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THEORY AND PRACTICE

Reviewing effective components of feminist therapy

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ABSTRACT *Despite the broad application of feminist techniques and advances in defining feminist theory for psychological practice, consensus regarding the effectiveness of core components and techniques specific to feminist therapy is still evolving. This paper identifies four core components of feminist therapy: consciousness raising, social and gender role analysis, resocialization and social activism, and evaluates existing research evaluating their therapeutic effectiveness. Research to date suggests that many of these core components are promising. Future research on each of these key components is proposed.*

Introduction

Feminist therapy has developed considerably since the 1960s. At present, feminist therapy consists of a diverse body of theoretical and therapeutic components, including consciousness raising, social and gender role analysis, and resocialization and social activism. Numerous articles and books describe feminist approaches to a variety of psychological problems, including depression (Rothblum *et al.*, 1993; Stock *et al.*, 1982), anxiety (Enns, 1993; Toner, 1994) and sexual abuse trauma (Enns, 1993; Sturdivant, 1980). However, the debate concerning the specificity of those techniques and the mechanisms accounting for their effectiveness continues (Dutton-Douglas & Walker, 1988; Enns, 1993; Laidlaw & Malmo, 1991) creating difficulty for those interested in evaluating the efficacy of feminist therapy (Brabeck *et al.*, 1997; Rigby-Weinberg, 1986).

The purpose of this paper is first, to identify and summarize the core components and techniques of feminist therapy, and second to review relevant research bearing on these core elements. Feminist therapy consists of a variety of techniques, many of which although central are no longer unique to feminist therapy. Problem solving, for example, is a key tenet of a variety of approaches, including, cognitive behaviour therapy, and interpersonal therapy. Although effective, problem solving is not unique to feminist therapy and therefore cannot be used to evaluate the unique contributions of feminist therapy. Second, there has been a recent movement toward the use of empirically

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supported treatments in many settings (Elkin *et al.*, 1989). Therapists are faced with increasing pressure from managed care and health insurance agencies to provide evidence that the treatments being applied are effective and/or efficacious. We believe that feminist therapy consists of several components which are unique and which may be responsible for producing treatment effects in clients. It is imperative that these components and techniques be more clearly defined and that systematic trials be conducted to validate feminist therapy. This review reflects an attempt to define and review research on components unique to feminist therapy. Both direct and indirect forms of evidence are included in this review to foster debate amongst feminist therapists and scholars regarding the core elements of feminist therapy. It is hoped that this review will lead to further research on the effectiveness of feminist therapy.

Defining feminist therapy: an abridged summary

In the late 1960s, traditional psychotherapies were criticized as non-supportive of women and often damaging to them (Cammaert & Larsen, 1988; Enns, 1993; Sturdivant, 1980). However, a shift occurred during this time period in which many female psychotherapists became critical of traditional views of mental health (i.e., medical model entrenched in biological determinism: Cammaert & Larsen, 1988). Evaluation of the social and cultural causes of mental distress was lacking. There was a need to develop therapies that would support a positive model of women's mental health and functioning; a model capable of empowering women living in a patriarchal society (Dutton-Douglas & Walker, 1988; Kashak, 1981). Many of the hallmarks that are specific to feminist therapy, such as consciousness raising, social and gender-role analysis, resocialization, and social activism evolved to address these issues.

Feminist movement activities such as the gathering of women in consciousness raising groups which provided forums for women to openly criticize sexist views toward women and the impact of patriarchal forces on women's development and experience influenced the development of feminist oriented psychotherapies. The emergent model incorporates biological, social and cultural causes of poor functioning in the etiology of psychological difficulties (Conarton & Kreger-Silverman, 1988; Laidlaw & Malmo, 1991). Feminist therapy acknowledges that sex roles, female socialization, and women's minority status in a patriarchal society are sources of psychological difficulty. For example, depression is conceptualized as a normal reaction to a patriarchal world, which benefits the male sex role more so than the female sex role (Stock *et al.*, 1982; Sturdivant, 1980). Many traditional therapies have been adapted, and several therapy techniques have been created that fit a feminist view of the world to successfully treat a wide variety of psychological problems. Techniques, such as *social and gender-role analysis*, fit this new conceptualization of women's mental health and functioning.

