COURSE #76883 — 5 CLOCK HOURS   RELEASE DATE: 04/01/20   EXPIRATION DATE: 03/31/23

An Overview of Feminist Counseling

HOW TO RECEIVE CREDIT

- Read the enclosed course.
- Complete the questions at the end of the course.
- Return your completed Answer Sheet to NetCE by mail or fax, or complete online at www.NetCE.com. Your postmark or facsimile date will be used as your completion date.
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Faculty

Alice Yick Flanagan, PhD, MSW, received her Master's in Social Work from Columbia University, School of Social Work. She has clinical experience in mental health in correctional settings, psychiatric hospitals, and community health centers. In 1997, she received her PhD from UCLA, School of Public Policy and Social Research. Dr. Yick Flanagan completed a year-long post-doctoral fellowship at Hunter College, School of Social Work in 1999. In that year she taught the course Research Methods and Violence Against Women to Masters degree students, as well as conducting qualitative research studies on death and dying in Chinese American families.

Previously acting as a faculty member at Capella University and Northcentral University, Dr. Yick Flanagan is currently a contributing faculty member at Walden University, School of Social Work, and a dissertation chair at Grand Canyon University, College of Doctoral Studies, working with Industrial Organizational Psychology doctoral students. She also serves as a consultant/subject matter expert for the New York City Board of Education and publishing companies for online curriculum development, developing practice MCAT questions in the area of psychology and sociology. Her research focus is on the area of culture and mental health in ethnic minority communities.

Faculty Disclosure

Contributing faculty, Alice Yick Flanagan, PhD, MSW, has disclosed no relevant financial relationship with any product manufacturer or service provider mentioned.

Audience

This course is designed for social workers, psychologists, therapists, and mental health counselors of the interdisciplinary team who want to gain an overview of feminist therapy/counseling.

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Disclosure Statement

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Course Objective

The purpose of this course is to increase the level of awareness and knowledge base of clinicians about the role of gender bias in construction of abnormality and the diagnostic and therapeutic process. Principles of feminist therapy/counseling, interventions, and ethics will be reviewed.

Learning Objectives

Upon completion of this course, you should be able to:

1. Discuss the demographic landscape of the United States as it pertains to gender.
2. Analyze how sex and gender influence cognitive scripts and behaviors.
3. Describe the historical context of feminism.
4. Identify and define the different types of feminism.
5. Discuss the role of gender biases in mental health diagnosis, assessment, and clinical practice.
6. Identify the premises of feminist counseling.
7. Outline interventions and therapy goals based on feminist counseling.
8. Discuss ethical implications within the context of feminist counseling.
9. Explain key controversies and future directions of feminist counseling.

INTRODUCTION

Female scholars and researchers have long argued against the preponderance of androcentric or male-oriented theories that have been developed by male scientists, which have resulted in a biased psychologic framework. Developmental theories, like Eric Erikson's stages of development theory, focus on separation of the self from others, and implicit in this theory is that all other contexts are deviant [59]. For example, women are more relational, and theorists like Carol Gilligan argue that women's development is embedded within the context of relationships [35; 59]. It is difficult to integrate this concept into Erikson's theory. Psychoanalytic theory maintains that penis envy causes neurosis for women, which is clearly androcentric. These theories neglect the role of gender as an important contextual variable that contributes to and is influenced by the differential power structures experienced by men and women [59].

Not only were many psychologic theories developed by men, the research studies used to test theories historically included only men. There were those who argued that women need not be included in psychologic and psychiatric research because men and women are essentially the same [33]. Others assert that women should not be included in studies because any existing differences due to hormones would lead to overwhelming variations in studies' findings [23].

Many female scholars and practitioners were also concerned that gender biases could affect the therapeutic relationship between the client and clinicians. In much of traditional therapy/counseling, the practitioner is viewed as the authority figure or the gatekeeper of knowledge, and the client takes in the practitioner's insights [60]. The question becomes: Who developed the knowledge? How might this knowledge reflect male biases? Ultimately, feminist scholars and counselors urged the field to look beyond the individual deficits model and seeking help through micro-oriented interventions like medication. They argue that placing pathology within the individual ultimately blames the individual [16]. Instead, the role of larger social context and macro-institutional structures in perpetuating gender inequalities and its role in various social problems must be examined.

This course will provide an overview of how gender influences cognitive scripts and behavior. This will include exploring the gender biases that exist in clinical practice such as diagnosing, assessment, the development of the *Diagnostic Statistical Manual of Mental Disorders* (DSM), and social constructions of abnormality. Feminist therapy/counseling will be reviewed, including its historical emergence, principles, interventions, and therapeutic goals. The topic of ethics will be discussed as well as key controversies that exist in feminist therapy/counseling.

WOMEN IN THE UNITED STATES: SOCIODEMOGRAPHIC PROFILE

Currently, women make up more than half of the U.S. population. As of 2017, U.S. Census data shows that, overall, women slightly outnumber men; 50.7% of the total population is female [74]. In 2017, there were 165.3 million women in the United States, outnumbering their male counterparts by 4.9 million [74]. There were 4.2 million women 85 years and older, outnumbering men in this age group by 1.9 million [74].

Over the years, the educational disparity between men and women has decreased. In 1970, 5% more men than women graduated from college. This gap decreased by 2000, when 23% of women and 26% of men graduated from college [65]. Among the employed population 25 years of age and older, 37% of women had attained a Bachelor's or more advanced degree as of 2010, compared with 35% of men [75]. In 2017, women comprised 54.3% of all enrolled college students; however, this gap closes almost completely by graduation [78].

This is also reflected in the occupational sectors, as more and more women are represented in professional fields. Overall, in 2017, women who are 16 years and over comprise 58.2% of the civilian labor force [74]. In 2012, the U.S. Census showed that 43.6% of persons working in the professional, scientific, and technical services fields were women; in 1970, only 17% of workers in comparable fields were women [65; 77]. In the medical fields, the number of female physicians and surgeons increased by 27% and female dentists by 23% between 2000 and 2010 [76]. Although women have made great strides in the last three decades, there continue to be disconcerting trends. In 2017, women were still not well represented in the business, management, and financial services sector (43.7%) and in the computer, engineering, and sciences sector (24%) [79].

Women tend to be over-represented as nurses, administrative assistants, and elementary and middle school teachers [88]. The U.S. Census Bureau indicates that women are still more highly represented as secretaries and administrative assistants than any other occupation [76]. In 2004, full-time employed women in the United States earned only 76% of the median annual salary of men [49]. In 2015, the median income for full-time employed men was $52,146, while for women it was $41,977 [136]. A female college graduate will earn $1.2 million less during her lifetime compared to her male counterpart [49].

SEX AND GENDER

The terms gender and sex are often used interchangeably. However, it was not until the 1970s that it was advocated that the two terms not be used interchangeably [80]. The term "sex" conveys that sex differences are biologic and fixed [137]. On the other hand, gender is a sociologic concept and refers to the characteristics and traits that are viewed as appropriate to men and women as defined by societal norms [16; 138]. In other words, gender is a social construct influenced by societal, institutional, historical, and cultural norms [63]. Gender affects patterns of societal, community, familial, and individual expectations; processes of daily life; intrapsychic processes; and social interactions [47]. Gender is also defined by existing institutions and ideologies and is imbued with views about power differentials. Meanwhile, sex is the biologic classification based on reproductive organs (i.e., male and female) [63]. Upon birth, an individual is classified as male or female based on the appearance of their genitals [16]. Sex revolves around what is biologic or natural, while gender is related to what is learned due to the social, political, and cultural influences [16]. This has important implications for discussions of differences between men and women. Is it implied that these differences are natural and unchangeable? Or can they be altered through activism and changes in social and institutional forces [80]?

The phrase "doing gender" can be helpful in understanding the differences between gender and sex. "Doing gender" refers to how gender is expressed or perceived in others [49]. When two individuals are engaged in a conversation, gender messages are disseminated by the individuals' appearance, the tones they utilize, and how they converse. Furthermore, each individual will perceive the gender of the other and will react accordingly, making gender dynamic, not static [49].

As mentioned, gender and sex as concepts were not differentiated until the 1970s [16]. Before this empirical differentiation, biology was viewed as destiny. There was little or no acknowledgement that individuals' behaviors and responses and the differences between men and women were influenced by societal norms based on what was expected for men and women [16]. Today, the dichotomy of the sex and gender debate is considered overly simplistic. Individual differences emanate from both biologic and social forces, and both shape behavior [80].

There are also four general approaches or perspectives to conceptualizing gender [110]. The deficit approach makes the assumption that women's behaviors and responses reflect a deficit, often in comparison to men's behaviors. The dominance perspective frames understanding of behaviors under the headings of men's power and women's subordination. The third approach is the difference perspective, which argues that differences between the genders are shaped by the different subcultures in which men and women reside. Finally, the dynamic or social constructivist perspective emphasizes the dynamic nature of interaction and the meanings ascribed to these interactions [110].

