encourage Jon to sidetrack her from what she wanted to say and allow him to "dump" his anger on her. With the therapist's help the client practiced various ways to try to stay with her expression of "I" statements, rather than attempt to figure out Jon's response pattern, as she had initially been doing.

The client expressed negative feelings towards her aggressive communication style of blaming. The therapist validated her ability to express anger as a positive aspect of her aggressive side but pointed out the need to moderate it in the form of "I" statements which would avoid blaming. The absence of her use of "I" was discussed by both as a possible part in her feminine socialization process that denied her the right to be responsible for her own feelings. Her lack of "I" statements in her expressions of anger paralleled her lack of "I" statements in her self-nurturance also. The client also gained an awareness of the ways in which her parents had modeled these types of behavior.

The fifth session was extremely unfocused in comparison to the previous two sessions. Many issues that were relevant to the client's problems were discussed but in a fast-paced and somewhat chaotic progression of topics. The client strongly expressed her emerging awareness of her

right to freedom of expression in respect to her needs and limits. She described many interactions where she was able to express her feelings versus hiding them behind name-calling and blaming behavior. Her use of "I" statements seemed to be resulting in her feeling heard and validated by her husband. She seemed to have gained an awareness of the way in which her learned behavior of holding resentments and then "blasting" the guilty party resulted in feelings of powerlessness and guilt. She recognized her tendency to "guilt trip" herself in respect to hurting other's feelings and had given herself pep talks on the importance of her own need to express her feelings.

She questioned her aggressive communication style as "being mean" in comparison to the passive and "sweeter" style of other women in the support group. A discussion then ensued as to the types of unhealthy and powerless communication styles women had learned in attempting to adapt to the role constraints of their feminine socialization (Bloom et al., 1975). She seemed to have developed an aggressive caretaking role where she had been able to maintain some status in her other-directed role as a nurturer of others. This was in opposition to the submissive and childlike caretaking role the other women had developed, yet was just as powerless.

This therapist self-disclosed her own struggles in moderating passivity as an analog to the client's aggressivity and validated her behavior as a strength that merely needed moderating. The fact that passivity was culturally more acceptable in women was acknowledged by both, but the self-actualizing benefits of the client's aggressive style were identified as assets.

The client also expressed in this session her continuing ambivalence towards her relationship but described it as more related to her own self needs. She expressed fears of losing her freedom and independence should her husband be able to stay "clean" and settle into a traditional relationship. This was in strong contrast to her previous concern as to his ability to make it on the "outside." She also expressed fears of being responsible only to herself were he to take more responsibility for himself. This awareness seemed to stem from the support group's discussion on women's fear of failure and need to blame someone else for their problems. Again this was pointed out by the therapist as resulting from a learned behavior of nurturing others.

This session seemed to indicate a growth in the client's ability to value herself and emphasized her high motivation to learn behaviors that were representative of the way in which she wanted to express herself.

The sixth session brought about some understanding for both client and therapist as to the confusing lack of focus in the last session. The discussion in the women's group the night before her fifth individual session had resulted in her recognizing her commitment to try to make her relationship work once Jon was out of jail. This awareness initiated considerable confusion and chaos for her as a result of the internal conflict she experienced between her continuing commitment to self-nurturance and self-actualization and her newly acknowledged choice to continue a commitment to Jon. She felt unsure of how to take care of her own needs within the complicating boundaries of the relationship. The confusion and conflict she demonstrated during the fifth session seemed to parallel the chaotic and unfocused process with which she was dealing both internally and externally.

In this sixth and last session Dianna seemed to focus on the ways in which she could maintain her relationship with Jon as well as her relationship with herself. The resolution of her ambivalence towards her commitment in her marital relationship seemed to open the way for rehearsal and affirmation of her newly learned self-actualizing skills. As in the last session, she related many self-affirming behaviors she was actualizing and strongly reaffirmed her refusal to give in and take care of Jon.

