FEMINIST APPROACHES TO PSYCHOTHERAPY

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Feminist psychotherapy came into existence in the late 1960's and early 1970's as a direct outgrowth of the second wave of the Women's Liberation movement. Women in the United States and other Western countries had begun organizing consciousness-raising groups (Freeman, J., 1972), based on the Speak Bitterness groups of the Chinese revolution. These groups were rooted in a life-changing idea that "The personal is political," initially popularized by Carol Hanisch in her article of the same name (Hanisch, 1970) and quickly adopted by feminists everywhere.

In these groups, women gathered to speak of the troubling personal issues in their lives and to make the connection between these issues and the politics of the society, to name the personal pain and transform it into political change. Such concerns as anxiety and fear, depression, body image and eating disorders among women, hidden and unspoken experiences of childhood sexual abuse and the incidence of rape began to be discussed and named in these groups (Brodsky, A.M., 1973). Previously, these experiences of abuse and molestation of girls and women were believed by the professions of psychology and psychiatry to be extremely rare; the number of women slowly but surely coming to consciousness and speaking out overwhelmingly demonstrated that this supposition was erroneous and unfounded.

For psychotherapists, the prevalence of these experiences, along with many other forms of distress, revealed the inadequacy of then contemporary models of treatment. From behaviorism to humanism to Freudianism, all the contemporary forms of psychotherapy ignored or distorted the actual experiences of girls and women in context.

Prominent among these was Freudian theory and practice, soon revealed to be biased by the perspective of Freud himself, whose ideas were being applied to demonstrate the inferiority and second class status of women (Mitchell, 1974;

Chodorow, 1978; Kaschak, 1992; Lerman, 1996). As a result of belief in such phallocentric concepts as the Oedipal complex, women's memories of childhood abuse had been considered, by most therapists of the time, to be the product of wish and fantasy. Kaschak (1992) eventually deconstructed and reconstructed the Oedipal conflict within a gendered and societal context and replaced it for women only with her Antigone complex, also a consideration of the female self in context. Through this lens, men could also be treated (Bograd, 1991) in a feminist context.

Naomi Weisstein (1968) published her classic article *Psychology Constructs the Female*, in which she stated, "Psychology has nothing to say about what women are really like, what they need and what they want, especially because psychology does not know" (1993a, p. 197). Psychological theories and models continued to be unmasked as based almost entirely on male experience. In Women and Madness (1972), Phyllis Chesler presented a scathing and incisive analysis of the patriarchal nature of the psychological professions. There followed an outpouring of theoretical, clinical and empirical studies demonstrating the biases of pre-feminist psychology in its understanding and treatment of women (Dinnerstein, 1976; Gilligan, 1981). A ground-breaking study by Broverman et al. (1970) demonstrated that therapists held women and men to entirely different standards of mental health. The healthy normal individual was considered by researchers and therapists alike to be a white male. The practice of more frequently diagnosing African-American patients as psychotic was also being revealed (Rayburn and Stonecypher, 1996). The sexism and racism that pervaded society was equally present in all aspects of the field of psychotherapy.

At the same time, as a result of Title IX and other federal legislation (Valentin, 1999), an entire generation of women was admitted into the graduate and professional schools of the United States in previously unprecedented numbers. Having arrived, these students instantly discovered that not only had they not been part of the academy or the professions themselves, but they were similarly absent from models or theories of psychology except as inferior versions of males. This generation set about changing all that by challenging subjective theories, the use of only white, male subjects in research and other related biases and practices

(Mitchell, 1974; Miller, 1976; Greenspan, 1983). Psychotherapy was revealed to be an enterprise that needed complete revision and many female therapists and trainees set about the task (Walker, 1979; Kaschak, 1976; Kaschak, 1981).

Having participated in time limited consciousness-raising (CR) groups, women also began to search for deeper psychological understanding and a therapeutic experience necessary to deal with these newly developed insights. Many who were already studying psychology or the few already in the field began to turn their efforts toward this problem. Some untrained women, as well, began of necessity to counsel the many women who had discovered that they had been abused in some way. The latter effort resulted in many of these "grassroots" counselors enrolling in graduate programs and becoming licensed counselors and therapists. Both groups, with a great deal of overlap in membership, became the founders of the field of feminist psychotherapy.

Feminist therapy set about equalizing the power differential in therapy by encouraging self-disclosure by the therapist, sliding scale fees and the idea that the personal is always also political. Lesbian and bi-sexual women were treated as normal in every way (Greene and Herek, G.M., 1994); considerations of gender and ethnicity/race were noted as central to any effective approach (Kaschak, 1976; Greene, 1986); and perhaps the most revolutionary of all, therapists would believe that what women said they had experienced had really happened and was not merely a wish or a fantasy. This was the first time women clients/patients were considered by their own psychotherapists to be telling the truth unless otherwise indicated.

Feminist therapists simultaneously began to develop models of psychotherapy that took into consideration the social and political contexts of women's lives, as well as their real lived experiences (Brodsky, 1973; Kaschak, 1976; Chodorow, 1978; Maracek and Kravetz, 1998; Jordan, J.V., Kaplan, A.G., Miller, J.B., Stiver, I.P. and Surrey, J.L., 1991). During the first decade of feminist psychotherapy, analysis and treatment were developed almost exclusively by collectives of feminist psychotherapists who had organized themselves in a few major urban centers, including Boston, New York, Philadelphia, San Francisco and

Los Angeles. There was also an analytically oriented group that created the Women's Therapy Center in London in 1976. Most members were young women who were still themselves students or early career professionals and had become involved in the feminist critique of psychotherapy. These groups developed the principles of feminist therapy (Lerman, 1983) and eventually formed into a national group known as the Feminist Therapy Institute (Hill and Ballou, 1998). Many, in fact most, of the ideas and principles introduced by these early feminists are now considered pro forma in virtually all psychotherapeutic approaches, first and foremost the acknowledgement of gender as a centrally important construct and acknowledging thereby the lived experiences of women.