Feminist therapy is influenced by a feminist analysis of society, and provides a model of empowerment for women who are treated as an oppressed minority in society. Feminist therapy may involve interventions, such as social activism, that extend beyond individual therapy sessions, in order to affect broader societal changes. Feminist therapy engenders the notion that the 'personal is political'; that personal experiences are embedded in a political context and reality. Feminist therapists recognize that women's

mental health can not be fully improved in individual therapy, but only through making effective structural changes to society. As a result, many therapists advocate for systemic changes which will ultimately lead to the betterment of women's lives and society.

Feminist theorists and therapists treat clients as unique individuals rather than assuming that all individuals share the same 'realities'. There is an explicit assumption that a client's status (e.g., gender, race, cultural, ethnic, sexual orientation) in society may affect psychological functioning (Atkinson & Hackett, 1988). For example, women from various minority groups may be at greater risk for developing difficulties as they are frequently stigmatized and blamed for their difficulties, implying that their difficulties stem from innate origins creating further oppression than that experienced by females from the dominant majority. The impact of these unique experiences are frequently issues focused on in feminist therapy (Comas-Diaz, 1987, 1988; Remer & Worrell, 1992). According to Comas-Diaz (1988), feminist therapists must have an understanding of 'the culture of each of their clients' as well as knowledge regarding the sex-role standards for members of that cultural group and should adapt techniques accordingly. Research evaluating the efficacy of feminist therapy must include information pertaining to individual differences which is central to feminist therapy theory and practice. Thus, researchers need to incorporate quantitative and qualitative research methodologies to accurately reflect the diversity within and across treatment populations.

Feminist therapy is often integrated within other therapy modalities making it difficult to ascertain which components of feminist therapy are unique to a feminist therapy theory (Dambrot & Reep, 1993; Enns, 1987, 1993; Srebnik & Saltzberg, 1994; Sturdivant, 1980) and even more challenging to evaluate the effective unique components. A challenge in evaluating feminist therapy is that it is often an adjunct to other therapies such as cognitive behavioural (Hurst & Genest, 1994; Srebnik & Saltzberg, 1994; Toner, 1994), gestalt (Enns, 1987), psychodynamic (Daugherty & Lees, 1988) and family systems therapy (Bograd, 1988) reflecting an eclectic approach to therapy.

Identifying core components of feminist therapy and evaluating their effectiveness

Concerns regarding the effectiveness of feminist therapy have been increasingly addressed in the feminist therapy literature in the 1990s (e.g. Enns, 1993; Remer & Worrell, 1992). Unfortunately, few reviews have explicitly evaluated the specific efficacy of feminist therapy techniques, as there have been neither large nor small-scale clinical trials of feminist therapy nor trials evaluating the additive effects of feminist therapy techniques. However, feminist therapy researchers are currently evaluating feminist therapy techniques using both qualitative and traditional methodologies (Morrow, August 1997; personal communication). It is our belief that future research on feminist therapy techniques will demonstrate their efficacy, and use in the treatment of difficulties facing women.

In the remaining sections of this paper, components specific to feminist therapy, and available research on these components, are reviewed. Specific factors, unique to feminist therapy, include consciousness raising, social and gender-role analysis, resocialization,

and lastly social activism for both client and therapist. Each component is briefly described, research germane to its effectiveness reviewed (direct and indirect support) and where appropriate recommendations regarding future research are made.

Consciousness raising

Consciousness raising began with the gathering of women into groups during the feminist revolution of the 1960s to discuss women's devalued status in society, its impact, and mechanisms for societal change (Dutton-Douglas & Walker, 1988; Enns, 1993; New, 1993; Rothblum *et al.*, 1993; Sturdivant, 1980). Consciousness raising was traditionally conducted in a leaderless format and involved discussion of women's individual and shared experiences (Stock *et al.*, 1982). This grass roots effort inspired women to connect their personal experiences with a larger sociopolitical reality. Topics discussed in consciousness-raising groups ranged from sexual harassment, inequalities in the work force, to the origins of depression in women.

Currently, consciousness raising is frequently incorporated into feminist therapy practice. As a therapeutic mechanism it helps women realize that they are not the sole cause of their distress and that others share their problems. According to Kravetz (1987, p. 56) consciousness raising shares many similarities with traditional group psychotherapeutic approaches including 'provision of role models, sharing personal experience, imparting information, peer support, identifying commonalties, and instillation of hope'. In contrast to other therapeutic techniques, participants examine how oppression over women contributes to personal distress and discuss solutions for creating individual and social change. Consciousness raising empowers women to feel able to take action against oppression through mutual support of members of the group and by engaging in social action if chosen by the participants (Stock *et al.*, 1982).

