Fam Proc 17:181-194, 1978

A Feminist Approach to Family Therapy

RACHEL T. HARE-MUSTIN, Ph.D.[a]

[a]Associate Professor and Director of Community Counseling Program, Villanova University, Villanova, Pennsylvania.

Although family therapy recognizes the importance of the social context as a determiner of behavior, family therapists have not examined the consequences of traditional socialization practices that primarily disadvantage women. The unquestioned reinforcement of stereotyped sex roles takes place in much of family therapy. A feminist therapy orientation that considers the consequences of stereotyped sex roles and the statuses prescribed by society for females and males should be part of family therapy practice. This paper describes the ways in which family therapists who are aware of their own biases and those of the family can change sexist patterns through applying feminist principles to such areas as the contract, shifting tasks in the family, communication, generational boundaries, relabeling deviance, modeling, and therapeutic alliances.

One might well ask what family therapy has to do with feminist therapy. Have not the family and the institutions that support it been the primary cause of maintaining women in their stereotype sex roles? As feminists can readily point out, "The family has been the principal arena for the exploitation of women, and however deeply rooted in social structure that exploitation may be, it is through family structure that it makes its daily presence felt" (10, p. 19). Chase's question, "What does feminism demand of therapy? (10, p. 3) is the question I would like to examine in the form, "What does feminism demand of family therapy?"

In discussing family therapy from a feminist point of view, I will first briefly consider the principles of feminist therapy and review the structure of the family as we know it today. I will then discuss how family therapy has evolved. Some of the ways in which family therapy differs from the feminist approach will be examined. Finally, I will present in greater detail the ways feminist values can be translated into techniques for working with families.

FEMINIST THERAPY

Feminist therapy grew out of the theory and philosophy of consciousness raising. Central to feminist therapy is the recognition that (a) the traditional intrapsychic model of human behavior fails to recognize the importance of the social context as a determiner of behavior, and (b) the sex roles and statuses prescribed by society for females and males disadvantage women (29, 30, 42, 45).

Feminism sees as the ideal for the individual the ability to respond to changing situations with whatever behavior seems appropriate, regardless of the stereotyped expectations for either sex. This idea of the androgynous personality reflects a recent shift away from dualistic notions of masculine-feminine personality types (21). In helping women develop in line with an androgynous model, feminist therapy has encouraged women not only to become aware of the oppressiveness of traditional roles but also to gain experiences that enhance their self-esteem as they try new behaviors as part of gaining self-definition. The feminist therapeutic relationship itself embodies these principles in its emphasis on greater equality between the therapist and the client. By differentiating what is personal from what is external, feminist therapy may be distinguished from nonsexist therapy or humanistic therapy. These approaches may encourage individual development free of gender-prescribed behaviors, but they do not (a) examine and (b) seek to change the conditions in society that contribute to the maintenance of such behaviors.

THE FAMILY

The American family as we know it from research and clinical practice is one in which the husband bears the main responsibility for the economic maintenance of the family and the wife bears primary responsibility for domestic work and child care. The nature of the family today is a consequence of the dramatic changes that took place during the nineteenth century, chief among which was the separation of work from the home (41). Where productivity was rewarded by money, those who did not earn money, such as women, children, and old people who were left at home had an ambiguous position in the occupational world (22). The instrumental role for males and the expressive role for females that evolved were held up as normative by Parsons and Bales (40) and even necessary for the well-being of individuals, the family, and society.

The employment of women outside the home has not released women from the assigned expressive role that accompanies homemaking responsibility. Employed wives labor longer than either employed men or full-time housewives, and the fact that child care is not available for working women in the United States reinforces the idea that women are not about to be released from their primary responsibility in the home merely because they work outside (6). Recent work patterns for women are actually not innovative but regressive in terms of the decreasing proportion of women in any but low-paying jobs (44). Being female is regarded as uniquely qualifying a woman for domestic work, no matter what her

interests, aptitudes, or intelligence (5). Equalitarian arrangements by which both parents share equally in domestic areas or by which contributions to the family are based on personal preferences and individual capabilities are rare when these preferences diverge from traditional role expectations.

In marriage, the power of the male in the family is guaranteed by society's expectation that he will be older, bigger, have more education, and come from a higher social class than his wife. This tends to assure that he has the strength, credentials, experience, special knowledge, and training on which power in part is based. Marriages in which this is not the case are regarded as deviant. The power in the female role that derives from the woman's responsibility in organizing the household, the children, and the husband has depended on being married and having children (22). With the decline in the importance of the family, such power has been reduced. Women's lack of power is obscured and attributed to women's being more emotional and less able to "handle power" than men. As in other unequal relationships, the dominant group defines the "acceptable" roles for the less powerful, which are those activities like domestic work that the dominant group does not choose to do. There is research demonstrating that loss of power or chronic powerlessness are frequent precursors of psychological disorder (31).

Marriage typically demands that women give up their activities or place of residence to adjust to the needs of men. It has been observed that the partner who sacrifices or gives up the most for the marriage must of necessity be the one most committed to it (37). The woman, who may have given up her occupation, family closeness, or residence for marriage must rely more on the marriage to fulfill her needs. The expectation that women will adjust to men's patterns leads to an often unrecognized difference in the number of stressful life events impacting on men and women. Dohrenwend (11) has found that women are exposed to a relatively higher rate of change or instability in their lives compared with men, which can be seen as contributing to frequent psychosomatic symptoms and mood disorders.