These self-affirming expressions seemed to validate and support her resolve to stay strong in her valuation and commitment to herself in preparation for her re-entry to the relationship. She recognized her commitment to herself in her decision to follow through on attending six sessions of individual therapy and ten sessions of group. In fact, she expressed her feeling that this commitment and the resultant skills she was learning played a large part in her commitment to self-affirmation. Her commitment to completing group and individual treatment was a new behavior for her. In the past she had "never finished" any of her attempts to pursue interests that focused on her own self-growth because of her desire to take care of Jon.

Her decision to terminate individual sessions at this point seemed related to the resolution of her ambivalence about her commitment to her marital relationship. Her next stage of making the relationship work could not be successfully dealt with until her husband returned home in six months from his jail term. Both client and therapist agreed that the initial identified issues concerning problems with self-esteem were being attended to in the women's support group. In addition, she had recently begun attending Nar-Anon meetings, at which she experienced an ability to stop hiding the drug-related aspects of her relationship

as she had done in Al-Anon.[14] Thus, another facade could be eliminated so as to allow for expression of her vulnerable feelings.

The client's decision to terminate precipitated a discussion of the ways in which she had learned to value herself and the "tools" she had acquired to continue building her self-esteem. She expressed her increasing awareness of the fact that, although her changes in behavior might precipitate changes in her husband's behavior, the only behavior she could actively change was her own. The therapist agreed and pointed out the contrasting difference in the client's presenting problem and her termination statements as an indication of an internalization of this knowledge. In her intake interview she had viewed the problem as her husband's need for behavioral change, whereas her termination statements dealt with "working on herself" as her goal.

The client also self-disclosed in this last session that she had also learned to "trust an outsider with her intimate feelings" in a way that she had never experienced. Her relationship with this therapist had been her first

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[14]Nar-Anon: An auxiliary group of the self-help group Narcotics Anonymous, designed specifically for the intimate others of drug users. Narcotics Anonymous follows the same format as Alcoholics Anonymous but is designed specifically for drug users.

experience with sharing intimate feelings with anyone outside of her family.

Group sessions. The women's group this client attended was developed and co-facilitated by this author. Its purpose was for consciousness raising and assertiveness training, with time allowed for individual problem solving. The group structure consisted of two facilitators and five members who met for one session per week of one and one-half hours. The leadership was shared with members of the group, who chose to lead a specific session. Members could miss two meetings, after which time they were dropped from group. The organization of sessions was as follows: (1) check-in--members shared something positive they had done for themselves and asked for time if needing to problem-solve; (2) topical discussion--stereotypical roles, assertiveness training, anger, sexuality, self-nurturance, women's legal rights, community resources for women, health issues; (3) individual problem-solving; and (4) wrap-up and homework assignments.

The women chosen for this group had been selected on the basis of commonalities in their role as caretakers and their desire to become more self-affirming in their attitudes towards themselves. All of the women were attending individual therapy--two with this therapist, two with the

group's other leader, and one with another therapist at the center.

This client attended the group regularly, never missing a meeting or arriving late. She was less verbally active than the other members of the group during the individual problem-solving time in the meeting. She took an active role in supporting and validating the other women in their attempts to be more assertive in their relationships but shared little in-depth feelings about her relationship problems. Finally, during the last two meetings she was able to self-disclose such intimate details as her drug-related history, Jon's incarceration, and her fears about making it in the relationship. Up to that point in time she concentrated more on her own need for behavioral change in terms of self-actualization in her career plans, assertiveness skills, and self-growth activities.

She was an active participant in the many assertiveness training and self-nurturance exercises. Of all the group members she could be counted on to attempt application in her own life of the many skills and exercises practiced in the group. Discussions on topics that centered around women's experiences as individuals separate from their relationship problems with men seemed to allow Dianna to self-disclose more comfortably. She took a leadership role in the assertiveness training role plays used to

facilitate understanding of aggressive, passive, and assertive behavior. She seemed more able than the other group members to express her outrage at the battering and emotional abuse some of the women experienced from their husbands or boyfriends. She also could be counted on for a wonderful sense of humor when the group needed a laugh to lighten their load. She was one of the primary spokespersons of the warmth and support and sense of "family" all of the women seemed to experience in the group. In the last meeting she initiated a discussion of continuing the meetings in each other's homes as a collectively run support group.

