Feminist family therapy: a client based description

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Feminist family therapy: A client-based description

Fitzgerald, Ane Kvale, Ph.D.
Iowa State University, 1994

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INTRODUCTION

The purpose of this study is to discover how family therapy is experienced by the clients of feminist family therapists. A client-based description generates data from clients' stories, narratives and responses.

A qualitative method is used in the study. The format is a long interview based on McCracken (1988). This method of interviewing is semi-structured and has open-ended questions. The data generated will form a description of feminist family therapy.
Family therapy is a relatively new field in the world of individual and group mental health services. Within the discipline, there are subgroups or evolving disciplines that have even more innovation; feminist family therapy is one of them. This section will focus on the historical roots and theoretical dimensions of feminism. This background is part of the context where feminist family therapy finds its roots.

"Modern feminism, born of Enlightenment ideals of democracy and energized by American Reconstructionist passion, has existed in the United States since the 1850's" (Leupenitz, 1989, p. 4). Much of the current American feminist movement is based in the political changes that occurred in the 1960's and 1970's. Feminist theory can be described as distinctly about the world of women. Humm (1990) states, "Unique to feminist theory is its insistence on the inextricable link between theory and practice and between public and private [life]" (p. x). Feminism is a praxis theory. It is a theory that does not develop or exist only in the realm of ideas, discussion and debate. Beyond thinking, feminism is about practice and action.

Another hallmark of feminist theory is its roots in the experience of women. Humm (1990) continues that feminist theory will always be the topography of voices, anchored in the lives and experience of individual women. Because of the nature of the theory, it has developed an indigenously-produced tradition of some sophistication.
In *The Dictionary of Feminist Theory* (Humm, 1990), four principles are seen at the core of feminist theory. First, it is a theory fundamentally about women's experiences. Feminist theory, secondly, takes the principle of contextualization seriously. Third, the principle of diversity is incorporated. Active agency and accountability are the fourth principle. These principles are detailed one by one in this section.

Experience is considered a valid source of information and therefore relevant to feminist theory. Experience is often used as the litmus test for validating feminist theory. Questions like, "How does this relate to me or my sisters? Has anything like that happened to me or people I know?" are frequently cited (Lerner, 1993).

Storytelling is one way that the theory acknowledges experience. Often at the beginning of a feminist consciousness raising, spirituality, self-help or service organization meetings, members are encouraged to share stories pertaining to the topic. This method of introduction and exploration validates women's experience as a source of information and theory formation.

The second principle, contextualization, expands the principle of experience. By contextualization, feminists and other researchers are looking for the location or particularities out of which the experience arises. Contextualization has helped feminist theory develop an awareness of the connections between women, race and class (Cole, 1993, Davis, 1981). This type of awareness provides ways to distinguish differences in experience based upon sexual preference, marital status, life-cycle stages, educational background and a multitude of other kinds of distinctions in the human condition.
Contextualization has also made it possible for the theory to develop respect for the principle of diversity. Because the origins of one's experience are firmly planted in the specifics of a cultural setting, the theory acknowledges differences and the unique contributions they generate. Feminists have struggled with and have ultimately determined that diversity is an asset and no one particular group or experience has the complete answer or a more valid position in society than another group.

Respect for diversity is demonstrated among the different forms of feminism. Lesbians have a particular brand, as do Black women. Alice Walker (1983) wrote, "Womanist is to feminist as purple is to lavender." Walker's point is that feminism is experienced differently depending on one's race. Womanist is Black feminism.

Active agency and accountability is the fourth principle. This principle requires feminism to move issues from a private sphere to a public sphere and encourages a process of action as well as reflection. For a person to be actively engaged in feminism, the theory requires that one is also engaged in the process of changing the status quo. To reflect only on the sources of oppression and to recognize the limitations placed on women is not enough. From insight and knowledge of patriarchy, one must move to challenging and redirecting the forces that influence the system to remain the same. Thus, a principle of feminist theory is that feminists must engage in some avenue of action.