Traditionally, there are two dominant approaches to studying gender identity. The trait approach argues that one identifies as having masculine or feminine traits. The second approach views gender identity as being associated with being part of the male or female group [139]. In more recent years, the binary categorizations of sex and gender have been challenged and a host of new terms has surfaced. Research regarding nonbinary gender identity and its role in identity creation, behavior, and cognition is still in its infancy.

ROLE OF GENDER IN BEHAVIORS AND COGNITION

Knowledge of an individual's gender provides information that ultimately influences how people behave, think, and react to individuals [38]. Hoffman and Pasley assert there are five cognitive structures influenced by gender [38]:

- Perceptions about men and women
- Attributions, or explanations based on being male or female
- Expectancies, or predictions based on whether one is male or female
- Assumptions regarding the nature of men and women
- Beliefs or standards, or the underlying systems that define how men and women "should be"

All five of these cognitive structures are dynamic, interrelated, and influenced by gender as a social category.

Gender stereotypes are beliefs or assumptions about men's and women's roles and characteristics; however, they do not necessarily correspond to reality. They have strong prescriptive effects on individuals' responses [49]. Gender stereotypes can lead to prejudice and discrimination. For example, an employer might hold a belief that women are too emotional (a gender stereotype), leading to dislike and prejudice (a negative attitude) toward female employees. Ultimately, this could lead to discrimination (a biased behavior), as the employer will not hire women for a particular position based on this gender stereotype [49].

Although women have made strides in an array of social domains, gender stereotypes are still deeply embedded in society [111]. In one study, a total of 191 participants were recruited and asked to rate the likelihood that men and women had a set of traits, roles, behaviors, and attributes. Participants tended to ascribe certain gendered traits, roles, and behaviors to men and women, and this remained stable compared with data collected in 1983 [111]. When parents and teachers adhere to gender stereotypes this affects children's beliefs about their competencies. For example, the stereotype that boys are more skilled in math is a common gender stereotype that may be reinforced in families or classrooms [140].

GENDER AND VULNERABILITY

A vulnerable population is defined as a group that is more at risk of physical, psychologic, and social harm or lacks the means to protect themselves [1]. A group's lack of protection may be due to past or existing marginalization or lack of access to services due to social, economic, and/or political circumstances [70]. Consequently, women as a group can be classified as a vulnerable population [1]. For example, women are twice as likely to be diagnosed with depression, and studies show that gender differences in presentation of depressive symptoms may start as early as adolescence [81].

They are also 1.5 to 2 times more likely than men to be diagnosed with an anxiety disorder [141]. Women are at a higher risk of violence by their intimate partners, and in some countries, they are at higher risk for human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS). Their gender and the differential access to resources and privileges impacts their protective capacities. A woman may be afraid to ask her spouse/partner to wear a condom because to do so could be perceived as accusing him of adultery and could result in negative repercussions, such as domestic violence [1]. Women who perceive and experience sex discrimination (conceptualized as a social stressor) are more likely to have poor health or a diagnosis of clinical depression [142].

HISTORICAL SNAPSHOT OF THE FEMINIST MOVEMENT AND FEMINIST THERAPY

Lear first used the "wave" metaphor to differentiate the women's liberation movement from the suffrage movement [143]. However, this term as been criticized, as some assert that it creates impediments among feminists of different generations and focuses on Western feminism [143]. Nevertheless, it has frequently been used to define the chronologic events and is used in this course in the interest of clarity.

FIRST WAVE

The feminist movement can be classified in three different waves. The first wave spanned the 19th century to the early 20th century. Middle-class women in the 1830s formed charitable and benevolent societies to help sex workers and the destitute. They later embraced the cause of slavery and put voice to the abolitionist movement [24]. Feminists during this time also advocated for the importance of bringing women's influence into men's spheres, such as for women's right to vote [112]. The Seneca Falls Declaration of 1848 rejected the prevailing doctrine of women's innate inferiority. After the Civil War, these first-wave feminists took up the temperance movement, which continued into the early part of the 20th century. During this time, they also focused on social welfare and labor reform, advocating for reform of working conditions in factories and for women and child laborers, specifically limiting women's working hours, developing minimum wage, and banning child labor [24]. After women won the right to vote in 1920, this first wave of feminism waned and lost momentum [16]. In this first wave, issues of class and race can affect women's lives were largely ignored [112].

SECOND WAVE

The second wave of feminism in the United States began in the 1960s and continued until the 1990s. The 1960s were a time of civil, social, and political discontent. The youth of this generation questioned the existing authority and government structures, the Vietnam War, and the marginalization and oppression of various minority groups (e.g., racial/ethnic minority groups, women, and gays and lesbians). In Betty Friedan's book *The Feminine Mystique*, she analyzed the time period after World War II and the social, cultural, and political forces that reinforced notions of women's bodies, domesticity, and femininity and how they impeded women's freedoms [144]. She later co-founded the National Organization for Women (NOW) [19].

Women's rights flourished in this social backdrop. Feminists advocated and argued for issues such as gender stereotypes in the media, reproductive rights, domestic violence, equal rights in the workplace, discrimination, day care, rape, domestic violence, sex work, and other issues relevant to women [112; 144]. In 1963, President John F. Kennedy formed the Presidential Commission on the Status of Women to examine the issue of gender inequality. The report of this Commission highlighted the different forms of discrimination against women and outlined specific recommendations to rectify discriminatory practices, such as implementing fair hiring practices, paid maternity

leave, and child care. In 1964, Title VII of the Civil Rights Act of 1964 was authorized and bars employment discrimination based on race and sex [32]. A main focus and slogan of the second wave of feminism was the belief that "the personal is political" [4; 112].

During this period, women's groups began to establish health clinics that were run by women, advocating health policies that were sensitive to the power dynamics between individuals and institutional systems. In 1976, the National Women's Health Network was established, and the publication *Our Bodies, Ourselves* was one of the main mechanism for health education and advocacy [145].

Prior to the 1970s, when sex differences were discussed in the context of psychology, men were the normative baselines to which women were compared. However, by the late 1970s, most textbooks used to teach courses on the psychology of women focused on women as humans in their own right [82].

Within this social climate during the 1960s and 1970s, the mental health system became a focal point for feminist psychologists, counselors, and social workers. Feminist professionals focused on two predominant themes [27]. The first theme involved critiquing the existing mental health establishment and traditional psychotherapeutic ideologies. The second theme focused on grassroots advocacy and consciousness-raising efforts to combat social injustices. Today, the principles of feminist interventions can be traced to three efforts that came out of the 1960s and 1970s: consciousness-raising groups, shelters from domestic violence, and the anti-rape movement [29]. Consciousness-raising groups were non-hierarchal, informal groups composed of women who came together to talk about their experiences within the larger social context [27; 146]. The goal of consciousness-raising groups was to learn from each other and ultimately challenge the status quo [146]. These groups were similar to the support groups that are now available in a variety of settings, including online. Second, domestic violence became a recognized social problem during this time. Feminists argued that violence against women was rooted in male patriarchy, as demonstrated in society's legal, political, and economic structures [21]. Feminists fought for principles of self-determination and ensuring domestic violence victims' protection and safety, which resulted in the creation of safe havens or shelters [58]. Finally, prior to the 1960s, rape and sexual assault were often invisible and were not conceptualized as a social problem. However, the feminist movement challenged traditional assumptions about rape victims' perceived culpability and causes [7].

During the 1980s, effort was spent in defining the principles, stages, and specific methods or interventions of feminist therapy. In other words, the focus was on defining feminist therapy [27]. In the academic circles, new peer-reviewed scholarly journals focused on feminism emerged, such as *Women and Therapy*, *Feminism and Psychology*, *Journal of Feminist Family Therapy*, and *Affilia*, a social work journal [27].

Despite the grounds gained by the women's movement during this second wave, there were also criticisms. Many felt that the movement reflected the experiences of heterosexual, middle-class, primarily white women. In addition, it created the myth of a superwoman, who had a successful career while balancing being a wife and mother [83].

THIRD WAVE

The third wave of feminism started in 1990 and continued to around 2013 [112]. With roots in black feminist work, this wave is considered diverse, with no one philosophical stance; however, the third wave was viewed as a new feminist discourse for understanding gender relations that takes into account the inadequacies of the previous waves [48; 82]. Third-wave feminists saw themselves as, "making right some of the second wave's wrongs. They posit many of their arguments in response to or in reaction to second-wave positions on sexuality, power, and culture" [57]. Third-wave feminists gave women the latitude to define feminism for themselves, and they strove to make the movement

more inclusive and diverse [32; 48]. This third wave has underpinnings in postmodernism, contending for individual choice and individualized feminism [112]. These feminists targeted young women who may believe in feminism but are concerned with the negative connotations [4]. Feminists of this period emphasized individual empowerment; however, critics assert that they did not adequately focus on collective activism to challenge systemic injustices and inequities perpetuated by structural forces [146].