This author assessed Dianna's lack of self-disclosure in the area of her marital relationship as possibly resulting from several factors. She was "on hold" in her relationship and thus did not deal as intensely with the day to day struggles of self-affirmation versus caretaking of others. Her husband's absence enabled her to concentrate more on her self-actualization process without the complicating factors of relationship issues interfering on a day by day, hour by hour basis. Her desire to appear "strong and together" combined with her sensitivity to other's need for support may have encouraged her to view her problems as less urgent, thus less important in group discussions. Her fear of trusting "outsiders" with intimate information may

have added to her hesitancy in self-disclosing her drug-related history. Additionally, the other women's passive behavior may have tapped her fear of seeming "too aggressive" and "unfeminine" were she to disclose her "outrageous" background with drug abusers.

Treatment Outcome

The decision to terminate individual sessions was initiated by the client and agreed to by this therapist. The original six-week contract of individual sessions had ended, and it was decided by both that the initial issues concerning problems with self-esteem were being attended to in the women's group and in community self-help groups. Her ambivalence about her commitment to her marital relationship, which had originally brought her into treatment, had been resolved for the present.

The most important outcome of the individual sessions seemed to be the many ways she had learned to value herself outside of her caretaking role. The many incidents of self-affirming behavior demonstrated by the client in individual sessions seemed to signify an increased sense of self-worth which was filling up the "empty" feeling the client had expressed in the beginning sessions. Her increased sense of self-worth as well as her motivation to learn assertiveness skills seemed to allow her to define

her own ego-ideal between adulthood and womanhood that was comfortable for her specific lifestyle. Her emerging ability to self-disclose more of her genuine feelings to others enabled her to receive support and validation from others and was a new source of nurturance.

Her energetic participation in the self-actualizing and self-nurturing exercises and discussions in the women's group signified a continuing commitment to her relationship with herself. Her choice to self-disclose some of her most guarded secrets in the last two sessions of group and her desire to continue the group seemed to signify a letting go of her need to remain "strong" and invincible and "alone" in her vulnerability. She had learned to trust "outsiders" and felt she had something of value to share with them--herself.

After the group ended, there was no further contact with this client.

Values and Theoretical Orientation of the Therapist

The values of this therapist are based on humanistic and feminist belief systems that stress equal opportunity for men and women, women's right to self-actualization, freedom from sex-role stereotypes, and the establishment of egalitarian interaction between people. The humanitarian and democratic values of social work ascribed to by this

therapist allow for an integration of these humanistic and feminist values. In addition, the values of this therapist result from a continuing struggle to attain a sense of self-worth as a "woman person" rather than fulfilling a "feminine role."

In respect to this research the particular values applied were in the area of women's right to self-actualization and freedom from sex-role stereotypes. It is the belief of this therapist that it is extremely difficult, if not impossible, for a woman to feel a sense of personal power. She must first establish a sense of identity as a worthwhile and significant individual outside the role constraints of the feminine ego ideal. This sense of self-worth is the basis for feeling effective in controlling one's own life--the sense of being "filled up." Unless a woman is fulfilled as an individual person, she cannot be fulfilled in any of the roles she may take on in her life. When a woman submerges her own needs for the sake of others without having first met her own needs, she is left with limited ability to be supportive to others or to herself. When a woman determines her own self-identity separate from other's expectations of her, she can choose the way in which she wants to behave and live her life. She can then integrate other's expectations with those of her own in order to reach a comfortable equilibrium of her own choosing

that will enable her to feel effective and validated in her life. A woman's mental health depends on her having personal power--being effective in controlling her own life. A woman's place is wherever she is most happy and comfortable. For some women that happy place is in the home, for others it is not. Neither choice should impose a penalty in terms of limited personal growth or the critical regard of others.