Research. The original studies on consciousness raising groups (non-therapy groups) such as Kravetz *et al.* (1983) and Follingstad *et al.* (1977) found that participants' attitudes aligned with radical feminist beliefs and participants identified themselves as members of the feminist movement. Having feminist and/or radical political attitudes usually preceded participation in such groups. Eastman's (1973) 9-month study of consciousness raising groups indicated that women joined to increase self-awareness, acquire emotional support, and analyse social and gender-roles and experience. Follow-up data from this study indicates that 89% of participants self-reported satisfaction with the experience and viewed it as constructive. In their evaluation of 32 consciousness raising group participants Lieberman *et al.* (1979) reported similar findings, but noted participation did not decrease psychological distress (e.g., depression, anxiety). On the other hand, Chambless and Wenk (1982) found that clients in feminist therapy groups reacted positively to the experience, as assessed through self-report. Kravetz *et al.* (1983) found that female participants in a consciousness-raising group reported feeling more capable of solving personal difficulties and internalized feminist values following participation.

Weitz (1982) studied 72 women involved in one of three, 10–16 week consciousness raising groups. Two weeks prior to group participation the women were interviewed and

completed the Centre for Epidemiologic Study Depression Scale and the Janis-Field Self-Esteem Scale. Forty-three of the women were re-administered the two scales after the consciousness raising groups had ended. Depression scores decreased from a mean of 18.40 to 14.36 and self-esteem scores increased from 63.96 to 68.33 indicating improvement. However, Weitz (1982) did not use a control group in this study, and data were missing for 30 women at follow-up, making it difficult to delineate the mechanism(s) through which consciousness raising was effective. Warren (1976) argues that participants experience a group identity and cohesiveness, feel comfortable disclosing personal experiences, and view the group as a peer support group. However, there is also some evidence to suggest that participants in leaderless consciousness raising groups find sessions frustrating as guidance for initiating personal/behavioural change is not provided (Kirsch, 1987). Thus having a therapist/co-ordinator may be useful in providing format and guidance for participants.

At present, consciousness raising appears to be the most studied component of feminist therapy. Consciousness raising is effective because it provides a supportive and nurturing environment for women to express themselves. Moreover, clients learn to externalize blame (from self to society) and may develop a sense of community with other women. In fact, Rogers (1957) argues that factors such as therapist empathy, consistency, and unconditional positive regard lead to positive change for clients. Consciousness raising groups provide such opportunities. Moreover, like Prochaska and DiClemente's (1982) transtheoretical model of change, consciousness raising serves as a core process which enables a client to move into a state in which she is willing to evaluate her difficulties and their roots in oppressive forces (e.g., from a stage of precontemplation to contemplation).

Kravetz (1987) suggests that more explicit specification of the nature and change produced by consciousness raising is necessary. Currently consciousness raising groups are used as part of treatment packages offered to women dealing with alcohol and drug abuse, sexual assault and abuse survivorship, as well as other specific issues/problems. It is necessary to study the effects of consciousness raising under each of these conditions (Kravetz, 1987). Research evaluating the impact of consciousness raising across racial, ethnic, socioeconomic, sexual orientation, age and other diversified populations is also important (Kravetz, 1987). Moreover, there is some evidence to suggest that behaviour change may only occur when a skills component is part of the therapy package as consciousness raising may not lead to changes in behaviour (Enns, 1993; Wolfe and Fodor, 1977). As a result, it is unclear which aspects of these combined therapies contribute to therapeutic outcome.

Future Research Directions. Consciousness raising is a core component that differentiates feminist therapy from other therapeutic modalities. Studies examining the effectiveness of feminist therapy should include measures that evaluate whether consciousness raising leads to feeling supported or bolsters self-efficacy. Researchers need to evaluate whether clients are able to actively and appropriately externalize blame (from self to society) following participation. Consciousness raising is purported to lead to a sense of community with other women. Thus, it would be interesting to assess whether clients learn to use other women in their own communities (i.e., friends, neighbours) as social

supports in times of difficulty. Finally, an examination of whether consciousness raising is a necessary core process of change in feminist therapy is warranted (Prochaska & DiClemente, 1982).