The inequality in the traditional family is rarely recognized by individual or family therapists. It has been observed that power aspects of sex roles are largely disregarded or denied, except when women have power (35). The formulation of dominant-mother/ ineffectual-father as the cause of practically every serious psychological difficulty is made without regard for the underlying inequality that leads to such a situation. Few therapists recognize that the stress on family members and particularly on women from required sex roles that assign them an inferior position has led to the family becoming the arena of conflicts that arise from the inequity sanctioned by the larger society (34).

FAMILY THERAPY

In the late 1940s and 1950s, researchers such as Wynne, Lidz, and others, focusing on the schizophrenic patient, identified the overinvolved mother as the source of pathology. In terms of the social events of the time, women who had been more fully involved in activities outside the home during World War II were now being encouraged to return to their natural feminine occupations as wives and mothers and to apply themselves to these responsibilities. The profound impact on the field of Parsons and Bales' (40) idea of fixed sex roles, with males having the instrumental role and females the expressive, has been pointed out (24). Observations of these stereotyped sex roles in the American family were then used by researchers and therapists as the basis for the argument that these were the necessary conditions for normal family life and successful child rearing. Advances in the 1960s saw the application of principles of general systems theory to the understanding of the family. The most notable change in family therapy in the 1970s, and one that has implications for women, is the growing acceptance of the family developmental point of view that follows from the work of Hill and other sociologists (19).

The family developmental orientation is analogous to the individual life cycle perspective in its focus on the stages in family development over the family life span—from the initial courtship phase to the death of the last member of the couple. Stages are defined in terms of the dominant developmental tasks faced by individual members of the family and the family as a system at that point. "Normal" crises in family development are usually identified as those that occur around the addition or loss of a member, whether actually by birth or death, or symbolically by change in activity or residence. The importance of this model is that it can provide an orientation toward prevention rather than pathology by identifying predictable crisis points in advance. Therapeutic interventions are directed at preparing the family for such stress points as well as helping the system move on from crises to resume its characteristic functioning.

If the systems approach to family therapy has adopted a prevention model of mental health and has shifted from a focus on the individual to recognizing social systems as determinants of behavior, one might ask why has it not been discovered and acclaimed by feminists as sex-fair therapy? In point of fact, while espousing a theory that might seem to assure equality for family members, family therapists in practice share the same biases and prejudices as others in the society and often have not freed themselves from their past training in a traditional orientation that views the mental health of males as akin to adulthood and that of females as not (9). For example, Bowen's Differentiation of Self Scale (8) can readily be identified as a sex stereotyped masculinity-feminity scale with femininity at the devalued end. Bowen's approach is akin to the Ego Strength Scale based on the Minnesota Multiphasic Personality Inventory (MMPI), which is biased in favor of males by including more masculine than feminine scored items (32). Bowen ignores the fact that women's socialization encourages

them to be emotional and intuitive rather cthan rational.

To restore the family to healthy functioning, family therapists often intentionally or unwittingly reinforce stereotypic role assignments for man, the doer, and woman, the nurturer, assuming that the traditional roles are the basis for healthy functioning. That some people are more comfortable in these roles for which they were trained cannot be denied, but, as suggested earlier, they may pay a price in psychological functioning. The fact that married women have a higher incidence of mental illness than men but single women do not (15) should lead family therapists to question the structure of the traditional family as it affects women. Representative of family therapists who support sex-stereotyped roles as important for healthy development are Boszormenyi-Nagy and Spark (7). They point out that "A heterosexual (therapy) team permits each individual to function more comfortably in his or her life-long assigned biological-emotional role.... Mutual respect is needed to confirm the differences between masculinity and femininity" (p. 204). They criticize women who live vicariously through their husbands and children, thus avoiding facing their own lack of identity; however, they also criticize women who seek identity elsewhere, as in the following example.

> A young married woman who received superior ratings as a school teacher refused to cook or shop for food since she considered this beneath her.... She seemed to expect the therapist as well as her family to be completely accepting of her passive, dependent attitude that it was beneath her dignity to fulfill this aspect of a woman's role. [p. 203]

Minuchin (37) sees himself as modeling the male executive functions, forming alliances, most typically with the father, and through competition, rule-setting, and direction, demanding that the father resume control of the family and exert leadership as Minuchin leads and controls the session. In a comparable manner, Forrest (12) describes the female therapist as using her feminine warmth, wisdom, and interest in men to appeal to their masculine instincts.

These illustrations reveal how the unquestioned acceptance and reinforcement of stereotypic sex roles takes place in much of family therapy, despite the possibilities inherent for change in the systems point of view. As Klapper and Kaplan (24) point out in their survey of sex-role stereotyping in family therapy literature, current writing has been minimally affected by the emerging consciousness. "Someone being trained as a family therapist would have to maintain stern vigilance in order not to be caught up in the oftentimes subtle reinforcement of behavior patterns which are so debasing and humiliating to women" (p. 28).