It is also the belief of this therapist that it is extremely difficult for a woman in this culture to feel a sense of self-worth because of the misogynic and patriarchal attitudes that prevail.[15] It is for these reasons that this therapist chose to integrate a feminist therapy approach with the psycho-social approach of social work in this case. Psychologically, that process demanded a feminist analysis of human behavior theories adhered to by this therapist. These theories include the following: self-actualizing theories of Rogers and Maslow, systems theory, learning theory, behaviorism theory, rational-emotive theory, communication theory, and ego psychology. Sociologically, it meant applying a feminist analysis to the sociocultural factors present in the client's environment.

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[15]According to Webster's New Collegiate Dictonary (1975), misogyny is defined as hatred of women.

CHAPTER SEVEN

Application of Feminist Therapy Assumptions and Intervention Strategies to the Case Study

The information presented in this chapter will include a general statement as to the application of feminist therapy to individual casework treatment, an analysis of its application to the case study in this research, and a summary of the analysis. Included in the analysis is the specific application of certain assumptions and intervention strategies of feminist therapy in individual therapy. Following this section is an analysis of the importance of the women's support group in facilitating the client's growth and subsequent problem resolution.

The application of a feminist therapy approach in individual casework treatment focuses primarily on the role of women in this culture and the ways in which the feminine socialization process has created or intensified women's emotional problems. Intervention strategies by the social worker involves identifying that process with the client. Once ascertained, this information enables both therapist and client to work towards resocialization of sex-role conditioning that may be precipitating and/or aggravating the client's problems. This treatment approach enables a

woman to self-determine her own ego-ideal between adulthood and womanhood that is comfortable for her specific life-style.

Individual Therapy

Attempting to distinguish at which point in the treatment process each assumption or strategy was implemented was difficult. The integration of assumptions and strategies throughout provided both therapist and client with th necessary knowledge and skills to formulate and implement a relevant treatment plan. Central to the integration process was the application of the assumption concerning the therapist's need to focus the client on self-nurturance. This assumption was a key to understanding and treating the client's problem.

In this particular case study it was determined by this therapist that a possible cause of the client's feelings of emptiness and of her ambivalence towards her marital relationship was related to her role as a nurturer of others. She had increased her awareness of the relationship difficulties that were related to her caretaking role with her husband through her participation in Al-Anon. However, she had not learned the skills that were important in establishing a more self-nurturant focus in her life. The client's insight into her caretaking behavior combined with

the therapist's assessment of the problem and knowledge of feminine socialization processes provided for an immediate application of a feminist therapy approach.

The intervention strategies used resulted from the application of feminist therapy assumptions that stressed consciousness-raising, assertiveness training, and egalitarian interactions between therapist and client.

Consciousness-raising helped the client to recognize and understand the role constraints of the feminine socialization process. Awareness of these role constraints assisted her in demystifying the process by which she had developed an other-directed emphasis in her life. Recognizing these gaps in her socialization process as a woman helped her to formulate a plan for resocialization that included a more self-nurturant emphasis. Assertiveness training improved the client's ability to express her feelings of anger and vulnerability in a more direct and genuine way. The androgynous integration of her aggressive and passive communication styles into an assertive style resulted in the client receiving support and validation for self-expression which increased her feelings of self-worth.

Participation in the establishment of her own treatment goals helped the client in learning how to apply her problem-solving skills to her own problems instead of to her

husband's problems. The process of continually checking the relevancy of the judgments of the therapist with the client encouraged her to question the therapist's authority and to value her own assessments. The egalitarian interactions initiated by the therapist through self-disclosure of personal values, feelings, and struggles in self-determination helped the client establish trust in an "outsider." This trust enabled her to self-disclose more of her intimate feelings and struggles with others, thus relieving her of the oppressive obligation to continually maintain an invincible emotional facade.