Essentially, consciousness raising involves discussing women's roles and the impact of these roles on well being with other group members. This discussion may lead to awareness that oppression can contribute to difficulties experienced by an individual. Moreover, consciousness raising should lead to feeling connected with other women due to the discussion of common experiences. Current data suggests consciousness raising provides therapeutic benefit by allowing women to feel supported, which is beneficial for a variety of health outcomes (Bergin & Lambert, 1978). Consciousness raising may lead to feeling empowered, and may help women cope with difficulties. Therefore, research should evaluate change in both attitude and coping efficacy following consciousness raising.

Social and gender-role analysis

Social and gender-role analysis is one of the hallmarks of feminist therapy, although the implementation of this component may vary (Brown, 1986; Enns, 1993). The therapeutic value of social and gender-role analysis is primarily diagnostic as the client's current psychological distress and method of coping is evaluated. Initially, clients learn about the impact of social expectations and cultural norms on women and how their lives are affected by these norms (Laidlaw & Malmo, 1991) to increase a client's awareness of how culturally prescribed social and gender role expectations negatively affect women (Remer & Worrell, 1992). Furthermore, it assesses the symbolic meaning of the client's behaviour and identifies which roles they perceive as being appropriate for women and men (Enns, 1993).

Clients may complete measures to assess gender role-identity/beliefs (Gulanick *et al.*, 1979; Remer & Worrell, 1992). The client and therapist carefully examine the values of the client and how these values are reflected in the client's role expectations for herself and others, and finally her attributions and self-statements based on these stereotyped beliefs (Brown, 1986; Cammaert & Larsen, 1988; Dambrot & Reep, 1993). The therapist assists the client in identifying both explicit and implicit sex role messages that the client has experienced and internalized over her lifetime (Remer & Worrell, 1992). A plan for implementing changes is subsequently developed. Social and gender role analysis can be conducted using several approaches as long as the focus is on assisting the client in identifying the messages she has received across her lifespan and their impact. For example, women may learn how society 'teaches them' to be submissive, and self-sacrificing. A woman who is depressed may realize that she has been raised to obey others which is socially prescribed and may even internalize these beliefs as part of her self worth. She may notice that her depression followed the departure of her youngest child from the home and may feel she no longer has a significant role in her family.

In contrast to some forms of cognitive-behaviour therapy or rationale emotive therapy, beliefs are not challenged as directly 'irrational' as feminist therapy does not see them as erroneous; instead they simply reflect a problem in how society views/limits women's roles. Moreover, clients learn that their methods of coping, through use of

traditional roles, have been adaptive for coping in an oppressive society rather than being viewed as self-induced pathology (Brown, 1986). These techniques enlighten clients to the possible origins or maintaining factors of their psychological distress (Sturdivant, 1980). Accordingly, social and gender role analysis serves to identify areas for change and to gain self-knowledge. It permits women to take roles that may not be socially prescribed and to seek the reward for taking such roles internally as opposed to taking cues from the larger society.

Research. Social and gender role analysis has been examined in the context of the second wave feminist movement. In a study of the Women's Movement from 1969–1971, Carden (1974) interviewed women to assess the impact of membership on their lives. Carden found that membership often led to changes in roles such as changing jobs, returning to work or school, and 15% of members went on to become involved in social action projects. Cassell (1977) found that participation often led to the questioning of traditional social and gender roles for women.

Gulanick *et al.* (1979) examined the benefits of treatment programmes for improving social and gender-role orientation and assertiveness. Gulanick *et al.* (1979) randomly assigned 51 females, who had high femininity scores on the Bem Sex-Role Inventory (BSRI) into one of three groups: a full treatment group who received social and gender-role analysis and assertiveness training with behavioural rehearsal, a treatment group who received social and gender-role analysis only, and a no-treatment wait-list control group. The participants in the two treatment groups attended six 2 hour sessions. Participants were followed up upon completion of therapy and later at 2 and 12 months. Immediately following treatment, sex-role orientation on the BSRI had not changed; however, the full treatment group scored higher in assertiveness in comparison to the partial treatment group who in turn scored higher in assertiveness than the wait-list control group. At 2 months the full treatment group had higher androgynous and masculinity scores than the wait-list control group. However, both treatment groups scored higher than the wait-list control group in assertiveness. One year after treatment, both treatment groups had higher androgynous and masculinity scores than the wait-list control group and were higher in assertiveness. These results suggest that treatments using social and gender-role analysis can broaden a client's perspective regarding roles women may choose as well as increasing instrumental and expressive behaviours.