TECHNIQUES FOR FAMILY THERAPY

Despite the fact that a feminist approach to family therapy has not developed, I would contend that such an approach is possible. The obstacles can be summed up as (a) the socially reinforced sex roles that exist in the family; (b) the therapist's own family and clinical experience that renders her or him unaware of and insensitive to alternatives to stereotyped sex roles; and (c) the family's concerns, which are rarely identified as related to traditional sex-role assignments. My purpose in what follows is not to analyze family therapy techniques, per se, but rather to consider certain areas of intervention in which a feminist orientation is important. These areas are: the contract, shifting tasks in the family, communication, generational boundaries, relabeling deviance, modeling, ownership and privacy, and the therapeutic alliance with different family members.

The Contract

Feminists stress the equality in the relationship between the therapist and the client as a departure from the paternalistic medical model in which the doctor is presumed to always know best. Recognizing that the capacity to influence people comes in part from their expectations (the placebo effect), feminists are contending that an equal relationship with mutual respect can still raise expectations that are beneficial in achieving goals (13). One method of attaining equality is by use of a contract.

Many family therapists use an informal or unwritten contract with families that come for help that facilitates agreement on arrangements for treatment and goals (18). As has been pointed out by the Nader group, a contract that is written assures the protection of client rights to an even greater extent (1). The contract is probably not intended to be legally binding, but it does establish a mutual accountability between the therapist and the family. Furthermore, the negotiation of the contract can be an important part of the therapeutic process itself. The contract can include arrangements for treatment, the amounts and kinds of responsibility to be assumed by the therapist and by the family, issues of confidentiality, the goals of therapy and measurement of their accomplishment, and provisions for renegotiation of the contract.

One of the problems in contracting with families is the need to involve all family members, some of whom are more reluctant to participate than others. Hines and Hare-Mustin (20) have pointed out the ethical problems in requiring reluctant children and adolescents to participate in family therapy. Most families come because the mother is distressed about something in the family. The father, from his less involved position, feels that there is nothing to worry about, while

the children have little choice. Too strong initial support by the therapist of any one member's point of view is likely to alienate the other members and lead to sabotaging or early termination of treatment. The therapist must reach some shared agreement with all family members.

To the extent that the father is paying for the sessions, he controls the sessions. It is hard to complain about the person paying the bills, as women and children are well aware. Part of the therapeutic process that relates to the contract and the setting of fees is the shifting of the conventional idea that the one who contributes money to the family is the only meaningful contributor. Unpaid services of other family members, primarily the mother, must be viewed as contributing to and subsidizing the person who is bringing in the money. Another aspect of the money economy is the inflexibility of most job schedules that can be pointed out to the family in connection with scheduling appointment times that the father can attend. In like manner, when babysitting arrangements are necessary, the value of the mother's unpaid work should be focused on, rather than merely her traditional responsibility for locating babysitters.

Beginning with the contract helps the family learn about negotiation and makes explicit the "rules" for the therapy. From the negotiations about the contract, the family can begin to understand how rules regulate the behavior of family members. Many family conflicts center about what the rules are and who makes them, which is basically the issue of power. In family conflicts, Zuk (49) has pointed out that the weak person traditionally espouses values such as justice, compassion, and relatedness, while the powerful person advocates control, rationality, law, and discipline. In husband-wife conflicts, wives usually espouse values concerned with caring, while husbands espouse rationality. In parent-child conflicts, children espouse the relatedness values, while their parents stress control and discipline. The family therapist can help the family recognize the value differences that accompany the shifts in power among participants in family conflicts.

Shifting of Tasks in the Family

Family therapists recognize that it is impossible to change the role of one family member without changing the role of another. However, the division of labor and functions in the family is often looked at in very limited perspective. Therapists who ask about the sharing of chores in the family may not recognize that the division of labor in the home is in part a result of the separation of paid work from the home and the consequent devaluing of domestic work. Traditional therapists who see some women having a greater share of responsibility and power within the home than men overlook the fact that men typically have power and status elsewhere. Family therapists should not rush to "restore" the power in the family to the father, thus further reducing the mother's self-esteem and limited authority. As noted earlier, the observation that fathers typically have the instrumental role and mothers the expressive role in families has led family and child care experts to assume that these role assignments are necessary for normal functioning, an assumption for which the evidence is at best equivocal.

Many couples share responsibilities without regard for traditional stereotypes until the birth of the first child (43). The arrival of a child precipitates a change in power and relationship status between the partners. Resentment can build up at this point in the person who has to shift to the major child care responsibilities—resentment that can lead to the breakdown of the bonds of affection established in the previous period. At the same time, the woman with authority is too often seen as a monster by her family and by therapists because for a woman to have authority deviates from the stereotype. In point of fact, the limited power that women have to make decisions and guide the lives of family members has declined as the family has declined in importance.

Often, women would like others to share more of the decision-making in the family (36). Mothers are burdened with many small decisions, but the fact that fathers do not participate signals to the mother as well as to the children that the decisions are about matters that are not really important. The family therapist needs to help family members examine how decisions are made and who shares in the process.