Third-wave feminists argued for intersectionality. The first and second waves of feminism downplayed the role of ethnicity and race and instead emphasized the unity of all women—the sisterhood of women and issues pertinent to all women [48]. Third-wave feminism argues that multiple, simultaneous oppressions exist, including oppression stemming from gender and race/ethnicity, and they are inseparable and intertwined [48]. In other words, women inhabit simultaneous conditions of marginality based on race, class, sexual orientation, age, and many more factors [82; 144]. As a result, the third wave of feminism advocated for a more inclusive approach, embracing other social groups (e.g., racial/ethnic minority women, gay women, etc.) [4]. Queer theory, for example, emerged during this period [144]. There are three core tenets of intersectionality [84]:

- Social identities are not unidimensional but multidimensional.
- Focus should be on oppression and marginalization, because it can be argued that everyone occupies multiple social locales.
- Macrostructural forces, such as racism, poverty, sexism, and discrimination, intersect with social identities on the micro level, which ultimately produces disparities.

Third-wave feminists also maintained that the macro unit of analysis be moved from the societal to the global level [48]. Women's lives are affected by the global economy, and women in developing countries are extremely diverse. The unique experiences and issues of these women are influenced by their social locations [48]. The emphasis is on heterogeneity, not homogeneity, of women's experiences [14].

FOURTH WAVE OR POST-FEMINISM

There are some who posit that a fourth wave of feminism started around 2008 and continues into today. Some of the issues of the second wave of feminism have emerged again, but the boundaries of what is considered "feminist" are not as clear [112]. This wave is woven with themes of spirituality and interconnectedness within a global community [85]. The theme of justice also prevails in this wave. Fourth-wave feminism questions "the limits of materialism; the need to turn from concerns about 'me' to concern for the planet and all its beings; and to put ourselves in the service of the world" [85].

With the pervasiveness of the Internet and digital technology, there is a sense of global connectivity that has challenged the need for the label "feminist" [86; 146]. The use of hashtags in the #MeToo movement, for example, brought collective voices to the social problem of sexual assault and harassment [146]. Because the stories and voices of other cultures are witnessed on a global scale, there is a realization that gender is not necessarily the dominant force in marginalization and oppression. Instead, there is an awareness of power and privilege (or lack thereof) across multiple areas, as is touched on in third-wave feminism [86; 146].

Some people claim that we are now in the post-feminism era, arguing that the injustices that women have previously experienced have been conquered [87]. However, others assert that women's injustices and marginalization have not been overcome, despite the gains made. For example, violence against women is still a significant problem in today's society, and a significant wage gap persists [112]. Others argue that feminism needs to be rebranded for a new market (i.e., millennials and generation Z) [86].

PSYCHOLOGY, COUNSELING, AND SOCIAL WORK: FOCUS ON WOMEN'S CONCERNS

The historical backdrop of the feminist movement and the different waves of feminism provides a context to understand how feminist counseling has been adopted in mental health fields such as psychology, counseling, and social work. As stated, with women gaining voices and visibility by their activism in the 1960s, feminism challenged the existing gender biases. In 1963, Betty Friedan published her book *The Feminine Mystique*, in which she criticized Freud's work for helping to devalue women's statuses [89]. All of this paved the way for the feminist movement's entrance into the field of psychology. In 1969, the Association for Women in Psychology (AWP) was formed. The AWP was formed by a group of women who noted that the American Psychological Association's (APA's) conference sessions did not offer topics pertinent to women, offered few presentations by women speakers, and did not offer child care, which made it difficult for women to attend the conference [10]. In 1970, the AWP made a list of demands to the leadership of the APA and lobbied to form a Division of the Psychology of Women, which was approved in 1973 and named Division 35 [16].

The term "psychology of women" has not been without criticism. The term was originated with the intent of being viewed more favorably and less political, but some have argued that this term connotes that somehow the psychology of women is distinct from "general psychology" [113]. Today, some psychologists have become frustrated that feminist psychology has not significantly advanced, particularly with the resurgence of interest in genetic and biologic determinism as evolutionary psychology has become more prominent [113].

In the counseling arena, women psychologists were beginning to make their voices heard in the 1970s. They were concerned with the lack of representation of women in counseling training programs and in research and the lack of recognition of the role of gender in the counseling process. As a result, the APA Division 17's Ad Hoc Committee on Women was formed [34]. Today, the APA's Society of Counseling Psychology (Division 17) has a section for the advancement of women.

Feminism impacted the field of social work as well. The Council on Social Work Education (CSWE), the national accrediting body for the accreditation of social work education programs, was formed in 1952 after the merger of the American Association of Schools of Social Work and the National Association of Schools of Social Administration [64]. Unlike many of the other helping professions, social work was unique in the 1960s in that it was comprised of many women [64]. Women were a large part of social work history in part because social work was perceived as an extension of women's role in charitable works [147].

Despite the number of women in social work and the values of social work and feminism being seemingly aligned, by the mid- to late-1970s social work associations still had not defined how feminism would fit into their professional identity. In 1974, the CSWE established the Task Force on Women in Social Work Education, whose mission was to promote educational content that reflected women's concerns [114]. However, also during this time, the CSWE was concerned that the field of social work was considered less "legitimate" and less prestigious than other professions; therefore, there was a deliberate effort to recruit more men. Despite the greater representation of women in social work, more men were represented in social work administration and in higher education [64].

There were minimal efforts to examine the role of sexism in social work theory and practice [13]. It was not until 1976 that there was a special issue on women in the leading journal *Social Work* [13]. Meanwhile, in 1975 the National Association of Social Workers (NASW) established the National Committee on Women's Issues (NCOWI) as a bylaws-mandated committee [51]. *Affilia: The Journal of Women and Social Work* began publication in 1986 [114]. Over the years, feminist social workers have promoted the intertwining of the political with the personal and the dismantling of the hierarchal relationship between the social worker and client [147].

TYPES OF FEMINISM

It is clear that the term "feminism" is broad. In its widest definition, feminism has been defined as a form of oppositional knowledge with a focus on challenging accepted dogma, sexism, and the oppression of women [50; 148]. Collins argues that feminism is a philosophical, cultural, and political way of looking at the world to explain the issue of women's oppression [13]. The overarching goal of feminism is to oppose androcentric biases evident in society. In reality, there are many types of feminism. Seven classifications are highlighted here; however, there are many others.

LIBERAL FEMINISM

Liberal feminists argue that the differences between men and women are due to sex role socialization and patriarchal ideologies embedded in social institutions [52]. The fight for gender equality is at the heart of liberal feminists' work, with a goal to pave equal opportunities and access for men and women. One of the solutions to remedy gender inequality proposed by liberal feminists is the implementation of laws to provide equal access [49].

RADICAL FEMINISM

Radical feminists link women's oppression to the sexism that permeates every dimension of day-to-day lives [49]. They argue that gender differences are rooted in the notion of essentialism [52; 148]. Essentialism propounds that women's identity is linked to a single trait, specifically that women are more caring and nurturing and less aggressive than men. Neither essential gender role is superior, but the existing social order is predominantly patriarchal and reinforces male attributes [52; 148]. Sexism is so deeply ingrained that some radical feminists have argued for separatism, advocating for an exclusive "womanculture"—a female science, female religion, female arts, rejection of the nuclear family, etc. [17; 115]. These political tenets had underpinnings of destruction, and Valerie Solanas's SCUM Manifesto became the prominent symbol for radical feminists [115]. One of the major criticisms of radical feminism lies in their assertion for essentialism, focusing on the objectification of a woman's body and a reductionistic explanation linking women's roles to biology [148].

MARXIST FEMINISM

Marxist feminism is viewed as revolutionary. Although these feminists argue for structural change, they focus on class structure, as they believe women's oppression is rooted in capitalism [17; 149]. Women's socioeconomic positions and classism are at the heart of this type of feminism. Marxist feminists trace patriarchy and women's oppression to women's roles being historically limited, meaning that patriarchy can only be eradicated if the separation of public and private work (i.e., housework) disappears [90]. Therefore, women are doubly oppressed as a result of their sex and class [149]. To Marxist feminists, domestic work is considered productive work, because although this work is "invisible," it is still important [116]. Therefore, Marxist feminists target women's work (both paid and unpaid) and focus on raising revolutionary consciousness of working women

to instigate change [17]. They also posit that classism results in disparities in access to resources, manifested as, for example, healthcare disparities. However, beyond this, Zrenchik and McDowell assert that classism also results in the unequal distribution of respect and admiration [91]. Segments of the poor in society are therefore often labeled as "immoral," "criminal," or "dirty" [91]. Marxism feminism has resurfaced in recent years as globalization has increased poverty, migration, and violence around the world [150]. Marxist feminists attempt to understand these trends as the struggle within class, race, and gender.

CULTURAL FEMINISM

Cultural feminism argues that certain qualities or characteristics (e.g., nurturing) are more prevalent in women. Cultural feminists believe these characteristics should be honored and valued as opposed to focusing on the similarities between men and women [49]. According to this school of feminism, society should be restructured in such a way that emphasizes cooperation rather than aggression [49].