Application of the assumption concerning self-nurturance was again adhered to in determining the client's progress and therapeutic outcome of treatment. The increase in the client's self-affirming behaviors and statements observed by the therapist throughout the sessions seemed to indicate her progressive movement towards higher degrees of self-worth. The contrast the therapist experienced between the other-directed emphasis of the presenting problem and the self-directed emphasis at termination seemed to indicate the client's attainment of a more self-nurturing attitude. Her expressed feeling that the only behavior she could change was her own contrasted sharply with her initial desire to change her husband's behavior. This shift in focus seemed to indicate the client's internalization

of the valuing of self that is necessary to be self-determining, thus self-actualizing.

Group Therapy

The therapist's application of the assumption that stresses group work because of women's isolation from each other was of primary importance in facilitating the client's growth in self-affirming behaviors throughout the treatment process. The support and validation of the group members around commonly experienced struggles with self-determination and self-nurturance helped the client to resolve self-doubts as to her right to fulfillment in these areas. Initial evidence of this fact was observed in the fourth individual session, which followed the client's attendance at the first group meeting.[16] The client's marked increase in self-affirming behaviors and statements as expressed to the therapist seemed to indicate the activating influence of the group. Basically, the client had begun to recognize her right to "strokes" through her discussions with the other women during the initial consciousness-raising exercises in the group.

The group emphasis on self-centered behavior as a neglected issue in women's socialization process seemed to

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[16]See pp. 109-111 of this research for a more detailed description of this session.

remove the client from an isolated position of feeling personally inadequate and lacking in self-determination. The use of assertiveness training and experiential exercises helped facilitate a more self-nurturant attitude in group members and emphasized their commonalities in this area. The client continually revealed insights she had gained about her own behavioral patterns as a result of another member's struggle in the same area. The shared process in group of learning to individuate from intimate others seemed to activate a desire in the client to establish a support network of her own that supported her changing attitudes. Evidence of this fact was observed in her initiation of a discussion in the last group meeting of continuing to meet in each other's homes as a support group.

Participation in group consciousness-raising provided the client with the opportunity to contrast her aggressive caretaking style with other member's submissive styles. The client's attitudes towards herself as "unfeminine" and "meaner" because of her aggressive style became less self-condemning as she gained insight into the role constraints from which both behaviors originated. She began to recognize her behavior as an aggressive adaptation to the powerless and other-directed role for which she had been socialized as a woman. She became more accepting of this behavior and could see that it did not diminish her basic

femininity or destroy her womanliness. In view of this insight she was better able to validate her aggressive traits as possible strengths that she could apply to her own self-actualization once they had been moderated.

Recognition of the possibility of applying her strengths to meeting her own needs seemed to enable the client to resolve her ambivalence towards her marital relationship. Again the group was the facilitating force in this process. She gained insight from another member's struggles in individuation as to how her enmeshment in a caretaking role was related to her own fears of being responsible only to herself. This insight into her fears of self-actualizing helped her to recognize ways to maintain a separate identity without necessarily divorcing her husband. This resolution on the part of the client seemed to indicate her newly emerging skills in self-determining her own ego-ideal that was comfortable for her chosen lifestyle.

Summary

The importance of the group's facilitating force in the client's growth emphasized the assumption that favors group work as a therapeutic tool, with short-term individual treatment used only when necessary. Group involvement seemed to help the client reclaim her personal power and right to self-determination in her life in a more accelerated fashion than one could anticipate in individual treatment.

Individual therapy seemed to be relevant in terms of helping her make a commitment to working on her own problems as well as making the connection to group. Once she became involved in the group, individual treatment became an opportunity to assess and define in depth the attitudinal changes she was experiencing. The therapist's experience with the initial anger and disjointed feelings one experiences in consciousness-raising efforts enabled her to provide support and reassurance for the client's expressions of similar feelings.

The fact that the therapist was a feminist and a woman who had participated in years of training and consciousness-raising in the area of sex-role analysis enhanced the therapeutic relationship. She was able to empathize with and self-disclose many of her own painful, conflicted, and sometimes humorous experiences in attempting to overcome the role constraints of the feminine socialization process. As a model and an interpreter she was able to assist the client in understanding and synthesizing the new learning taking place in her life.