The practice of the mother's thanking other family members for household chores also needs to be examined. As long as the mother thanks others and they expect to be thanked, the implication is that they are doing her work, rather than family work, and they are doing it as a favor to her. In addition, children are not going to participate willingly in chores that the father signifies by his nonparticipation are demeaning.

What should take precedence, the job or the family? The feminist therapist needs to be aware of the complexities of this question. The intense pressure on the person working with technology in the money economy often results in a choice having been made in favor of the job. Because men bring in the money, it is expected that women and children will adjust to their needs. Yet, when a woman works, the family still demands primary allegiance (6). Women who work are expected to be interrupted by and respond to the demands of the family. I had a case in which an unemployed father and the teen-age daughter waited for the working mother to come home and cook supper. Not all therapists would have questioned this practice.

Family therapists need to be aware of the options for women as well as men and not oversell work for women outside the home when the jobs available are frequently repetitious, demeaning, and underpaid. In addition, there are women whose socialization is such that they are genuinely happy with the "professionalization" of housework in their current lives. The

encouragement of women to go out to work without a reduction of their work load at home may be but a thinly disguised punitive act. The economic realities are also such that if both individuals work part-time or if the woman works full-time instead of her husband, there will be a loss in family income owing to the differentials in earning power of men and women and the loss of fringe benefits for part-time work. Despite these limitations, outside work can be an enhancing experience. Therapists need to help the family recognize not only the positive aspects but also the enormous societal barriers operating against meaningful change in the family and not advocate facile solutions that may have slight chance of success. On the other hand, counseling women to remain in traditional roles can have repercussions for their families in terms of anger, frustration, and a smothering over-involvement with their children (47).

The mother, as well as other family members, needs to give up the view that she should be totally available to respond to every demand family members make upon her. If she is to give up some of the power associated with being central in the family, she must be connected with areas outside the home where she can have autonomy, respect, earning power, and opportunities to develop her capabilities. Women's ambivalence and resistance to giving up responsibility in the family is often a defense against the guilt they feel about not fulfilling their traditional sex roles and the anxiety they experience when departing from the familiar patterns of wife and mother. Some of the specific directions the therapist can take with the family are drawing up and trying out new schedules of household chores, involving the father in home tasks, child care, and decision-making, assigning age-appropriate responsibilities to the children, and helping the family develop network supports that will be encouraging of the anticipated changes. More appropriate assertive behaviors can be developed by the mother at the same time she is learning to set more realistic goals for herself. One of the first things that signals change may be a reduction in the mother's behavior as a critic, which is an often unacknowledged consequence of her inferior position. All family members can benefit from consciousness-raising as a part of family therapy. Understanding of different roles develops as parents and children are asked to examine what they like and do not like about being male or female.

Communication

Many family therapists focus on communication, but few have analyzed the relation of communication styles to male and female roles. Women are typically not listened to as having something important to say because the woman in a family or marital relationship is viewed as an adjunct. ("Hello, Mrs. Smith. What does your husband do?") Like children, women are not taken seriously, or when they talk about serious things, are accused of imitating a man (4). Research on nonverbal communication consistently shows that women are treated and behave as inferiors (33). There are several consequences of this lack of confirmation experienced by women that therapists should be aware of: women are regarded as nags because they talk constantly in seeking to be attended to or as devious or vague because they express themselves indirectly and tentatively in order to avoid disapproval.

The transactional nature of family therapy reveals habitual family communication patterns as no other approach has been able to do. For example, the nagging person can be viewed not only in terms of the withdrawn or disinterested partner that provokes the nagging behavior, but also in terms of the third person in the triangle who is being given a lesson, drawn in, distanced, supported, alienated, or the like. Changing communication patterns in the family is regarded by some family theorists as the single most important technique for changing behaviors and attitudes (16, 48). The family can practice new ways of communicating, shifting roles through role play, critique, and practice in order to learn new ways of interacting and to understand the confining aspects of one's own or another's traditional role.

Rules for communication have been developed by women's consciousness-raising groups to help women express themselves and be heard. Some of these are similar to those used by family therapists, such as not interrupting, relating the particular experience to the universal (generalizing), becoming specific ("What does that mean to you?"), and attaching significance to feelings, not just to facts. The latter leads to less disqualifying of women's experiences or style of expression than the rational mode to which men have been socialized. The therapist can also reinforce a greater range of genuine emotional expression and sensitivity to emotions in men who have avoided or disparaged emotional expression.

Generational Boundaries

Clear generational boundaries are often seen as congruent with healthy family functioning (37). The breakdown in boundaries can occur when one of the parents is more closely allied with a child than with the spouse. The therapist who is not sensitive to the power differences in family roles may not understand the alliance of the powerless mother and child against the powerful father or the father and child against the demanding mother. Sometimes there seem to be no generational boundaries but an amorphous unit consisting of parents and children in which the parents avoid the burden of decisions and responsibility by a spurious equality. Children may find themselves parenting the parent with exaggerated dependency needs. The low status accorded to older people in our society and particularly to older women needs to be kept in mind by the therapist who sees a mother trying to be an age mate to her daughter. The therapist should work to restore the alliance between the parents without the exaggerated status differences that have evolved between adults and children in modern times.