WOMEN-OF-COLOR FEMINISM

This type of feminism asserts that many of the other feminist perspectives do not take into account other factors of female diversity, such as race, ethnicity, social class, and sexual orientation, although these dimensions affect the lives of women as well [49]. Black feminism (also referred to as black standpoint) falls under this category and argues that black women's social realities, stories, and experiences are invisible, having been overshadowed by a focus on white women's experiences [92]. Social transformation occurs in the lives of African American women when their racial identities are intersected with economic and political consciousness [117]. In a study of African American women's experiences in the healthcare system, many of the women's "feminist" perspectives and emancipatory resistances were laced with their faith and religion [92].

GLOBAL FEMINISM

Global feminists emphasize the issues of oppression, marginalization, and discrimination among all women globally. They maintain that other nondominant and non-Western perspectives should be taken into account, focusing on oppression as it relates to neocolonialism (economic structures created by former colonial powers to maintain colonies' dependencies) and global capitalism [16; 118]. Issues such as education, sex work, and access to health care are important topics for global feminists [16].

POSTMODERNIST FEMINISM

Postmodernism is an intellectual movement that argues against the traditional and universal ways of theorizing and reasoning and Western notions of science [56]. Postmodernist feminists emphasize the importance of the multiple and subjective experiences of women and other oppressed populations [148]. Postmodernists are also opposed to the language of binary opposites (e.g., male/female, white/black, etc.). Postmodernist feminists emphasize the importance of deconstructing discourse to identify sexist and patriarchal tones and biases in the ideologies and practices of Western culture [56; 119].

POSTSTRUCTURAL FEMINISM

Post structural feminists focus on how language and text reinforce patriarchal ideologies. Specifically, they challenge the notion of women's shared experience and dichotomous thinking (i.e., male/female terminology) [151]. The goal is to respect differences in order to eliminate a "them/us" mentality and promote liquid thinking, or using metaphors to capture the experiences of the marginalized [93].

POSTCOLONIAL FEMINISM

The focus of postcolonial feminism is on women in developing countries. Postcolonial feminists argue that Western and androcentric models of feminism are not appropriate for women born and living in developing countries, particularly those that experienced white/Western imperialism [149]. Their struggles and subjective experiences are uniquely different from white women in Western industrial countries [149].

GENDER BIASES

CONSTRUCTION OF NORMALITY AND ABNORMALITY

The notion of abnormality is heavily influenced by social and cultural norms. Early philosophers have depicted women as irrational beings [16]. Harris and Lighter assert that, historically, when women were the focus of attention in the mental health fields, they were "in the role of patient or repository of psychopathology, not as exemplar of healthy personality development" [36]. In the 1700s and 1800s, women's mental illness was linked to sin and vice [152]. Later, women's mental illness was tied to the "weaker" female constitution due to menstruation, pregnancy, and menopause [71; 152]. Some even argued that a woman's womb moved aimlessly throughout the body, causing insanity and draining life energy [71]. Hysteria, a disorder that involved the nervous system, was commonly diagnosed among women in the 18th and early 19th centuries, and many physicians believed this was a natural state for women (e.g., excitability, difficulty, egocentrism), but a "morbid state" for men [120].

In the early 1900s, when Sigmund Freud introduced the concept of psychoanalysis and the roles of the unconscious and drives in influencing behavior, many scholars, including feminists, were enthusiastic about his frank discussions about human sexuality [16]. However, Freud attributed much of women's behaviors to be the result of their inferior sexual genitalia, specifically developing the notion of penis envy. Freud maintained that a young girl's psychosexual development hinges on her realization that her genitals are not like her male counterparts (penis envy), leading to the conclusion that she has been castrated (castration anxiety). Ultimately, according to Freudian psychoanalysis, all girls feel inferior without a penis [22]. It has also been argued that the focus on the mother as the primary influence of personality development in Freud's theory can have negative repercussions for women [94].

Some have argued that the negative construction of women's bodies and behaviors essentially functioned as social control. Women's roles were maintained and perpetuated by labeling socially unacceptable behaviors as "hysterical," "insane," or "neurotic" [71]. Overall, a feminist approach to science minimizes a "masculine" approach to ensure it is not the predominant perspective [153].

CLINICAL PRACTICE

Diagnosis and Assessment

The DSM was first published by the American Psychiatric Association in 1952, and since this first edition, there have been a total of seven versions, with the most recent published in 2013 [16]. Because psychiatric constructs are not static, the revisions in each edition have been influenced by the social, political, and cultural climate in which they were published.

Some experts have argued that the DSM is androcentric and that the diagnostic labels are gender biased, arising from the psychopathologization of women and their roles [121]. In 1968, the DSM-II portrayed hysterical personality disorder as an extreme parody of femininity [120]. Personality disorders like dependent personality disorder, borderline personality disorder, and histrionic personality disorder reinforce notions about the pathology of dependency and emotionality, attributes generally ascribed to women [154]. Interestingly, dependent personality disorder is not associated with men, despite the fact that, historically, men were often reliant on women to care for the home and to provide caregiving [27; 72]. Border-

line personality disorder is also diagnosed more often in women than men and is characterized by impulsivity, instability in relationships, and intense fear of abandonment, which consequently leads to behaviors to avoid abandonment [95]. Many have argued that the constructs behind this diagnosis are inherently laden with gender bias. Other personality disorders are more likely to be diagnosed in men (e.g., antisocial personality disorder). It has been hypothesized that personality disorder diagnoses reflect certain gender stereotypes based on age, class, and marital status [43]. In general, women are more likely to be diagnosed with borderline, dependent, and histrionic personality disorders, while men predominate in compulsive, paranoid, antisocial, schizoid, and passive-aggressive personality disorders [28]. Some of this bias is inherent to the diagnostic criteria, but individuals' own cultural values and beliefs regarding gender roles (their socialization) will affect how they respond to diagnostic assessments as well [73].

Premenstrual dysphoric disorder (PMDD) is another condition tied to assumptions of femininity [120]. The emotional lability associated with PMDD is seen by some as reinforcing traditional ideas of women's irrationality [120]. However, research regarding the correlation between mood and menstrual cycle is largely divided [155].

Conversely, certain disorders may be underdiagnosed or misdiagnosed among women, negatively impacting help-seeking. Autism may be one such example [156]. In addition, sexual behaviors such as exhibitionism, frotteurism, pedophilia, and sadism are viewed as "male disorders" and are less likely to be pathologized for women [157]. Alcohol use disorder is also predominately associated with men [153].

Overall, many feminists question the development of constructs such as masochism, femininity, and masculinity [45]. Feminists also criticize many psychologic and personality assessments for focusing on stereotypical male roles and settings; when women score "low" on these measures, they are interpreted as deficient [45].

Clinical Theories

Many clinical and counseling theories are based on socially constructed norms of healthy male development. For example, Erik Erikson's developmental theory delineates life-span tasks from birth to death. The goal of every developmental task is for the individual to begin individuating and achieving autonomy in order to develop a healthy ego [67]. One of the main feminist criticisms of Erikson's theory is that the notions of autonomy and independence are based on male norms in Western society. Women, on the other hand, are more relational and strive to be connected in relationships [67]. If women do not fit into this developmental cycle, will they develop pathologic symptoms?

Many counseling theories (e.g., humanistic theories) focus on an individual's transformation through working on his/her relationship with others and the world [59]. However, these theories often fail to account for important variables, such as gender, race, ethnicity, and class, in producing unique differential power relations and the effect of these power relationships on behaviors and emotions [59]. Some clinical theories do not take into account how dimensions of the environment shape behavior [122].

BASIC PRINCIPLES OF FEMINIST THERAPY

Although there are several types of feminism, a few principles or overarching themes are common among them and in feminist therapy. It is important to remember that feminist therapy is not meant to exclude men or to isolate women from men. The goal of feminist therapy is to assist every individual to break out of stereotypical expectations regarding gender norms and behaviors that ultimately lead to dysfunction [4].

PERSONAL IS POLITICAL

In counseling, the belief that the personal is political essentially means that women's personal problems are affected by social politics. Every client's personal experiences are unique and can be set within a larger sociopolitical context that is influenced by patriarchal tenets [94; 158]. Therefore, a client's symptoms, feelings, and behaviors do not stem completely from within the individual but are influenced by external social and political forces [15]. This is not to say that feminist practitioners abandon all intrapsychic causes; instead, they also take into account the social context and assist female clients to examine how much their lives are shaped by societal norms [15; 20]. According to this belief, women should not be labeled as "offenders, instigators, or willing participants" in damaging activities [3]. Overall, feminist therapy or intervention is characterized by a gender-free, interactionist approach that takes into account the fact that experiences are shaped by socialization processes, are contextual, and are not fixed at any point in the lifespan, such as childhood [96].

POWER IMBALANCES

Another important aspect of feminist counseling is de-emphasizing hierarchal relationships. Patriarchal ideologies and power imbalances permeate society. As such, many relationships that women experience may be hierarchal and oppressive. In feminist counseling, the therapeutic relationship should minimize hierarchal relationships and reflect a more collaborate and egalitarian partnership between the client and the clinician [15; 158]. One way to promote egalitarian relationships in the clinical process is for the practitioner to be transparent with the objectives of the therapy and to avoid the use of clinical and professional jargon that the client cannot understand [20]. Facilitating mutual goal-setting and providing information about therapy are also recommended [158].