With an understanding of Humm's (1990) discussion of the four principles of feminist theory, this brings the discussion to an examination of the varieties of forms that exist within feminism. The following section details that feminism is not monolithic and can take several forms. What each group brings to the discussion is a consensus that a feminist framework is a "comprehensive analysis of the nature
Jaggar and Struhl (1978) have categorized feminism into four groups. Tong (1989) has introduced eight varieties of feminism. Each has its own understanding and theoretical base, which informs social analysis and how solutions will be developed. The discussion of the varieties of feminism will form the basis for the application of feminist therapy discussed later in this dissertation. In this section four Jaggar and Struhl categories will be discussed and two varieties that are unique to Tong's analysis will be reviewed.

The first group Jaggar and Struhl describe are Liberal Feminists. This group has its roots in 17th and 18th Century political theorists and philosophers. Equal rights, equal opportunity, and individual freedom are part of this tradition. Economic and legal restraints are at the center of this group's focus. Their work has been more in the public sphere than the private.

The second group are Socialist Feminists. They draw on the Marxist tradition and its analysis of the oppression of women. This perspective leans towards cultural determinism over biological determinism. In addition to understanding class analysis, this group of feminists would ask questions about the oppression of women across classes. Questions pertaining to reproduction are added to the questions on production. From this group connections are made between patriarchy and capitalism. This perspective alludes to the view that such paired systems, patriarchy and capitalism, reinforce men's ability to control women's labor.

Radical Feminists are considered the newest branch and the most current evolving framework of feminism. Radical feminists would see "oppression of
women as the fundamental oppression - i.e., that it has operated across time, across culture, across class- and that it is embedded in every aspect of life, including language, and is therefore the hardest form of oppression to eradicate" (Avis 1988, p. 25). In this framework, what is personally experienced is a reflection of the larger social structure. Finally, Radical Feminists assert that gender is a fundamental category of human existence.

The fourth group mentioned is Feminism and Women of Color. This group highlights the connections between sex, race and class. They are careful to note the particular situation of minority women and how it differs from that of white women (Jaggar & Struhl, 1978).

Existentialist Feminism, according to Tong (1989), finds its historical roots in the works of Simone De Beauvoir's (1953) *The Second Sex*. A simplistic understanding of De Beauvoir's work is that it is an application of Jean-Paul Sartre's (1956) *Being and Nothingness* to women's specific situations. A broader understanding is that De Beauvoir presents a theoretical source to "analyze and relentlessly question our situation as women in so many domains- literature, religion, politics, work, education, motherhood and sexuality" (p. 195). Ultimately, this branch of feminism has adopted the ontological and ethical claims of existentialism, and is aware that man has named himself the "Self" and woman the "Other."

Postmodern Feminism is similar to postmodernism in general, in that it does not assert there is one explanation for why women are oppressed and one series of steps that all women must take to achieve true liberation. This variety of feminism does not seek an overarching analysis and thus pushes the movement to always consider plurality, multiplicity and differences when analyzing women's
oppression. This movement has had strong links with French feminism. Perhaps the greatest contribution of this branch of feminism is its "offer to women the most fundamental liberation of all- freedom from oppressive thought " (Tong, 1989, p. 223) and the understanding that the meaning of feminism is ever changing.

Why Feminist Family Therapy is Needed

Charles Figley (1988) writes in the introduction of Women, Feminism and Family Therapy that a feminist application of psychotherapy calls into question the basic assumptions of the work of psychotherapy. Some of the assumptions include that men and women are not equal, that North America is basically patriarchal society and that "marriage is a political institution, which from the wedding day on, structurally limits the resources and choices of wives in comparison with their husbands" (Figley, 1988, p. 2). He asserts that therapists equipped with a more feminist-sensitive perspective and specific strategies for validating women's realities, interpretations and contributions, will be more sensitive human beings.

In a critique of traditional therapy, Williams (1976) suggests several reasons why feminist therapy evolved. Among female clients, there was an increase in the demand to experience support and guidance from a woman, rather than the traditionally male expert. Female clients were looking for therapists who had shared experiences and who did not have a stake in keeping them in passive, dependent or subservient roles. Female clients were also eager to work with a therapist who did not appeal to their sexual feelings in a provocative or seductive manner.