It has been pointed out that children have a deteriorating effect on the marital relationship in terms of a decline in understanding, love, and general satisfaction (19). This could well be a consequence of the mother's dissatisfaction with the burden of her assigned role and the lack of genuine sharing and interest in child care by the father. The availability of the mother to the children leads to close alliances as well as the perpetuation of stereotyped sex roles. Mothers tend to use their daughters (or sons) as confidants because their isolation in the home from other adults confines them to housewife and mothering functions. In this way, women pass on their sense of worthlessness and denigration to both daughters and sons. The unavailability of fathers affects sons and daughters as well as mothers, sons because the unavailable father does not provide a model for learning, daughters because the father's unavailability leads them to develop an image of the male as a romantic stranger, an unrealistic ideal that cannot be satisfied when they reach adult life.

During adolescence, daughters are particularly torn between identification with the mother and with the father. This is the time when it becomes increasingly apparent to young women that career paths may be closed to them. The daughter who has a close relationship with her mother but is interested in a life different from her mother's may see herself as betraying and competing with her mother. If she aspires to a career path and identifies with her father, this can interfere with her relationship with her mother as well as with the development of feminine aspects of her identity (38). The therapist who is sensitive to the confusion of young women during this period can provide support to the girl as a facilitative model who values both career and family.

Siblings can sometimes develop a strong subsystem independent of the parents. Freedom from assigned sex roles among siblings can be supported by the therapist and the parents. It is frequently not recognized how much siblings contribute to one another's development through socialization, control, and rescuing operations.

Younger children are often coopted by one or both of the parents in terms of their own needs. Therapists need to be aware of the extent to which children bring zest and life to a family and misbehave to keep the family system functioning. A range of behaviors should be equally allowed both girls and boys. Children's disturbing behavior may be subtly encouraged by the parents who can be united only when dealing with a child's misbehavior. School refusal and other disruptive behaviors may actually be supportive of a depressed parent, usually the mother. To the extent the family therapist can help the mother develop independence and self-esteem, as well as gain the positive regard of the father, the therapist frees the children from the need to rescue the mother by "bad" behavior.

Relabeling Deviance

Diagnostic labels are not useful in a family systems approach because they carry intrapsychic and causal connotations that do not fit into a systems model. Like the feminist therapist, the family therapist can avoid labels implying that the attribute belongs to the individual rather than the situation. Diagnostic labels, by focusing on the individual, serve to mask the prevalence of particular conditions in society that stress individuals. That behavior has become habitual as a result of socialization patterns of reinforcement does not mean that the therapist should shift to the intrapsychic model. For example, it should be recognized that the unhappiness of women in families is too widespread to be viewed as an individual weakness or defect. As Halleck (17) has emphasized, treatment that does not encourage the patient to examine and confront her environment merely strengthens the status quo.

The use of language is important because in this way sex differences can be exaggerated, often with disparaging connotations (14). Some of the pejorative labels used are imposed by the male-dominated culture such as pretty, sexy, ugly, blonde, dumpy, and the like (23). Others clearly reflect the double standard of terminology for men and women. The use of the generic masculine pronoun denies women's experiences. Consider also, for example, "father absence" and "maternal deprivation." Or the fact that a family is called traditional when the man is breadwinner but matriarchal when the woman is the breadwinner (35). "Weak" is a label applied to women and pejoratively to men, but like "strong," its meaning can only be understood in transactional terms. All too often, the weak person in the family, by appearing incompetent, is shoring up the strong one in order to prevent the latter's true fraility from becoming apparent. In this way, the inadequate housekeeper or the fearful woman is making her partner as well as other family members appear strong, and so in reality, she is protecting them.

An example of a pejorative and overused label in contemporary society is "passive-aggressive." What the therapist needs to do is examine the conditions that make individuals use covert and indirect means rather than direct means for gaining their ends. Some behaviors, such as phobic behaviors can be understood as exaggerations of the dependency and timidity that women are taught or as a consequence of women's inexperience and the taboos against women successfully coping with and overcoming obstacles in a "man's world." Too often therapists, like others, blame women for the dependency in which they have been trained.

There are a number of ways by which therapists who are sensitive to the misuse of labels can bring about change. They can help both women and men free themselves from stereotypic expectations that lead them to try to hide attributes in themselves they have been taught are unacceptable. In addition, therapists can often perceive attributes of family members that are not usually noticed and by drawing attention to them can shift family members' ways of perceiving and interacting.

Labels of "good" and "bad" illustrate how labels deny the complexity of persons. In the case of an older "bad" sister who was always in trouble, I was able to shift some of the "good" from the younger "good" child to the "bad" one by drawing the family's attention to the contribution that older children make to younger ones by testing the limits and the rules in the family. This emphasized the similarities between the children rather than their differences.

Modeling

Feminists recognize that one of the important aspects of consciousness-raising groups is the opportunity for women to model for each other. There are a variety of successful male models available in public life, business, the professions, and the media, but women have lacked female models because of the relatively few women in positions of prominence. Women have also been isolated from others in their daily lives in their homes. The female therapist can model a successful woman for clients. I have found that it is hard for even the most liberal male to acknowledge that a female therapist could provide something that he could not. Some male therapists claim that they are better therapists for female clients because they can provide a different kind of male model than the client is accustomed to (26). What goes unrecognized is that the male therapist, in providing a different male model, is reinforcing traditional stereotypes by assuming that the female client needs a special male who will treat her differently than other males have done. What a woman needs to learn is not that some men are different but how she can become a different woman.