WOMEN'S EXPERIENCES

Women's experiences have been traditionally underrepresented and devalued in the sciences and social sciences. In the feminist clinical context, clients should feel that their voices are heard and placed within the context of women's, not men's, experiences [15]. Furthermore, if women's experiences are understood and validated within the larger social and cultural context, this will reduce pathologizing symptoms and client blaming [123; 158].

FOCUS ON CHANGE

One of the predominant goals of traditional therapy is to reduce symptoms and bring the client back to a state of equilibrium. The goal of feminist therapy is not to simply reduce symptoms but to bring about long-lasting positive change. One aspect of this change is an engagement in skills development [60]. According to the APA, contemporary feminist counseling is conceptualized by "a shift from focusing the 'microscope' on individual change and responsibility to the more balanced focus on identifying and working to effect environmental and institutional change" [4]. Strategies employed involve promoting skills and decision-making in order to bring about egalitarian relationships, analyzing gender roles to help the client understand expectations that have been created by society, and evaluating how power is exhibited differently between men and women [124]. This would result in changes on the micro and macro levels.

EMPOWERMENT AND SOCIAL ACTION

Because gender stereotypes, discrimination, prejudice, and other forms of oppression are rooted and reinforced at institutional levels, social action is needed to bring about change [60]. The notion of empowerment is key when working with women in this feminist context. Empowerment results when individuals are assisted to develop skills and enhance their inner capabilities, thereby increasing their self-esteem and sense of self-efficacy [6; 158]. The goal is facilitate women's sense of control over their lives by raising awareness that men and

women are equal [124; 158]. This can be done on multiple levels—microsystem, exosystem, and macrosystem—with the ultimate goal of increasing empowerment on all levels [125].

In a survey study, 140 counselors and therapists who identified themselves as feminists were asked to define feminism and identify how feminism is translated into practice [8]. Three themes emerged: feminism as women-centeredness, feminism as a belief, and feminism as a critique against patriarchy. Women-centeredness was defined as placing a priority in analyzing and examining women's positions in society. Participants discussed the theme of feminism as a belief or a philosophical system that pervades the conscious and unconscious and that recognizes that women's position in society is affected by traditional gender role socializations. Finally, feminism as a critique against patriarchy was defined as contradicting the embedded ideologies in society in which women are devalued [8].

FEMINIST THERAPY VS. NONSEXIST THERAPY

DeVoe argues that feminist therapy is nonsexist, but nonsexist therapy is not necessarily feminist [20]. The principle of the personal as political is the foundation of feminist therapy; this is not necessarily true of nonsexist therapy. Clients who find feminism threatening or who do not subscribe to feminist ideals may be more amenable to nonsexist therapy [20].

Feminist practitioners advocate for social change in order to eradicate injustices and oppression. On the other hand, a nonsexist clinician focuses on assisting women to minimize the distress they experience due to traditional gender role socializations and to adjust to discrimination and gender role inequalities. Feminist counseling/therapy emphasizes change at the macro level, to cultural, social, and political forces, that will help to eliminate women's problems and result in social justice. Nonsexist counseling/therapy focuses more on a client's intrapsychic state rather than the environment in which the client exists [20].

FEMINIST INTERVENTIONS AND STRATEGIES

GENDER ROLE ANALYSIS

The goal of gender role analysis is to assist clients to identify the specific gender role expectations and messages that influence their behaviors [124]. Five steps are necessary in true gender role analysis. First, the clinician helps the client to identify various gender role beliefs and expectations experienced from early childhood [60]. Second, the clinician and the client discuss how these expectations have affected the client's life negatively and positively. Third, the client works to identify internalized beliefs based on these gender role expectations. Fourth, with the help of the clinician, the client will decide which of the internalized beliefs he/she would like to address. Finally, a specific plan is developed to implement and monitor changes [60]. It is important for clients to understand the sources of gender role messages and to identify what reinforcers and punishments exist for adhering to these messages [159]. Clients should be encouraged to evaluate the costs and benefits if they were to eliminate certain messages.

BIBLIOTHERAPY

Bibliotherapy involves the use of literature as part of the therapeutic process. Clients are provided readings (fiction and/or non-fiction) on topics that are relevant to the issues that the client is experiencing [15; 160]. The goals of bibliotherapy are several-fold. It can educate clients about problems, create awareness of how others cope and solve problems, and help identify problem-solving solutions [40]. Chrisler and Ulsh conducted a survey study with 249 members of the Association for Women in Psychology [11]. The vast majority (94%) of respondents indicated they identified as feminist therapists, and 93% utilized bibliotherapy.

Interestingly, locating the appropriate books was not the predominant barrier in employing bibliotherapy; rather, respondents indicated that the major barrier was that their clients were not readers or simply could not afford to purchase books.

Again, feminist therapy is not limited to women. For example, men who are diagnosed with body image dissatisfaction can use bibliotherapy within a feminist framework to educate themselves on healthy body image, nutrition, and self-esteem [97]. Any intervention aiming to ultimately empower clients to move out of socially learned scripts may be feminist.

ASSERTIVENESS TRAINING

Assertiveness has been defined as behaviors that involve standing up for one's rights without violating the rights of others [60; 161]. Assertive skills training frequently involves cognitive-behavioral strategies to assist clients in verbalizing their needs/desires, developing social skills, and reducing anxiety that arises when executing assertive behaviors [161]. Many feminist practitioners argue that women may need to be taught assertiveness skills due to the fact that assertiveness is not usually considered a desirable female attribute. The underlying assumption of assertiveness training is that after women are educated about their personal rights and taught skills to overcome perceived barriers, other positive outcomes (e.g., enhanced self-esteem) will follow [25].

REFRAMING

Looking within oneself as the root of the deficit is the norm in many traditional therapies. However, feminist counseling/therapy encourages clients to understand how societal forces impact deficits or problems [60]. Reframing tends to focus on relabeling three areas: symptoms as a manifestation of role conflict, behaviors as coping strategies to handle oppression and discrimination, and distress as a manifestation of socialization in traditional gender roles [29].

BALANCING POWER

Feminist practitioners work with clients to promote awareness of the differences in power relations between men and women in society (also known as power analysis) [60; 124]. The first step is to explore definitions of power with the client and to assist clients to identify which definition of power best fits within the client's value orientation. Subsequent steps involve helping the client to recognize internalized messages about power and to alter them [15]. In order to model egalitarian relationships, the therapeutic environment becomes crucial. As discussed, in feminist counseling and therapy the clinician/client relationship is collaborative. Instead of the clinician simply diagnosing the client's distress, the therapist and client dialogue and work collaboratively to discuss potential reasons and meanings of the symptoms [29]. Clients are given the position of the expert and control what occurs in therapy. They also have the freedom to voice disagreements with the practitioner [18].

SOCIAL ACTION

It is important to remember that the heart of feminist counseling/therapy is changing the larger community in which the client exists [28]. In other words, it is not enough to simply work with a couple in conducting a gender-role analysis in how traditional gender role socializations have influenced their domestic decisions. Working in an advocacy and consultant capacity in the community to educate and raise awareness about gender issues in order to promote change in areas such as child care, education, and occupational policies is equally as important.

FEMINIST THERAPY IN CONJUNCTION WITH OTHER THERAPIES

Feminist practitioners utilize a range of interventions; they do not rely on one modality. When infusing feminist tenets with other clinical theoretical orientations, feminist practitioners shift the focus from intrapsychic processes to the larger social context [12]. In addition, sources of gender bias should be identified within the existing theoretical frameworks [60; 152].

Feminist Psychoanalytical Therapy

As discussed, many feminists have criticized Freudian concepts such as penis envy, the Electra complex, and mothers as roots of psychologic disorders. One of the predominant themes in feminist psychoanalysis is that because of experiences during infancy, women tend to have a deeper emotional connection with others [12]. In feminist psychoanalysis, the client is encouraged to explore how Oedipal issues reinforce existing gender identities and male domination [60]. The role of the clinician is to simultaneously serve as the mother and therapist to facilitate the client's work in balancing the tasks of individuating and emotionally connecting with others [12].

Feminist Behavioral Therapy

Behavioral therapy focuses on how learning is shaped and reinforced. One of the major feminist criticisms is that behavioral theory does not take into account the impact of social and political forces on how behaviors are learned [60]. Feminist behavioral therapists emphasize empowering women to learn new behaviors, skills, and competencies to succeed in different life arenas [12]. This approach to therapy can be successfully used with men as well, such as male batterers. Abusers often use violence, and this is reinforced when they see that the violence assists to maintain their control. Feminist behavioral interventions focus on helping abusers (regardless of sex) learn to identify controlling and abusive behaviors and their consequences and replace them with non-violent and non-abusive behaviors [126].