Hare-Mustin (1983) writes that traditional therapists have participated in "the turn of the screw," meaning that they have participated in the same culturally-
restrictive attitudes as others in society. Such attitudes denigrate and disadvantage women. Clinicians have asked women to accept and adjust to traditional roles and behaviors that have unhealthy consequences. Hare-Mustin continues describes the frequency of male therapists practicing while uninformed about women's nature and experience, and how they reinforce the ascendancy of the male in their clinical relationships.

Avis (1988, in Braverman ed.) writes about five sexist biases prevalent among family therapists. First, family therapists assume that remaining in a marriage would result in better adjustment for women. Second, family therapists demonstrate less interest and sensitivity to a woman's career than a man's. Third, family therapists traditionally perpetuate the belief that a child's problem and child rearing are primarily women's responsibility. Fourth, family therapists exhibit double standards regarding the wife's versus the husband's extramarital affairs. And finally, family therapists defer to the husband's needs over the wife's.

**Definition of Feminist Therapy**

"...There is no monolithic feminism, but rather various feminisms that have certain commonalties but also definite differences. Feminist counselors and therapists, therefore, may ascribe to these differing philosophies and thus approach the counseling process somewhat differently....Feminist counseling and therapy is distinguished more by its philosophical assumptions and consequent value orientations than by any unique set of techniques" (Enns and Hackett, 1990, p. 33). The Women's Project in Family Therapy philosophy is, "Feminist family
therapy is about a critique of power relationships that affect the structure, rules, and composition of family life" (Rutter, 1992, p. 4).

Given the diversity of feminism, a starting point for a definition can be succinctly given as: "feminism as it relates to family therapy is a recognition of women's historical and current subordination and inferior social position, an analysis of the forces that maintain it, a commitment to changing it and a vision for the future equality between men and women" (Avis, 1986).

Perhaps the greatest difference between feminist therapy and traditional therapies is the perspective. Like humanist therapy, the concern of feminist therapy is on the individual, not on societal conformity (Klein, 1976). In the new perspective, therapists scrutinize their own attitudes, values and therapeutic practices for obvious and subtle evidence of sexism. They espouse principles of feminism and actively incorporate them in the practice of therapy (Marecek, Kravetz, & Finn, 1979).

To clarify feminist therapy and the interaction between the therapist and the client, it is helpful to identify what qualities define a feminist therapist. A core of activities and assumptions may be used as indicators of feminist therapy. In the following section, a number of descriptions of feminist therapies' assumptions and practices are examined.

Braverman (1988) writes that feminism and family therapy have much to offer one another, and that they are not essentially incongruent. She continues that techniques of the major schools of family therapy lend themselves to solving clinical issues of women. The problem is not in the technique, but in the values of the therapist employing them and her or his sensitivities to the feminist perspective.
Braverman elaborates on seven considerations that are evident in a feminist-sensitive approach to treatment (1988, p. 8-9).

1. understanding the impact of a patriarchal system on both men and women, and acknowledging that the social and political contexts, as well as the family context, have significant influence on the problems of women.

2. recognizing the limitations of traditional theories of psychological development based on the male model of maturity.

3. familiarity with women's problem-solving processes which tend to focus on connection and relationship, rather than on logic abstraction, and rationality.

4. understanding that the "personal is political," that is: motherhood, child rearing, and marriage are not simply life-cycle events, but institutions that carry particular sociocultural legacies for women.

5. a sensitivity to biological effects of the female life cycle (including menstruation, adolescence, pregnancy, childbirth and menopause) on women's symptom presentation and interpersonal relationships.

6. understanding women's sexuality and sexual responsiveness so that confused and mistaken notions, such as the exclusivity of vaginal orgasm, are not perpetuated.

7. valuing women's relationships with each other as a special source of support, different from their relationships with men.

Braverman (1988) states that feminist family therapy is not gender blind in theory or practice and that it sees gender on par with generation in diagnosis and interventions. Feminist approaches avoid the bias of mother-blame and women-centered solutions (i.e. all family members are participants and co-creators in finding solutions). A functional family can take on a variety of forms and creative gender roles are actively sought.
Incorporating Williams' (1976) hypothesis would add several points to a definition of feminist therapy. First, such therapy would increase a client's sense of their own power, self-esteem and autonomy. Successful therapy would help a client seek financially rewarding and personally gratifying work. In sexual and love relationships, a woman is able to experience at least as much satisfaction as she is providing for her partner. Finally, a woman in feminist therapy is brought to awareness of victim behavior in which she participates and that keeps her unfulfilled and frustrated.