By modeling different behaviors, the female therapist can help women free themselves from minority group traits that they have developed because of lack of power and secondary status, traits such as dislike of one's own sex, a negative self-image, "shuffling," insecurity, low aspirations, and appeasing behaviors (23). Another quality that female therapists can model for all the family is competency in a woman. However, in family therapy, the therapist needs to be careful not to render family members incompetent by being a better parent, a better mother, or a better partner—more wise, just, and all-seeing. Traditional therapy has too often fostered the woman's view of herself as incompetent. The therapist who can acknowledge a lack of knowledge in some areas is a better model for parents and family members than one who is either a superwoman or a superman.

Ownership and Privacy

Just as Gestalt therapists have sought to develop ownership of an individual's feelings and attitudes by "I" statements, so family therapists can encourage ownership. Women typically have not been sure of their share in family resources that relate to the money world. Therapists may need to help women negotiate with other family members to gain ownership of many aspects of their lives. Women often lack ownership of the means of privacy, such as personal space, their space being that associated with their household job, like kitchen or sewing room (28). They also do not own personal time without feelings of guilt or the use of money without accountability. A sensitive therapist can also encourage a woman to own and develop her talents and hobbies, as well as her thoughts and feelings. By encouraging ownership in other areas, the therapist may be able to help women assert ownership of their own bodies. Experiences like menstruation, menopause, hot flashes, tension around menstrual periods, impregnation, lactation, and childbirth can be crisis situations that women never discuss with male therapists.

Is family solidarity incompatible with individual ownership in the family? The therapist needs to point out that personhood for the mother as well as other family members is important, that the family need not be either a fortress or a prison. Since women have been raised to believe that their self-worth and identity is inextricably bound to finding the right husband and caring for a family, they may use therapy to talk about relationships with men rather than about their own identity (3). The family therapist deemphasizes "talking about" in the favor of interaction and can be influential in reinforcing assertive steps toward a sense of self that does not result solely from identification with family goals, family service, and family responsibility.

Therapeutic Alliances

An issue raised in modeling and in the interventions and alliances of the family therapist is the therapist's own gender. Does the therapist interact differently with men and women? Can a male be a feminist therapist? Certainly a nonsexist male therapist is better than a sexist female one. The power differential between males and females is still an enormous obstacle. Furthermore, because the stereotyped male role requires men always to appear competent, it may be that men find it harder than women to recognize and acknowledge sex biases in themselves. These therapist blind spots lead to reinforcing traditional patterns, whether the male therapist is allying with a woman to "protect" her, which is really a competitive move against her husband, or allying in a male bond with the husband, against the wife.

An essential aspect of family therapy is that the therapist must be committed to each person in the family (20). This means the therapist must frequently shift alliances congruent with therapeutic goals. An alliance does not necessarily mean an "agreement" with. The experienced family therapist can ally with one family member in terms of feelings, attention, or

emphasis on syntonic aspects of therapist and client personalities, while supporting the views and attitudes of another family member. For example, an initial alliance of one kind may need to be made with the typically reluctant father in order to assure his attendance and participation in the beginning stages of therapy.

The female therapist will frequently be viewed as allied with the mother because of their common gender just as the male therapist will be perceived as allied with the male when sometimes this is not the case. The husband and the therapist as the two reasonable (powerful) persons are often assumed to have a natural alliance. Rawlings and Carter (42) report a family therapy session with two therapists, a psychiatrist and social worker, both males, where the mother felt like a rabbit being attacked by a wolf pack. Women may need the support of a female therapist to oppose traditional alliances and to be able to release pent-up rage, helplessness, and envy of men (25).

Many married couples who do cotherapy assume that they provide a model of a normal or a liberated couple, as the case may be. I would agree with Sager (46) that "the therapy couple's use of themselves as role models is a dubious procedure based on the treating couple's idealization of their own self-image" (p. 188). Marriage per se of a cotherapy team is no guarantee of therapeutic effectiveness (27). If there are differences in experience, training, and status of the cotherapy pair, there is a basis for inequality that is not lost on family members, no matter what roles the cotherapists imagine they are playing in the therapy sessions. Male-female cotherapy teams have been found to reinforce patterns of behavior that are oppressive to women (2). The cotherapy team in which the female rather than the male therapist is the senior member is virtually unheard of. Some therapists prefer a cotherapist because they recognize that family therapy can take on aspects of an adversary proceeding in which each spouse is seeking an ally for a scolding match (42).

The family therapist needs to be aware of the alliance-seeking behaviors of some family members who draw the therapist into a triangle at the expense of other family members. Therapists who expect and assume that female behaviors toward males are basically envious or seductive are themselves locked into stereotyped thinking that will interfere with their capacity to be helpful. Nor can one disregard the enormous emotional significance of men qua men in our society. Orlinsky and Howard (39) have pointed out that the client's emotional reactivity solely to the sex of the therapist may override the experience, talent, and warmth that the therapist brings to bear. A problem for the male therapist may be to deal with the woman's anger as she recognizes the irrelevance and goallessness of the activities that are her daily lot. A problem for the female therapist is the lack of respect and questions of therapeutic competence that are leveled at the female professional. As the husband and children learn to deal with the competent female therapist, they will learn to deal with the wife and mother in the family in a new way.