In a similar study examining the effects of assertiveness training on social and gender-role identity, Haimo and Blitman (1985) studied 14 agoraphobic women from a mental health clinic. Participants completed the Personal Attributes Questionnaire, which assesses instrumental and expressive characteristics, and the Rathus Assertiveness Questionnaire before and after treatment. The women were divided into a group receiving seven 2 hour sessions of assertiveness training and a control group. Mean Masculinity scores for the treatment group increased from 13.4 to 17.0, whereas mean Masculinity scores for the control group remained the same (12.4, 13.6). Mean assertiveness scores increased for the treatment group but the trend was non-significant (50.8, 69.1) and was not significantly better than increases observed in the control group (48.7, 54.1). Debate exists regarding the use of the BSRI and PAQ to assess sex role attitudes and behaviours including the reliability and validity of these scales in predicting psychopathology and

recovery (see Cook, 1985; Frable, 1989; Pedhazer & Tetenbaum, 1979; Remer & Worrell, 1992; Spence, 1991, 1993; and Whitley, 1983, for comprehensive critiques). Therefore, researchers and clinicians should use the BSRI and PAQ with caution or should use other measures (e.g., Attitudes Survey of Gender Related Items: Ashmore and Del Bocca, 1984). Therefore, comprehensive assessment of client behaviours and life history are necessary to understand the client's social and gender role belief system and its impact on their psychological functioning and behaviour.

Gray, Alterman, and Litman (1988) compared mental health providers in feminist therapy training to address the psychological effects of sex-role stereotyping on women, to a control group of mental health providers who did not participate in the training program. Participants in the feminist therapy-training group received 30 hours of instruction on feminist therapy using standard lecture/reading formats and role-playing and consciousness raising exercises. Ninety-one per cent of participants in the feminist therapy training group rated the experience as being positive and indicated a greater knowledge of the impact of sexism and its relation to women's mental health as measured by the Feminist Therapy Attitude Survey in comparison to the control group (Gray *et al.*, 1988). After training, this group also indicated a belief that psychotherapy is a form of political activity and a form of empowerment, whereas such attitudes were not consistently observed in the control group. Unfortunately, this study did not evaluate how therapists' knowledge about the negative effects of sex-role socialization for women transferred to therapy sessions with their own clients.

Therapists have also used different methods (e.g., interviewing or psychometric testing) for social and gender-role analysis making cross-study comparisons difficult to evaluate. Non-supportive findings have also been reported. Cassell (1977) found that social and gender role analysis lead to difficulties for some clients in their daily lives and personal relationships as the new knowledge about patriarchal domination led to subjective distress. Also, the knowledge, in and of itself, did not lead to personal change. Gray *et al.* (1988) also reported that participants in the feminist therapy-training group did not necessarily view the programme as enhancing their therapeutic skills. Therapists, thus, need to assess whether social and gender-role analysis will negatively affect a client, especially if the client has no real means or desire to change their current living environment. Social and gender-role analysis by itself does not necessarily lead to individual change. When improvement is observed, it may be achieved through other mechanisms such as behavioural rehearsal.

When working with women from diverse ethnocultural backgrounds traditional social and gender-role assessment methods may require modification. Psychometric tests may be invalid for non-white non-western clients as these tests may have been developed for, and normative data collected on white women only. Research reveals that many African American women rate themselves as high on stereotypically masculine traits such as assertiveness, capability, and along with their male counterparts make few distinctions between men and women on the basis of sex-role stereotypes (Rice-Murray, 1981). Furthermore, surveys of African American male and female college students indicate that both males and females expect the wives to work, whereas such expectations may not exist for other groups. Thus attitudes and role expectations may differ cross-culturally.

Women from diverse ethnocultural backgrounds are often doubly oppressed by race/ethnicity and gender which affect client's role perceptions. The 'deleterious effects of sexism, racism, and elitism' (Espin, 1994, p. 272) must be dealt with in sessions. When working with clients from diverse backgrounds, Comas-Diaz (1994) advocates the use of 'ethnocultural assessment' as outlined by Jacobsen (1988) which is a diagnostic tool used to assess a client's level of ethnocultural identity. This analysis should then lead into therapeutic work focused on aiding these clients in finding solutions to their problems.