**Chronology of Feminism in Family Therapy Literature**

Feminist therapy did not emerge as a precisely-defined concept upon its discovery. Rather, it has evolved over the past twenty years with a variety of emphases and indicators that combine to form a cogent definition. This section traces the historical development of feminist therapy and elaborates on the central variables, dimensions and indicators as noted in the literature.

Hare-Mustin (1978) wrote that traditional intrapsychic models of human behavior fail to recognize the importance of social context as a determinant of behavior. Feminists began incorporating the notion that societally-prescribed sex roles and statuses for men and women place women in disadvantaged positions. Much of the focus of feminist therapy was helping individuals to develop appropriate roles uniquely derived for their specific situation rather than proceeding with stereotyped expectations. In this period the model of androgyny was incorporated into therapy.

Libow, Raskin and Caust (1982) discuss feminism's commitment to a critical rethinking of traditional sex roles. They link the outmoded roles to overall constraints of an oppressive social structure. Following this train of thinking, the
form that therapy takes is closely aligned to peer counseling collectives and consciousness raising groups. Some of the topics that are explored with clients include fostering assertiveness and encouraging flexibility in vocational, sexual and family choices.

Another development was that the relationship between the client and the therapist moves away from the traditional patient-expert pair to an egalitarian model in which the client asserts more control over the therapy process and relationship itself. One dimension of this change is modeled in the therapist's use of self to demystify the relationship through self-disclosure and modeling competency and instrumentality for the client. Much of the work during this time period moved away from a style of therapy that uses indirect suggestion and manipulation.

Expansion of the understanding of the symptom occurred. Libow, Raskin and Caust (1982) note and accept the use of linear thinking. For example, they believe there are causal events and antecedents to behavior. This theme is reflected in that symptoms are viewed as naturally occurring manifestations of oppression in a sexist society.

By 1984 the Women's Project, led by Betty Carter, Olga Silverstein and Marriane Walters, was beginning to solidify the internal movement of feminism within the family therapy field. Their work questioned the cherished concepts pertaining to the roles and functions in a family. They felt that much of the previous work done in the field was conducted in a social and political vacuum (Simon, 1984).

One indicator of Carter, Silverstein and Walters' feminist style of therapy was the view that the family should have space for two adults. Additionally, one
person's life should not be for the service of the other. The Women's Project became critical of the family as a mechanism to maintain patriarchy. They asserted that the inferior position of females in the conventional family places the male in the leadership role (Simon, 1984).

This political notion is elaborated by Riche (1984). She asserts there is no such thing as a value-free style of therapy. Here words like "victim" and "oppressor" become part of the analysis and labeling in therapy.

Layton (1984) questioned the training of family therapists. The field of family therapy was accused of having formal theories and training programs that are asexual at best and stereotyped at a minimum. The theories are viewed as not being helpful in employing gender distinctions therapeutically.

In 1985 Virginia Goldner made the dichotomization of social domains an issue in therapy. Her work points to the need to demystify the so-called realms of home and world and affective and instrumental tasks. She states, "The division of labor and the distribution of power in families are structured not only according to generational hierarchies but also around gendered spheres of influence that derive their legitimacy precisely because of the creation of a public/private dichotomy. To rely on a theory that neither confronts nor even acknowledges this reality is to operate in the realm of illusion" (Goldner, 1985, p. 43-44).

Goldner's work adds significantly to the field by its critical analysis of social structures and the role therapists play in challenging or maintaining the status quo. An example of her insight is her ability to name clinical paradoxes. For example;

"-Mom wants to be the medium through which Dad speaks, but he has nothing to say.

-Mom is supposed to be the medium through which Dad speaks, but she
disagrees with him.

-Dad, because he is male, is supposed to embody superior skills and judgement, but Mom is clearly more adept at most things.

-Dad does possess superior skills and judgement but he deactivates these capacities at home, because family life is 'Mom's concern' "(Goldner, 1985, p. 36).