CONCLUSION

Family therapy provides opportunities for social change unavailable in other therapeutic approaches. The therapist is addressing problems in the family that reflect the traditional norms and expectations the parents bring from their own families of origin and attempt to maintain in their current family. The systems approach to family therapy is congruent with feminist therapy in examining behavior in terms of its economic and social determinants rather than using an individual-centered approach. A feminist-oriented family therapist can intervene in many ways to change the oppressive consequences of stereotyped roles and expectations in the family. As consciousness-raising takes place in families, family members come to recognize the sociocultural pressures that perpetuate traditional sex roles and seek ways to free themselves from these pressures. A review of family techniques from a feminist perspective indicates that family therapy is indeed possible without encouraging stereotyped sex roles.

REFERENCES

1. Adams, S. and Orgel, M., *Through the Mental Health Maze,* Washington, Public Citizen's Health Research Group, 1975.
2. American Psychological Association, *Report of the Task Force on Sex Bias and Sex Role Stereotyping in Therapeutic Practice,* Washington, Author, 1975.
3. Barrett, C. J., Berg, P. I., Eaton, E. M. and Pomeroy, E. L., "Implications of Women's Liberation and the Future of Psychotherapy," *Psychother.: Theo. Res. Pract., 11,* 11-15, 1974.
4. Beauvoir, S. de, *The Second Sex,* New York, Bantum Books, 1970.
5. Bem, S. L. and Bem, D. J., "We're All Non-conscious Sexists," *Psychol. Today,* November 1970, p. 22.
6. Bernard, J., *The Future of Motherhood,* New York, Dial Press, 1974.
7. Boszormenyi-Nagy, I. and Spark, G. M., *Invisible Loyalties: Reciprocity in Inter-generational Family Therapy,* New York, Harper & Row, 1973.
8. Bowen, M., "The Use of Family Theory in Clinical Practice," *Compr. Psychiat., 7,* 345-374, 1966.
9. Broverman, I. K., Broverman, D. M., Clarkson, F. E., Rosenkrantz, P. S. and Vogel, S. R., "Sex Role Stereotypes and Clinical Judgments of Mental Health," *J. Consult. Clin. Psychol., 34,* 1-7, 1970.