CHAPTER EIGHT

Summary and Conclusions

The information presented in this chapter will include the following: summary of this research investigation, limitations of the study, recommendations for further research, and conclusions generated from the case study analysis.

Summary

The purpose of this research was threefold. First it was designed to examine the importance of incorporating in social work practice a mental health assessment and treatment modality that deals with the psychological effects on women of social conditioning, sex roles, and secondary status. A primary focus in this investigation was the way in which cultural norms and institutions have participated in the creation and aggravation of women's emotional problems. To this end, the feminist therapy approach to individual casework treatment was researched for its therapeutic relevance in social work practice.

Secondly this research was intended to demonstrate the way in which feminist therapy could be effectively applied to individual casework treatment in social work

practice. A descriptive case study approach was utilized to illustrate this application.

Thirdly this research was intended to provide a knowledge and practice base by which this author could incorporate a feminist approach in her professional development as a social worker. Due to the lack of emphasis on this approach in social work training this research was also conducted to stress the importance of its inclusion in social work education.

Limitations and Recommendations

As a single case example, this research cannot be considered representative of all women clients and all feminist therapists. Thus results cannot be generalized. In addition, the client in this study fits researcher's descriptions of the ideal candidate for psychotherapy: young, verbal, intelligent, sophisticated, and nonpsychotic (Rawlings & Carter, 1977). Her highly developed ego strengths and high motivation enabled her to respond quickly and easily to the values and strategies of feminist therapy. Little research has been done as to the benefits of a feminist therapy approach with clients who do not display the strengths and motivation similar to the client in this research. It would be important for researchers to pursue this avenue of study in order to define the possible

limitations or necessary adaptations in application of this approach to specific client populations--e.g., alcoholics, drug abusers, psychotic disordered. This author also recommends that more extensive research be conducted concerning the overall effectiveness of this psychotherapeutic approach. This type of study would help to validate and/or define the limitations of a feminist therapy approach in the field of mental health. Larger sample size should be included in future research so as to increase the generalization possibilities to a large population.

Conclusions

The progress and problem resolution achieved by this client through the application of feminist therapy assumptions and interventions strategies to this case illustrates the effectiveness of this approach with one woman client. The use of specific assumptions and strategies concerning consciousness-raising, assertiveness training, and group work seemed especially relevant in facilitating the client's growth and subsequent resolution of her problems. The effects that group participation had on this particular client's growth towards self-determination seemed to indicate the specific relevance of group work for women. In view of the obstacles encountered by women in this culture when attempting to self-determine the course of

their lives, women's groups seem to be an important source of support and validation.

In addition, this therapist recognized that her particular therapeutic style affected the treatment process with this client. The ability of the therapist to disclose personal values, feelings, and experiences as well as establish an egalitarian relationship with the client seemed to facilitate the development of a trusting relationship. Trust is essential in the establishment of a working relationship with a client whereby she can successfully resolve her problems (Egan, 1975; Hollis, 1972). The client stated at termination that the therapist's skill in this area was a determining factor in her remaining in treatment and reaching a successful resolution of her problems. She expressed the feeling that her increase in self-worth and problem-solving skills resulted from the therapist's support of the client's life experiences and skills as equally valid to those of the therapist's.

Feminist therapy enlarges the scope of these analyses to include a feminist perspective in casework treatment with women clients. The progress achieved by the client in this case study illustrates the importance of the inclusion of this perspective in social work practice. Additionally, the fact that women are seen in inpatient and outpatient psychotherapy (Chesler, 1972) more than men

makes this perspective extremely relevant to direct practitioners in the field of social work.

This research has helped to shape and define this author's therapeutic style by providing a foundation for the integration of pre-existent feminist values with professional aspirations in the field of social work. The feminist value base to which this author ascribes has evolved over several years of personal striving toward a more self-actualized sense of her identity as a woman. The impact of this feminist perspective has led this author to move towards integrating these values in social work with women clients.

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