Goldner's other work in this period has advanced the seriousness with which gender issues are taken into account. She has given clinicians ways to talk about gender issues through discussions of money, power, fairness and the ability to leave.

Harriet Goldhor Lerner is a practitioner of Bowen's Family Systems theory with a feminist point of view. In her work, she strives to bring the wider context into the generational understanding that systems tries to develop. Lerner states that "the personal is political...the problems clients bring to our consulting rooms are inextricably interwoven with women's prescribed de-selfed and subordinate status in the public sphere" (Lerner, 1985, p. 336-339). Examples of ways Lerner applies her feminism in therapy include: the therapist validates women's status as less valued and explores how this has affected the client's ways of relating; the therapist makes power issues explicit; discussions pertaining to equality of economic and domestic matters are addressed directly, while acknowledging that society does not always make responsibility easy or possible.

By the late 1980s there were several textbooks published on feminist therapy (Walters, Carter, Papp & Silverstein 1988, McGoldrick, Anderson, & Walsh, 1989). The tone of the writing moves from a defense of the field to an assumption that the reader is seeking to practice with gender sensitivity and philosophical orientation toward the equality of women.
Some of the general assumptions include the essential balance of power between a wife and husband. Adaptability is seen as a clue to a well-functioning family. Cohesion is viewed as necessary for a shared commitment to a relationship and its continuity. Communication patterns are both process and content conscious and problem solving skills are developed. A new development is the co-evolutionary life-cycle perspective. The perspective takes into account the needs of the individual and the partners simultaneously. It is expected that transitions will occur, some simultaneous and some separate. In order for continued growth in the relationship, renegotiating of the quid pro quo must happen at each transition.

In addition to textbooks, another sign of establishment of the field of feminism in family therapy is the publication of a journal solely devoted to the topic. In its first issue, The Journal of Feminist Family Therapy reported that feminism had moved beyond the mere cybernetic description of the marital interaction. Feminism looks for more than an elaborate description; it seeks the content (Ellman, Rampage, and Goodrich, 1989). Like the work in the mid-1970's, feminist therapy moving into the 1990's still utilizes gender-specific, culture-wide and culture-ratified issues in its analysis and therapeutic process.

By the late 1980s, feminist concepts gained a firmer foothold in the training programs and organizational hierarchies of the profession. The Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE) required feminist research to be part of the curriculum of marriage and family therapy training programs (Rutter, 1992). In 1986 Judith Myer Avis published her dissertation on training and supervision in feminist-informed family therapy. This was the first dissertation to address the topic of training and supervision from a feminist perspective.
Two research instruments pertaining to feminist family therapy were developed by faculty and students at Purdue University. Chaney and Piercy (1988) published "A Feminist Family Therapist Behavior Checklist." Black and Piercy (1991) published "A Feminist Family Therapy Scale." In the checklist, 39 behaviors of specific and concrete techniques currently practiced by feminist family therapists are identified. In the feminist family therapy scale research, therapists were given the opportunity to describe different ways they conceptualize gender, clients and the process of therapy.

The journal, Psychology of Women Quarterly, included an article by Laura Brown (1991) that addressed ethical issues in feminist therapy. Although, this journal is primarily targeted at a psychology audience, Brown makes three points that are relevant for family therapists. She states that feminist therapists must be aware of boundary overlap issues between therapist and client. Her work acknowledges role-related strains, frequently created because of the public advocacy roles in which a feminist is often engaged. Brown further elaborates that the feminist therapist may need to develop context-specific ethics.

The latest development in feminist family therapy literature has been the decision to examine issues from an international perspective. An important marker of this decision was the May, 1991, International Women's colloquium in Family Therapy held in Copenhagen (Carter, 1992). From this colloquium came the determination to "increase the participation of smaller, non-northern [sic] hemisphere countries in the international forums of family therapy. Oppressive processes had not only been silencing women in family therapy but also silencing people of smaller nations, indigenous people and minorities" (Hindmarsh, 1993).
Feminist therapy strives to bring the wider social context into the consulting room. It is clear that all therapy modes involve a political and value stance and feminist therapy is explicit in owning this fact. Feminist therapy states that its underlying assumption is that women are denied full participation in the creation of culture and systematically deprived of the freedom to determine their lives. Feminist therapy strives to challenge patriarchy, critique masculine assumptions and validate women's concerns, perspectives and interpretations. The epistemological premise of feminist family therapy is that, in all interactions between women and men, the woman is in the inferior position and the man in the superior position. This hierarchical arrangement is seen as destructive and that such inequality of power, influence and value is at the root of many, if not all, social problems.