10. Chase, K., "Seeing Sexism: A Look at Feminist Therapy," *State and Mind,* March-April 1977, pp. 19-22.
11. Dohrenwend, B. S., "Social Status and Stressful Life Events," *J. Pers. Soc. Psychol., 28,* 225-235, 1973.
12. Forrest, T., "Treatment of the Father in Family Therapy," *Fam. Proc., 8,* 106-117, 1969.
13. Frank, J. D., *Persuasion and Healing,* Baltimore, Johns Hopkins University Press, 1973.
14. Gingras-Baker, S., "Sex Role Stereotyping and Marriage Counseling," *J. Marr. Fam. Couns., 2,* 355-366, 1976.
15. Gove, W. R., "The Relationship Between Sex Roles, Marital Status, and Mental Illness," In A. G. Kaplan and J. P. Bean (Eds.), *Beyond Sex-Role Stereotypes: Reading toward a Psychology of Androgyny,* Boston, Little, Brown, 1976.
16. Haley, J. (Ed.), *Changing Families,* New York, Grune & Stratton, 1971.
17. Halleck, S. L., *Politics of Therapy,* New York, Science House, 1971.
18. Hare-Mustin, R. T., Marecek, J., Kaplan, A. and Liss-Levinson, N., "Rights of Clients, Responsibilities of Therapists: A Training Module," Unpublished manuscript, 1977.
19. Hill, R. and Rodgers, R. H., "The Developmental Approach," in H. T. Christensen (Ed.), *Handbook of Marriage and the Family,* Chicago, Rand McNally, 1964.
20. Hines, P. and Hare-Mustin, R. T., "Ethical Concerns in Family Therapy," *Profess. Psychol., 1978, 9,* 165-171, 1978.
21. Kaplan, A. G., "Clarifying the Concept of Androgyny: Implications for Therapy," Paper presented in Symposium on Applications of Androgyny to the Theory and Practice of Psychotherapy at the meeting of the American Psychological Association, Washington, September 1976.
22. Keller, S., "The Female Role: Constants and Change," in V. Franks and V. Burtle (Eds.), *Women in Therapy,* New York, Brunner/Mazel, 1974.
23. Kirsh, B., "Consciousness-Raising Groups as Therapy for Women," in V. Franks and V. Burtle (Eds.), *Women in Therapy,* New York, Brunner/Mazel, 1974.
24. Klapper, L. and Kaplan, A. G., "The Emerging Consciousness of Sex-role Stereotyping in the Family Therapy Literature," Unpublished manuscript, 1977.
25. Kronsky, B. J., "Feminism and Psychotherapy," *J. Contemp. Psychother., 3,* 89-98, 1971.
26. Lazarus, A. A., "Women in Behavior Therapy," in V. Franks and V. Burtle (Eds.), *Women in Therapy,* New York, Brunner/ Mazel, 1974.
27. Lazarus, L. W., "Family Therapy by a Husband-Wife Team," *J. Marr. Fam. Couns., 2,* 225-235, 1976.
28. Lennard, S. H. C. and Lennard, H. L., "Architecture: Effect of Territory, Boundary, and Orientation on Family Functioning," *Fam. Proc., 16,* 49-66, 1977.
29. Lerman, H., "What Happens in Feminist Therapy," Paper presented in Symposium on Feminist Therapy in Search of a Theory at the meeting of the American Psychological Association, New Orleans, 1974.
30. Marecek, J., "Dimensions of Feminist Therapy," Paper presented in Symposium on Liberating Psychotherapy: Changing Perspectives and Roles among Women, at the meeting of the American Psychological Association, Montreal, September, 1973.
31. Marecek, J., "Powerlessness and Women's Psychological Disorders," *Voices: J. Am. Acad. Psychotherapists, 12,* 50-54, 1976.
32. McAllister, A. and Fernhoff, D., "Test on the Bias: An Experiential Assessment of Sex Bias in the Psychological Battery," *Division 35 Newsletter, American Psychological Association, 3(4),* 10-12, 1976.
33. Mehrabian, A., *Nonverbal Communication,* Chicago, Aldine-Atherton, 1972.
34. Miller, J. B. and Mothner, I., "Psychological Consequences of Sexual Inequality," *Am. J. Orthopsychiat., 41,* 767-775, 1971.
35. Millman, M., "Observations on Sex Role Research," *J. Marr. Fam., 33,* 772-775, 1971.
36. Minturn, L. and Lambert, W. W., *Mothers of Six Cultures, Antecedents of Child Rearing,* New York, Wiley, 1964.
37. Minuchin, S., *Families and Family Therapy,* Cambridge, Mass., Harvard University Press, 1974.
38. Nadelson, C. M., "Adjustment: New Approaches to Women's Mental Health," in M. L. McBee and K. A. Blake (Eds.), *The American Woman: Who Will She Be?,* Beverly Hills, Glencoe Press, 1974.
39. Orlinsky, D. E. and Howard, K. I., "The Effects of Sex of Therapist on the Therapeutic Experiences of Women," *Psychother.: Theo. Res. Pract., 13,* 82-88, 1976.
40. Parsons, T. and Bales, R. F., *Family, Socialization, and Interaction Process,* Glencoe, Ill., Free Press, 1955.
41. Peal, E., "'Normal' Sex Roles: An Historical Analysis," *Fam. Proc., 14,* 389-409, 1975.
42. Rawlings, E. I. and Carter, D. K., *Psychotherapy for Women,* Springfield, Ill., Thomas, 1977.
43. Rice, D. G. and Rice, J. K., "Non-Sexist 'Marital' Therapy," *J. Marr. Fam. Couns., 3,* 3-10, 1977.
44. Rosenthal, E. R., *Structural Patterns of Women's Occupational Choice,* Ph.D. dissertation, Cornell University, 1974.

45. Sachnoff, E., "Toward a Definition of Feminist Therapy," A *WP Newsletter,* Fall 1975, pp. 4-5.
46. Sager, C. J., *Marriage Contracts and Couple Therapy,* New York, Brunner/Mazel, 1976.
47. Smith, J. A., "For God's Sake, What Do Those Women Want?", *Personnel and Guidance J, 51,* 133-136, 1972.
48. Watzlawick, P., Weakland, J. H. and Fisch, R., *Change,* New York, Norton, 1974.
49. Zuk, G. R., "Family Therapy: Clinical Hodgepodge or Clinical Science?", *J. Marr. Fam. Couns., 2,* 229-304, 1972.

Reprint requests should be addressed to Rachel T. Hare-Mustin, Ph.D., Director of Community Counseling Program, Villanova University, Villanova, Pennsylvania 19085.

Resources for Feminist Family Therapy

1. Feminist Family Therapy video-which is somewhat long http://ctiv.alexanderstreet.com.mutex.gmu.edu/view/1779190/timecode/190/play/true

2. **Ch. 13 Feminist Approaches- 40 minutes**
   http://www.youtube.com/watch?v=kB6W3RhwM8c&feature=related Good general overview. This will help you realize that being a Social Worker and acting on Social Work values is the same as being a Feminist. Choice is involved, differentiation and connection, the ability to think for one's self and have beliefs that might not sit so comfortably on the same page, but that one acknowledges the struggle and the dichotomy and leaves room for the difference and the discourse. For instance being anti-abortion yet believing women and men have a right to fair and equal housing, pay, child care needs, etc. Feminism does not mean everyone is pro-abortion. It is understanding that we are all "pro-life", that words get co-opted; used for political reasons often connected to oppression, that the personal is political and one can believe both.

3. http://www.psychotherapynetworker.org/component/content/article/226-1993-may-june/957-ghosts-in-the-therapy-room Fabulous article please read this, it brings so many theories, therapies and concepts together, a great article to start the closing of our time and study together!