Feminist psychology soon produced an ethical code (Feminist Therapy Institute, 1990; 2000) that paid particular attention to "boundary violations" and the imposition of sex on clients and patients by some male therapists, who defended the practice as therapeutic (Lerman, L. and Porter, N. 1990; Rave and Larsen, 1995). The treatment of the various abuses that girls and women experience, sexually and otherwise, expanded to become the separate field of trauma, now deemed a specialty within psychology with its own experts, journals, conferences and APA division (Walker, 1976; Dutton, 1992; Herman, 1992; Freyd, 1996; Curtois, 1996).

Feminist psychology was rapidly adopted by feminist practitioners of family therapy, which had been dealing with issues of power and control inside the family without dealing clearly with issues of gender in that same family (Watzlawick et al., 1967 ; Haley, 1989). While they met as much resistance as had the individually-oriented group, they persevered and eventually their analysis could no longer be resisted (Hare-Mustin,1978; Luepnitz, D.A., 1988; Kaschak, 1978; McGoldrick, 1998).

Feminist psychologists and psychiatrists also undertook a profound critique of the holy grail of diagnosis (Caplan, 1995), the then third edition of the Diagnostic and Statistical Manual (DSM-3) of the American Psychiatric Association (American Psychiatric Association, 1978). Partially in response to these early feminists, the DSM has undergone several revisions in the ensuing years and many of the gender-biased diagnoses have been removed or radically revised (American Psychiatric

Association, 2013). Nevertheless, many feminist practitioners consider the entire enterprise of psychiatric diagnosis to be unscientific, culturally biased and in the service of the American insurance industry rather than of the professions.

Originally, the nascent field of feminist psychotherapy organized itself into three groups: radical feminist therapy, liberal feminist therapies and non-sexist therapies (Kaschak, 1981; Enns, 2004). The most significant differences were that radical therapy maintained that society had to be changed at the roots; liberal feminists believed that equal rights and other modifications were sufficient change; and the non-sexist therapists felt that they could make therapy non-sexist without having to adhere to feminist principles. The radical faction often included lesbians, women of color and other marginalized individuals in their ranks. The more liberal faction emphasized the importance of women's relationships and, after many years of suffering criticism as essentialist, have acknowledged the crucial importance of the cultural context. In recognition of this shift in emphasis, the group responsible for the development of Self in Relation Therapy officially changed its name to Cultural Relational Therapy (CRT). The majority of the more radical group had practiced Self in Context approaches (Brodsky, 1980; Kaschak, 1992; Brown, 1996; Worrell and Remer, 2003) and cultural complexity from inception.

Early on, feminist therapy became multi-cultural and global, mostly as a result of feminists working in the United States also having cultural roots in other countries (Kaschak, E. and Sharratt, S.,1985; Kaschak, E. and Bruns, C., 2009; Kaschak, E., 2007; Sharratt, S. and Kaschak, E. 1999; Norsworthy, and Kaschak, E., 2012) with feminist therapy developing in such countries as Poland, Costa Rica and Russia. As well, there was a prominent group in England.

In the United States, Crenshaw (1991) introduced the concept of intersectionality, which was enthusiastically adopted by practitioners of feminist and multi-cultural approaches. (Comas-Diaz, L. (2000; Comas-Diaz, L. (2010; Comas-Diaz, L. and Greene, B., 1994; Enns, C.Z. and Byars-Winston, 2010). Kaschak (1992) soon after discussed the inclusion of the entire cultural frame in understanding multiple cause and effects, including, race, class, ethnicity and a multitude of other influences and characteristics. She named that approach the

Mattering Map (Kaschak, 1992; Kaschak, 2010; 2012). McIntosh (1999) presented the issue of white privilege in her forceful article that added significantly to the paradigm. It became clearer than ever that women suffer from many gender, ethnicity, class (Rothblum, 1996) and sexual orientation related disorders originating in societal discrimination as much as in personal experience. Precisely there is no purely personal experience, according to feminist therapy.

In 1978, the American Psychiatric Association voted on a new diagnostic category, which they called Post Traumatic Stress Disorder (PTSD) to be applied to returning Vietnam veterans. Feminist psychiatrists and psychologist were able, through political pressure, to have "women's issues," such as surviving rape, domestic violence and abuse included in the description of the disorder. As the incidence of abuse of women and girls was revealed, this aspect of feminist therapy morphed into an entire "field" now known as trauma-based treatment (Herman, 1992; Curtois, 1996). As well, there is a separate field dealing with eating disorders (Roth, 1992; Orbach, 1976) that grows larger all the time.

The field of feminist therapy continues to thrive in the 21st century, with many books and articles published every year, annual meetings of the Association for Women in Psychology (AWP) and an active division (35) of the American Psychological Association, among other organizations. The journal Women and Therapy was founded in 1983 and other journals, such as Feminist Family Therapy, Psychology of Women Quarterly, Sex Roles and Feminism and Psychology are also published regularly. Sadly the fields of trauma and eating disorders have also grown exponentially and continue to thrive in their own right. A liberation movement had created a cultural revolution that, in turn, has resulted in the development of many new tools, prominent among them an entirely new profession, feminist therapy.

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