**Research in Feminist Therapy**

This section reviews five research projects pertaining to feminist therapy. The first three studies can be logically clustered as studies pertaining to treatment populations. The first two examine the similarities and differences between clients of feminist and nonfeminist therapists and the third study examines the effectiveness of feminist therapy with a chronically disturbed population.

The second cluster of research articles pertains to client perceptions of feminist therapists. These studies are differentiated by their overt published announcement or overt spoken announcement of feminist values.

The Feminist Therapy Collective of Philadelphia, a psychotherapy center that integrates feminism into its practice, conducted an exploratory study that attempted to answer three questions, “(1) Do our clients resemble other women in
therapy in terms of complaints, problems and level of pretherapy distress? (2) Do our clients improve as much as women in other therapies? (3) What specific therapeutic factors do our clients find most helpful?" (Johnson, 1976, p.73).

Group psychotherapy is the primary mode of service at the center. Most client diagnoses are in the area of neurotic problems or character disorders. The average age of the clients is 27, half of them are single, with equal numbers of married and separated-divorced women. Seventy five percent of the clients stated that they would accept nothing else but feminist therapy.

This study compared Collective clients with a similar population in a University of Pennsylvania study. Both groups described similar problems when they began therapy, similar levels of distress at that time, similar post-therapy improvement and satisfaction with the therapy experience. The findings suggest that short-term group therapy in the Collective was as effective as clinic or private practice long-term therapy.

Clients at the Collective ranked the following three items as the most helpful aspects of their experience: seeing the therapist as a competent women; knowing that, as women, therapists have shared the female experience; and discovering that other women are central and helpful. Group cohesiveness and universality rated high. Re-enactment of family experiences within the group and viewing the therapist's relationship to the client as a model of a good relationship rated low in helpfulness.

Marecek, Kravetz and Finn (1979) compared 201 women in feminist therapy with 207 women in traditional therapy. The sample was drawn from a national survey of women in consciousness raising (CR) groups. Demographic characteristics, evaluation of therapy and political views were compared. The
research was conducted with a survey instrument that covered the following topic areas: 1) demographic information, 2) information on political views and involvement in the women's movement, 3) a measure of stressful life events, 4) a symptom checklist, and 5) information about the respondent's therapy experience.

The results showed there were very few demographic differences between the two groups. In the detailed analysis, traditional therapy attracted more women who had separated from their husbands in the year prior to therapy (n=66) than feminist therapy. Women entering feminist therapy were less likely to have children than women entering traditional therapy.

In describing their political views, women entering feminist therapy were more likely than women entering traditional therapy to describe their overall political views as radical. The results did not define "radical," but rather pointed toward self-identified members of the women's liberation movement. Active membership in a women's political organization was not predictive of which kind of therapy the women entered.

Overall, the differences on a 41-item stress index showed no significant difference between the two groups. When comparing married women, those entering feminist therapy had higher life stress scores than those entering traditional therapy. The comparison of pretherapy distress levels showed that the overall symptom rating was similar for each group. Hostility, depression, anxiety, obsessive-compulsive and somatic complaints were reported in both groups.

In the analysis of clients' therapy experiences, 72% of all respondents reported positive reactions to their therapy experience. Clients in feminist therapy reported more positive evaluation of their therapy experience than clients of traditional therapy. Feminists' clients reported therapy to be very helpful in 67% of
the cases, compared to 38% of traditional clients reporting their experience as being very helpful.

Marecek, Kravetz and Finn concluded that clients of traditional and feminist therapy differ mainly with regard to political attitudes. Movement members and radical women viewed traditional therapy much less favorably than other women. The results suggest that, among women, feminist therapy may be beneficial to a wider group of clients and that the range of fit for traditional therapy is smaller group of clients. An implication for practitioners is the importance of taking into account the political views of women when making referrals. A productive therapeutic alliance may be enhanced by referring certain clients to feminist therapists.