Feminist Cognitive Therapy

The foundation of cognitive interventions is that irrational or erroneous beliefs lead to maladaptive behaviors. Feminist cognitive clinicians argue that many women have mistaken beliefs that have been shaped by gender role socialization. These misconceptions include the beliefs that a woman must find approval and love from everyone, others' needs take precedent over one's own needs, and a woman is not independent and strong, but needs a strong person for support or protection [12]. For example, a therapist may work with the client to identify automatic thoughts about her feelings of lack of self-worth and how these thoughts are tied to societal cultural values [127]. Employing a strengths-based perspective to highlight a client's capabilities, strengths, and resources can help to gradually eliminate these thoughts.

Feminist Couples Therapy

Many couples fall into harmful relationship patterns that are shaped by stereotyped gender role messages [41]. Feminist therapists or counselors assist couples to examine how latent gender role beliefs influence conflict, relationship stability, and satisfaction and how unequal power distributions negatively impact day-to-day life. A feminist clinician would work in promoting a couple's awareness of the invisible power dynamics that support gender entitlements [41]. The goal is to facilitate equality in the relationship by teaching couples to value both parties' voices and make decisions collaboratively [128]. In this orientation, the feminist counselor does not automatically align him/herself with the woman; rather, the focus is on challenging traditional gender roles and male domination, helping the couple to modify previously learned patterns of behavior [98].

Feminist Family Systems Therapy

This type of therapy focuses on the family system, a group of individuals characterized by marked transactional patterns and dynamics of interpersonal relationships [66]. These patterns are the focal points, as they influence how members act and react [66]. Five elements have been identified as the heart of feminist family therapy [68; 128]:

- A collaborative and nonhierarchical therapist-client relationship
- Gender as a topic in therapy
- Encouragement of egalitarian relationships by valuing female partners' needs
- Promotion of awareness of nontraditional and nonstereotypical relational patterns and teaching skills to make changes

- Affirmation of women's stories, experiences, and feelings
- Reframing problems within the larger sociocultural context

Positive Feminist Therapy

The core tenets of positive psychology, an emphasis on resilience and strengths, can be incorporated with feminist therapy to assist clients to overcome the challenges. Using this approach, clients can rebuild their identity and self-worth by transcending negative experiences. In addition, clients may come to understand how the various systems influenced their lives and how they can tap into these systems to enable change. Empowerment is also a key concept [99]. Principles of mindfulness have been used in positive psychology, and mindfulness and feminist interventions have commonalities [129]. Both espouse the social and contextual basis of self. Mindfulness emphasizes liberation from suffering, while feminist interventions focus on empowerment. Finally, mindfulness highlights the importance of connecting with others, which supports feminist attempts to help women break free from isolation [129].

Multicultural Feminist Therapy

Multicultural feminist therapists emphasize the importance of the role of race, ethnicity, culture, and other forms of diversity in power and privilege. They question Western psychologic theories and concepts when applied to oppressed subgroups (e.g., racial/ethnic minority women, gender and sexual minority women). Multicultural feminist therapy builds on the tenets of feminist theory and incorporates into the therapeutic space the importance of understanding how migration, cultural values/norms, poverty, acculturation, assimilation, disability, sexual and gender identity, and other contextual factors affect women's experiences [162]. These often invisible intersectional stressors can impact minority clients' well-being [163].

ETHICAL ISSUES

It has been argued that five core themes should be included in discussions of feminist work and ethics [100]:

- Women and their experiences have moral significance.
- Attentiveness and subjective knowledge can illuminate moral issues.
- A feminist critique of male distortions must be accompanied by a critique of all discriminatory distortions.
- Feminist ethics should engage in analysis of the context and attend to the power dynamics of that context.
- Feminist ethics require action directed at achieving social justice.

KOHLBERG'S THEORETICAL FRAMEWORK OF MORAL DEVELOPMENT

Lawrence Kohlberg was a pre-eminent moral-development theorist. According to Kohlberg's theory, there are six stages of moral development that people go through in much the same way that infants learn first to roll over, sit up, crawl, stand, and finally walk [42]. Kohlberg characterized these stages in a number of ways, but perhaps the easiest to remember them is by the differing kinds of moral justification employed in each stage. Regarding any decision, the following replies demonstrate the rationale made within each stage.

Stage 1: When a person making a stage 1 decision is asked why the decision made is the right one, he or she would reply, "Because if I do not make that decision, I will be punished."

Stage 2: When a person making a stage 2 decision is asked why the decision made is the right one, he or she would reply, "Because if I make that decision, I will be rewarded and other people will help me."

Stage 3: A stage 3 decision maker would reply, "Others whom I care about will be pleased if I do this because they have taught me that this is what a good person does."

Stage 4: At this stage, the decision maker offers explanations that demonstrate his or her role in society and how decisions further the social order (for example, obeying the law makes life more orderly).

Stage 5: Here, the decision maker justifies decisions by explaining that acts will contribute to social well-being and that each member of society has an obligation to every other member.

Stage 6: At this final stage decisions are justified by appeals to personal conscience and universal ethical principles.

ETHICS OF CARE

Kohlberg's theory of moral development has been criticized for being androcentric, meaning the dilemmas capture male moral development and do not apply to women. Furthermore, some experts argue that Western conceptualizations of ethics are based on the premise that there are a set of universal, rational, neutral, objective, and impartial rules that are applied to everyone [53]. For example, the concept of justice is based on the assumption that the individual is autonomous and independent, with a rational ability to exercise control [46]. Carol Gilligan, a leading critic of Kohlberg's work, asserted that men and women have different ways of conceptualizing morality, and therefore, the decisions made will be different [35]. In her study, for example, girls did not want to make a moral decision without considering the social context; they wanted to avoid conflict, and their thinking reflected a need to take into account interpersonal relationships. In a cross-cultural study in Turkey, women managers scored higher on reproductive moral imagination (i.e., taking on the perspectives of another individual) than men [101]. The authors argued that women tend to take interpersonal relationships into account in their moral decision making.

Skoe reconceptualized the levels of ethics of care in six levels [130]:

- Level 1: Survival (care of self)
- Level 1.5: Transition from self-care to responsibility
- Level 2: Self-sacrifice
- Level 2.5: Transition to reflective care
- Level 3: Balanced care for self and others
- Level 3.5: Integrated care for self and others

These gender differences do not mean women's moral reasoning is deficient; rather, women represent "different voices." Nor does this necessarily mean that one way of thinking is better or that women are irrational or dependent. Humans are comprised of both rational and emotional dimensions, and to focus only on one element provides only a partial view of human nature [46]. Some have maintained that men have a morality of justice while women have a morality of care [5]. The feminist ethics of care is rooted in the notion of the "relational self," in which the moral compass is inextricably connected and embedded in social relationships [53]. This longing for relatedness and connectedness results in a "feminine" ethic of care, and it is this that guides the majority of women's ethical decision making [31]. Noddings asserts that care ethics is a relational ethic [102]. In other words, the decision-making process includes both a rationale-cognitive component as well as a personal-emotive one. The "feminine ethic of care" involves a dynamic process of balancing objectivity, systematization, and rationality to reflect upon the moral dilemma without forsaking the affective component [31]. As such, the ethics of care can help to redefine power relationships/dynamics and promote more egalitarian relationships and a more equal environment, focusing on human interdependency [164]. The goal is not to elevate one form of moral development as the scientific standard; rather, it is crucial to view female ethics of care complementing the "standard" theories of moral development. Furthermore, an ethic of justice must be balanced with an ethic of care [46].

The ethics of care theoretical framework should be moved from the private to the public sphere [131]. Professionals should consider how it be extended to the larger political, social, and global contexts and applied to social problems such as poverty and human rights violations [131].

FEMINIST THERAPY CODE OF ETHICS

The Feminist Therapy Institute developed a Feminist Therapy Code of Ethics, which offers a set of guidelines to supplement rather than replace the code of ethics of the field in which a practitioner practices (***Table 1***). The Feminist Code of Ethics covers five areas that direct practice, training, and research [30]:

- Cultural diversity and oppressions
- Power differentials
- Overlapping relationships
- Therapist accountability
- Social change

FEMINIST ETHICAL DECISION-MAKING MODEL

Frequently, practitioners will confront an ethical dilemma that has no clear right or wrong answer or a simple solution. In such cases, the practitioner uses a host of resources, including the code of ethics and discussion with supervisors and colleagues, to make a decision. In the context of feminist therapy/counseling, an ethical decision-making model that adheres to feminist principles has been established [37]. This model involves several dimensions: (1) the practitioner's emotional-intuitive responses, which involves examining how the practitioner affects the process, (2) contextual factors, such as gender, race, socioeconomic status, religious orientation, and sexual orientation, that affect the parties involved, (3) recognition of the power dynamics inherent in the practitioner and client relationship, and (4) collaboration with the client.

The feminist ethical decision-making model involves seven steps. Although it is presented in a linear manner, the practitioner frequently moves back and forth through the steps [37].

Step 1 involves recognizing the problem. The recognition of the problem is influenced by a range of factors, including the practitioner's level of experience and his/her values system. Often, a feeling of discomfort might arise for the practitioner, and it will be crucial to identify feelings and reactions that might influence understanding of the problem.