Future research directions. Social and gender role analysis enables clients to examine the impact of social expectations and cultural norms on their own mental health as well as the impact of differential socialization patterns for males and females. Accordingly, research should examine the impact of this information on both clients' attitudes and behaviours as well as on therapists' ability to identify core problems requiring change. Available research suggests that social and gender-role analysis is likely to provide therapeutic benefit by providing clients with the opportunity to identify difficulties and adopt different, more assertive, problem-solving roles. This implies that knowledge gained through social and gender-role analysis is beneficial to clients.

Resocialization

Resocialization techniques follow from work done in social and gender-role analysis. Resocialization involves (cognitive) restructuring of the client's belief system (Dutton-Douglas and Walker, 1988). Clients learn to take on non-traditional roles and self-views as well as developing new coping strategies. Techniques such as cognitive reframing and behavioural rehearsal may form part of the therapy, although specific techniques may vary depending on the therapist's theoretical orientation. (Dambrot & Reep, 1993). The client may learn to be assertive or to increase their self-esteem. For example, clients with anxiety may be taught to say 'I am equal to men and deserve to have my position and the power that goes along with it and thus have no need to fear that I am inadequate' instead of saying 'As a woman I cannot be as effective a speaker as a man and should not embarrass myself by trying'. In essence, resocialization provides an experience in which women can build a positive self-image that is broader in scope than that prescribed by traditional western society. Indeed, clients may learn to adapt new solutions to their difficulties. Following mastery of these solutions the client may experience an increase in well being.

Research. Initial research on resocialization techniques by Gottlieb *et al.* (1986) reveals that resocialization enables single mothers and abuse survivors to decrease self-blame and to seek opportunities for self-advancement via education and skill development. Wolchick *et al.* (1986) tested a 7-week protocol for bulimia. Eleven clients were assigned to a group therapy programme and seven clients were assigned to a wait-list control group. All clients completed the Kurtz Body Attitudes Scale, the Rosenberg Self-Esteem Scale, the Beck Depression Inventory, questions concerning the frequency of bingeing and purging at baseline, at 7 weeks, and 17 weeks from baseline. Treatment sessions focused on decreasing depression, increasing self-esteem, increasing assertiveness, and decreasing the frequency of bingeing and purging using a psychoeducational

approach. Aspects of the treatment protocol focused on issues pertaining to social and gender roles (e.g., cultural pressures and expectations for thinness in female members of society, role limitations for women) as well as the implementation of resocialization exercises (e.g., learning self-acceptance, increasing self-esteem, decreasing depressive thoughts, improving body image). For the period between baseline and the last treatment session body image scores decreased from 112 to 87.5 indicating a decrease in negative body-image, self-esteem scores improved from 22.1 to 26, depression scores decreased from 18.4 to 7.5, binges decreased from 44 to 18.51 per month, and purges decreased from 35.1 to 16.6 for the treatment group. Such decreases were not observed for the control group between these two periods. At 17 weeks body image scores further decreased while self-esteem scores improved. Depression levels and frequency of bingeing and purging also decreased. This study demonstrates the utility of incorporating feminist therapy techniques in the treatment of disordered eating.

Future research directions. Resocialization represents a very active component of feminist therapy in which clients learn to take on new roles within therapy sessions. This is a very important step in the therapeutic process and the generalization of this new learning to the client's real environment is particularly crucial if therapy is to have any long-lasting or beneficial effects for the client. This implies that research should examine how well newly learned roles are implemented for the client in their daily environment, and differentiate sources of support and self-efficacy garnered from new roles, from social support and efficacy garnered from old roles. Furthermore, researchers may want to evaluate resocialization as an outcome variable.

Social activism

The last component discussed in this paper is relatively controversial and is not advocated by all feminist therapists; it is the role of social activism in feminist therapy. Social activism is embedded in the feminist movement motto 'the personal is political' (Dutton-Douglas & Walker, 1988; Enns, 1993; Laidlaw & Malmo, 1991; Parvin & Biaggio, 1991; Sturdivant, 1980). Social activism may involve participation by both client and therapist in organized protests, letter writing campaigns, or speaking on behalf of special interest groups, or simply being involved in groups. Although most feminist therapists and scholars argue that social change is crucial for the betterment of women's mental health and the mental health of the broader society, there is a lack of consensus regarding the use of activism in a treatment protocol. The debate focuses on whether it is beneficial or necessary to combine therapy with political advocacy (Dambrot & Reep, 1993). Although it is possible that activism will have no direct effect on the mental health of an individual client, it may have a positive impact on the mental health of other women and may thus be beneficial for improving the lives of others. From this perspective, some would argue that social activism is necessary for 'real' change to occur in women's lives and that this should take precedence over individual needs.