Defining the problem is step 2. This consists of identifying the nature of the conflict and whether it stems from potential discrepancies between the code of ethics, laws, clinical issues, and agency guidelines. To the extent possible, the client should assist in defining the nature of the problem. Defining the problem also involves evaluating how the practitioner's and client's contextual factors (e.g., gender, race/ethnicity, age, and other social variables) affect the situation. On the emotional-intuitive side, the practitioner should begin to examine his/her feelings of potential discomfort.

Step 3 of the feminist ethical decision-making model is generating solutions. As various potential solutions are brainstormed, a cost-benefit analysis should also be conducted for each option. The risks and benefits should also be considered. The client should be involved to the fullest extent possible in the brainstorming and cost-benefit analysis. The emotional-intuitive component continues in this step, as the practitioner should reflect on initial reactions that arise with each option.

The next step is selecting a solution. Practitioners should determine the solution that is the best fit both emotionally and rationally for both the client and him or herself. It should be a solution that meets everyone's needs, can be implemented, and is acceptable to both parties [37; 165].

FEMINIST THERAPY INSTITUTE ETHICAL GUIDELINES
I. Cultural Diversities and Oppressions A. A feminist therapist increases her accessibility to and for a wide range of clients from her own and other identified groups through flexible delivery of services. When appropriate, the feminist therapist assists clients in accessing other services and intervenes when a client's rights are violated. B. A feminist therapist is aware of the meaning and impact of her own ethnic and cultural background, gender, class, age, and sexual orientation, and actively attempts to become knowledgeable about alternatives from sources other than her clients. She is actively engaged in broadening her knowledge of ethnic and cultural experiences, non-dominant and dominant. C. Recognizing that the dominant culture determines the norm, the therapist's goal is to uncover and respect cultural and experiential differences, including those based on long-term or recent immigration and/or refugee status. D. A feminist therapist evaluates her ongoing interactions with her clientele for any evidence of her biases or discriminatory attitudes and practices. She also monitors her other interactions, including service delivery, teaching, writing, and all professional activities. The feminist therapist accepts responsibility for taking action to confront and change any interfering, oppressing, or devaluing biases she has. **II. Power Differentials** A. A feminist therapist acknowledges the inherent power differentials between client and therapist and models effective use of personal, structural, or institutional power. In using the power differential to the benefit of the client, she does not take control or power that rightfully belongs to her client. B. A feminist therapist discloses information to the client that facilitates the therapeutic process, including information communicated to others. The therapist is responsible for using self-disclosure only with purpose and discretion and in the interest of the client. C. A feminist therapist negotiates and renegotiates formal and/or informal contacts with clients in an ongoing mutual process. As part of the decision-making process, she makes explicit the therapeutic issues involved. D. A feminist therapist educates her clients regarding power relationships. She informs clients of their rights as consumers of therapy, including procedures for resolving differences and filing grievances. She clarifies power in its various forms as it exists within other areas of her life, including professional roles, social/governmental structures, and interpersonal relationships. She assists her clients in finding ways to protect themselves and, if requested, to seek redress. **III. Overlapping Relationships** A. A feminist therapist recognizes the complexity and conflicting priorities inherent in multiple or overlapping relationships. The therapist accepts responsibility for monitoring such relationships to prevent potential abuse of or harm to the client. B. A feminist therapist is actively involved in her community. As a result, she is aware of the need for confidentiality in all settings. Recognizing that her client's concerns and general well-being are primary, she self-monitors both public and private statements and comments. Situations may develop through community involvement where power dynamics shift, including a client having equal or more authority than the therapist. In all such situations, a feminist therapist maintains accountability. C. When accepting third-party payments, a feminist therapist is especially cognizant of and clearly communicates to her client the multiple obligations, roles, and responsibilities of the therapist. When working in institutional settings, she clarifies to all involved parties where her allegiances lie. She also monitors multiple and conflicting expectations between clients and caregivers, especially when working with children and elders. D. A feminist therapist does not engage in sexual intimacies nor any overtly or covertly sexualized behaviors with a client or former client.
Table 1 continues on next page.

FEMINIST THERAPY INSTITUTE ETHICAL GUIDELINES (*Continued*)
IV. Therapist Accountability A. A feminist therapist is accountable to herself, to colleagues, and especially to her clients. B. A feminist therapist will contract to work with clients and issues within the realm of her competencies. If problems beyond her competencies surface, the feminist therapist utilizes consultation and available resources. She respects the integrity of the relationship by stating the limits of her training and providing the client with the possibilities of continuing with her or changing therapists. C. A feminist therapist recognizes her personal and professional needs and utilizes ongoing self-evaluation, peer support, consultation, supervision, continuing education, and/or personal therapy. She evaluates, maintains, and seeks to improve her competencies, as well as her emotional, physical, mental, and spiritual well-being. When the feminist therapist has experienced a similar stressful or damaging event as her client, she seeks consultation. D. A feminist therapist continually re-evaluates her training, theoretical background, and research to include developments in feminist knowledge. She integrates feminism into psychological theory, receives ongoing therapy training, and acknowledges the limits of her competencies. E. A feminist therapist engages in self-care activities in an ongoing manner outside the work setting. She recognizes her own needs and vulnerabilities as well as the unique stresses inherent in this work. She demonstrates an ability to establish boundaries with the client that are healthy for both of them. She also is willing to self-nurture in appropriate and self-empowering ways.
V. Social Change A. A feminist therapist seeks multiple avenues for impacting change, including public education and advocacy within professional organizations, lobbying for legislative actions, and other appropriate activities. B. A feminist therapist actively questions practices in her community that appear harmful to clients or therapists. She assists clients in intervening on their own behalf. As appropriate, the feminist therapist herself intervenes, especially when other practitioners appear to be engaging in harmful, unethical, or illegal behaviors. C. When appropriate, a feminist therapist encourages a client's recognition of criminal behaviors and also facilitates the client's navigation of the criminal justice system. D. A feminist therapist, teacher, or researcher is alert to the control of information dissemination and questions pressures to conform to and use dominant mainstream standards. As technological methods of communication change and increase, the feminist therapist recognizes the socioeconomic aspects of these developments and communicates according to clients' access to technology. E. A feminist therapist, teacher, or researcher recognizes the political is personal in a world where social change is a constant.
Source: [30] © Copyright 2000, Feminist Therapy Institute, Inc. 912 Five Islands Road, Georgetown, ME 04548 *Table 1*

Reviewing the process is step 5. In the review process, the practitioner should carefully consider how a solution was reached. Questions that may be helpful to this process include:

- "Do I want to be treated in this manner?"
- "How am I using my power?"
- "To what extent am I comfortable in being transparent with others in the solution identified?"
- "Does this feel right?"

Implementing and evaluating the solution should be undertaken next. The plan will be implemented, and the consequences can be observed and noted. In some cases, new information comes to light and the problem will be redefined.

The final step in the process is continuing reflection. The lessons learned from the experience should be reflected upon in order to be applied to future situations. Practitioners should determine what they would do differently, what they have learned, and how they have changed as a result of the decision [165].

KEY CONTROVERSIES AND TRENDS

MULTICULTURALISM AND FEMINISM

Feminism and multiculturalism share many commonalities and roots. Both concepts grew out of social movements in the 1960s that challenged the established norms. Both recognize the marginalization and discrimination experienced by women and racial/ethnic minority groups and how this is reinforced and perpetuated by societal infrastructures, and both emphasize strength, human growth, and potential instead of pathology [55]. The client, rather than the clinician, is considered the expert in telling his/her story [103]. Because of their concerns with oppression and marginalization, counselors from both perspectives are entrenched in social advocacy work, fighting for justice and equality, and reducing disparities [103]. Despite sharing similar values and coming out of a shared history, these two philosophies have remained in their distinct spheres [55].

Feminism in general has been criticized for neglecting other factors that contribute to the marginalization and oppression of women, such as race/ethnicity, sexual orientation, ability, religion, socioeconomic status, and age. In their call for a unifying sisterhood, some argue that feminists have failed to recognize the heterogeneity within the broader category of women. Women from racial and ethnic minority groups may not connect or identify with feminism for several reasons. First, they may feel that feminism is rooted in and reflects white women's experiences, particularly those from privileged backgrounds [49]. The issues of racism and discrimination are vital concerns to many ethnic minority communities, and women of color may be concerned that their communities will feel that they are divesting themselves of one group's advocacy movements by focusing on women in general [49].

Many feminist values originated from Western European traditions [16]. Feminist principles of autonomy, for example, are not consistent with collectivistic principles espoused by other cultural groups. For instance, the traditional therapeutic model consists of talking about problems, believing that this cathartic experience will cure the problem. The emphasis on disclosing private and intimate information to a nonfamily member is primarily a Euro-American value [44]. Goals for self-improvement, empowerment, and self-actualization are Western tenets; these same concepts are dissonant to collectivistic orientations that emphasize the primacy of the collective groups' needs and desires over the individual needs [61].