In contrast, many clients do not wish to be advocates for a movement and might shy away from therapies that require them to do so. Moreover, there is a risk of ethical boundary violations as a therapist might be imposing their belief about the necessity of

social action on a client, and the client relinquishing out of guilt and engaging in a political activity such as a pro-choice protest. There is a conflict in asking women to develop personal autonomy and to then engage in group solidarity and social activism to make advances for that group as a whole without regard to the impact that it may have for individuals (Parvin & Biaggio, 1991). These conflicting value systems are of great concern to feminist therapists and scholars and continue to foster considerable debate. Due to these concerns, feminist therapists are cautious in the prescription of social activism and advocate its use only when it may be of benefit to the individual client. However, feminist therapists and scholars agree that social activism is necessary to affect social change and may strive as individuals to be involved in social activism or to support the involvement of colleagues, clients, and other members of society in such endeavours.

Future research directions. Systematic research on the impact of social activism in the context of feminist therapy has not been conducted and thus the benefit of this technique for individuals is unknown. The role of social activism in feminist therapy is still under consideration. As a result, therapists and scholars are challenged in evaluating this component. On the one hand the effectiveness of social activism may be based on how it benefits an individual client or conversely, whether it affects broader societal change and improves the mental health for members of society. It is possible that the increased opportunity for socializing and voicing one's thoughts, feelings and opinions may lead to a sense of empowerment and mastery for individuals who engage in social activism. Moreover, active women may have more opportunities to engage in emotional expression which may have been suppressed in the past. Women may be exposed to new opportunities which were not previously available to them as a result of the new contacts that arise from being involved with others. Finally, participation may lead to a sense of personal empowerment and a sense of affecting broader societal changes that will improve the mental health of all women and society.

Surveys are needed to assess how clients feel when they are asked to be involved in activist activities or when they are asked to involve others. Research examining whether social activism increases an individual's sense of empowerment and whether it improves an individual's mental health is necessary. Methods must also be developed to assess whether social activism leads to societal changes that improve the mental health of women and the broader society. Finally, the impact of social activism on therapists should also be examined.

Conclusion

This paper evaluated several components of feminist therapy, including consciousness raising, social and gender-role analysis, resocialization, and social activism. We believe that these components are fundamental to feminist therapy and are conceptually distinct from other techniques. Despite the growing number of studies that support this view, future studies need to focus on evaluating the efficacy of these techniques (Grossman *et al.*, 1997) including how these techniques are effective, for whom, and for which problem(s). Outcome studies examining how individuals respond to feminist therapy techniques (i.e., therapy efficacy), and experimental studies to examine the processes

underlying important aspects of feminist therapy, such as disclosure or consciousness raising must also be conducted.

Some have argued that empiricist methods of evaluating feminist theory and therapeutic techniques may be inadequate (Enns, 1993; Crawford & Kimmel, 1999; Grossman *et al.*, 1997; Reinharz, 1992; Sturdivant, 1980). Feminist theory engenders a way of knowing that is both objective and subjective. Qualitative analyses may be beneficial in this regard (Stoppard, 1999). For example, *standpoint analysis* (Harding, 1986), acknowledges that boundaries between subject (participant) and object (investigator) are often blurred. With this approach, the participant's viewpoint becomes the data, not the investigator's interpretation of the data, and the investigator relies heavily on the use of qualitative data analyses. Similarly, feminist postmodernism recognizes that individuals experience multiple realities. Accordingly, this approach involves gathering information from several sources as no once source can provide 'truth' as truth is webbed within 'complex historical contexts, social constructions, and relationships' (Enns, 1993, p. 25). Researchers using this method focus on how meaning is negotiated, discovered, and how people control that meaning (Grossman *et al.*, 1997; Unger, 1990). Finally, cross-cultural and ethnographic research methodologies (Reinharz, 1992) may be particularly useful for studying the efficacy of feminist therapy methods for women of diverse backgrounds and experiences.

Combining information from traditional empirical methods and feminist non-traditional techniques (i.e., qualitative) will enable us to answer the questions that have been posed about feminist therapy theory and techniques. Having knowledge will allow us to improve upon existing techniques and theory that are beneficial, to refine or remove harmful techniques, and to create new ones.

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