A collaborative alliance between feminism and multiculturalism is the ultimate goal. Discussions of egalitarianism should be rooted in how diversity intersects with power and how this shapes human behavior and social problems [132; 166]. Reynolds and Constantine note [55]:

> The irony is that most multicultural and feminist psychologists already know how to deconstruct dominant views and identify ways in which psychology has internalized racist and sexist ideas or values. Thus, the primary questions are: What stops multicultural psychologists from fully embracing the centrality of gender? Why do many feminist psychologists have difficulty moving beyond a cognitive connection to the importance of race and culture?

Multiculturalism and feminism have a joint goal of empowering individuals on the micro and macro levels. Social justice and social action are vital components of both [132].

FEMINIST THERAPY WITH MALE CLIENTS

Another controversy involves the suitability of feminist therapy for male clients. Some have argued that feminist therapy cannot be employed with men because, simply put, they are not women. But many feminist practitioners believe the principles and practices of feminist therapy are not exclusive to female clients. Heterosexual and homosexual male clients can benefit from learning how traditional gender role socializations and norms impact their relationships and identity [16]. Some argue that the loss of power can trigger psychologic distress, so men can also benefit from feminist multicultural therapy [167]. Those who are opposed to feminist therapy for men argue that the goal may be to make men more like women [104].

Those who advocate for men participating in feminist therapy maintain that all cultures have norms about manliness and masculinity [104]. In Western culture, these norms include being a risk-taker, emotionally in control, independent, dominant (including being in control over women), an achiever, a "playboy," and a provider. Conformity and nonconformity to these norms could trigger stress, which could then result in mental health and health issues, and challenging dominant gender roles is part of feminist therapy [104; 167]. Furthermore, feminist therapy may be helpful for men dealing with issues such as anger, expressing distress and psychologic pain, and excessive focus on performance and achievement [60; 133; 167]. The use of gender role analysis can be beneficial in assisting male clients to understand how society reinforces and rewards men for performance and how their sense of identity is tied to these gender stereotypes [60; 133]. For relationship issues, feminist therapy could help male clients to work on listening skills and to learn how to work collaboratively with women. In these cases, the goal is to break out of traditional gendered notions of masculinity [60]. When working with men, feminist counselors should reflect on their own notions of what it is to be a man and what a man should be like [104].

MALE FEMINIST CLINICIANS

There is a divide among feminist practitioners regarding whether it is possible for men to be feminist clinicians. Some argue it is not possible, while others assert that men should not be excluded in fighting against oppression. According to Enns, a feminist practitioner is an individual who self-identifies as a feminist, one whose value systems and clinical approach align with feminist tenets and values [26]. Men who have reflected and developed an awareness of how gender roles and embedded patriarchal ideologies in social institutions impact their upbringing and socialization, how androcentric views contribute to women's oppression, and who champion and advocate on women's issues can be effective feminist clinicians [25]. While some men can relate to marginalization and oppression due to class, race, or sexuality, they should be willing to admit that their experiences are limited and that they cannot completely align themselves with women's experiences [105].

In one survey study, the attitudes and practices of 81 self-identified feminist and non-feminist male therapists were examined [62]. Approximately one-quarter of the participants identified themselves as feminists. Men who self-identified as feminist therapists scored significantly higher on their attitudes toward feminism and the women's movement, had more liberal gender role attitudes, and engaged in practice behaviors that were more aligned with feminist therapy compared to the non-feminist male therapists. In a similar vein, a qualitative study of 12 male feminist therapists explored how their feminist identity developed [2]. The researchers found their feminist identity developed over time through a series of events that made them realize how sexism and traditional gender roles were in ingrained in society [2]. The therapists also identified a sense of connectedness with women and with the feminist community. Three of the participants were also gay, and these men discussed how they identified with the issue of marginalization.

THE MEN'S MOVEMENT

In the 1970s, the men's movement emerged alongside the women's movement to examine masculine gender roles and how they impact men's lives [49]. There appear to be three schools within the men's movement, one of which is profeminism [49; 134]. Profeminist men argue that they want to eliminate the negative effects of gender oppression and inequality, gain a better understanding of how gender and traditional images of masculinity shape men's behaviors and experiences, assist men to realize their full potential, and commit their energies and efforts to other oppressed groups, such as women, gays/lesbians, people of color, the disabled, and the elderly [49]. Most feminists agree that men who adhere to profeminist tenets should be viewed as allies to the women's movement.

A second wave of the men's movement emphasized paternal rights, with a focus on custody rights and child support [135]. Participants in this movement maintain that there is gender bias and discrimination family law, but some have criticized this agenda as focusing more on equality and rights versus the actual care of children [106].

Another type of movement is the mythopoetic men's movement, which is a blend of a quasi-religious and self-help approaches [107]. Members of this group maintain that men are the victims of oppression by the feminist movement's removal of their masculinity. Spiritual journeys are believed to help men revive and reclaim their identities [134]. The mythopoetic men's movement was made popular in the 1990s by Robert Bly's book *Iron John: A Book about Men*. The message is that men are losing their manhood and should rediscover it alongside other men; this may involve taking part in "wildman retreats" [107].

ATTITUDES TOWARD FEMINISM

The terms "feminism" and "feminist" have many associations, including negative stereotypes. Throughout history, feminists have been called "manly," "man haters," "femi-Nazis," and "child haters." This first emerged with the suffrage movement and the first wave of feminism [16]. In the 1970s, these negative images resurfaced, and terms like "Amazons," "lesbians," and "extremists" were used [16; 135]. In the 1980s, the media casted feminism as outdated. During this period, media generally indicated that gender equality had been achieved, and the outcome was a host of negative effects, such as the breakdown of the nuclear family [16].

Porter observed that although women in general have more freedom today in various economic, educational, and political arenas, many gender inequality issues remain. Problems such as violence against women, pornography, blatant sexualization of women's bodies (e.g., on the Internet and in the media), increasing eating disorder rates among women, and the wage gap seem to indicate that oppression continues to be an issue for women [54].

Labeling oneself as a feminist generally involves being willing to endorse the statement "I am a feminist" and adhering to feminist tenets [108]. A small percentage of Americans identify themselves as feminists today, and surprisingly, college students show lower levels of identification with the feminist movement despite the fact they state they agree with feminist tenets [69]. There may be several reasons for this trend. Some scholars maintain that the principles of feminism are more ingrained in our day-to-day lives, making the issue of gender inequality seem less pressing than in earlier decades. Others believe that the negative images of feminism are still rampant, causing young women to reject these negative stereotypes [39; 168]. In one study of college students, 44% associated feminists with negative characteristics, describing them with such words as "femi-Nazi," "bitch," "fat," "militant," "aggressive," "whiny,"

"raging," and "crazy" [39]. More than one-quarter of study participants also associated the term feminist with "lesbians" or "butch" [39]. The students in this study were also generally confused about the definition of feminism and were not able to identify the goals of the feminist movement.

In a study of 233 female university students in the Midwest, participants who stated that they identified as feminists were more likely to engage in feminist activism, regardless of beliefs [108]. It would appear that, in this study, activism was at the core of identifying as a feminist [108]. In one study, a feminist man was viewed more positively than a feminist woman; however, a feminist man was perceived as less powerful and less heterosexual than a non-feminist man [169].

In a 2015 online survey with 332 students, 49.7% were neutral, reporting no strong feelings of identifying as a feminist/pro-feminist. In comparison, 45.8% described themselves as feminist/pro-feminist [135]. The meanings of feminism varied widely among participants. For some, it was described as a set of ideologies, while others described feminism as action-based. Some linked feminism to women, but others believed it applied to both genders [135].

CONCLUSION

The journey of feminist therapy and counseling has been rich and colorful. Today, it is a recognized orientation, covered in major counseling textbooks. Feminist therapy/counseling has come together with a unified set of practice and theoretical principles, and its values and interventions have been adopted by other clinical orientations (e.g., psychoanalytic, cognitive, behavioral). However, some experts note that in order for feminist practitioners to move feminist therapy forward, it must expand beyond anecdotal data and demonstrate empirically that it is effective [29]. Feminist practitioners, scholars, and researchers should also be mindful in being more inclusive and recognizing the multiple oppressions that exist in society. As stated by Walker, "There [is] no one correct way to be a feminist" [109].

RESOURCES

American Association of University Women
https://www.aauw.org

Association for Women in Psychology
https://www.awpsych.org

Feminist Majority Foundation
http://feminist.org

Massachusetts General Hospital
Center for Women's Mental Health
https://womensmentalhealth.org

National Coalition for Women
and Girls in Education
https://www.ncwge.org

National Organization for Women (NOW)
https://now.org

National Institutes of Health
Office of Research on Women's Health
https://orwh.od.nih.gov

U.S. Department of Justice
Office on Violence Against Women
https://www.justice.gov/ovw

American Psychological Association
Division 35: Society for the
Psychology of Women
https://www.apadivisions.org/division-35

U.S. Department of Health
and Human Services
Indian Health Service
https://www.ihs.gov

Violence Against Women
Online Resource Library
https://vawnet.org

U.S. Department of Health
and Human Services
Office on Women's Health
https://www.womenshealth.gov

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