A possible limitation of this study is the homogeneity of the population in the consciousness raising groups. They consisted of 99% white women, 90% attended college, 45% had postgraduate training, most were middle and upper class, average age 33, range 25-44.

The effectiveness of feminist therapy with women in the chronically and profoundly disturbed population was assessed with 28 female clients enrolled in a partial hospitalization (Adult Day Treatment or ADT) program of a community mental health center (Alyn & Becker, 1984). Characteristics of this population include multiple psychiatric hospitalizations, a predominance of affective and schizophrenic diagnoses/disorders, and more severe behavioral and functional disruptions. Members of this population are also characterized by low self-esteem, learned helplessness, poor coping and lack of material support.

The study employed a form of the recurrent institutional cycle design, over a two year period, with four cycles of the Women's Awareness Group. "The recurrent
institutional design is described by Campbell and Stanley (1963) as a strategy for field research in which a given aspect of an institutional process is, on some cyclical schedule, continually being presented to a new group of respondents'(p. 57)". Clients were tested at three intervals. Sex role socialization, women's health issues, sexual awareness, and feminist music were interspersed in structured and nonstructured sessions.

The measurements used included the Tennessee Self Concept Scale (TSCS), Sex information Questionnaire (SIQ) and Attitudes Toward Women Scale (AWS). Participation in the group improved the TSCS and SIQ scores and showed no change in AWS score upon completion.

The research concludes that chronicity or severity of functional disturbance should not obscure the need to address socialization and conflictual cultural role issues. This study supports the application of feminist therapy to women in the chronically and profoundly disturbed population. Ultimately, self-esteem can be enhanced and options for more effective and productive adjustment can increase with participation in a feminist treatment mode.

A weakness of this study is that it did not have a control group. Without such a group, it is hard to compare how the scores might have changed for chronically disturbed women who participated in a typical ADT group. In addition, 50% of the subjects dropped out of the study between test 2 and test 3. The anecdotal remarks support that the majority of the drop-outs occurred when the subjects stabilized, became employed or discontinued treatment.

The last two studies to be examined in this section pertain to feminist values in the announcement of service and a comparison of women's reactions to variants in counseling. Investigation of potential clients' perceptions of traditional and
feminist therapist announcements of services was conducted by Schneider (1985). Fifty-two men and 52 women read one of four announcements and completed the Counselor Rating Form-Short (CFS-S) and a list of 20 problems. The four announcements conveyed differing amounts of information that reflected a traditional (T), a feminist (F), an explicit feminist (EF), and an explicit traditional (ET) therapists.

Significant interaction for the CRF-S trustworthiness dimension and main effects for announcements on three problems emerged. Subjects expressed considerable confidence in the feminist therapist but little confidence in the explicit feminist therapist. In addition, they expressed less confidence in the helpfulness of the EF therapist for marital and parental problems but greatest confidence in the EF therapist for career difficulties.

The study may have limited application because it was conducted with college women and men enrolled in a psychology course. The authors concluded that saying less may be more helpful in advertising and that other factors, not tested in this study, may be more influential in the selection of a therapist.

Enns and Hackett's 1990 study was concerned with client-counselor matching along the dimension of attitudes toward feminism. Their subject pool consisted of 150 college women. The students viewed 12 videotaped counseling vignettes that were varied by the feminist orientation of the counselor and the explicitness of the counselor's value statement. The comparison used a methodology that presented videotaped vignettes portraying second session contact with a two minute leader tape that described the therapist's orientation.

The study used a 3 x 2 x 2 factorial design: Orientation of counselor (nonsexist-humanistic, liberal feminist, or radical feminist) x Statement of values
The results show that the students recognizing the behavioral and political differences of the three counselors. Feminist and nonfeminist students alike indicated a greater degree of willingness to see the feminist counselors than nonsexist counselors for career and sexual assault-harassment concerns; no preference across counselors was observed for personal-interpersonal concerns. All counselors were perceived as equally attractive. The feminist counselors were viewed as more trustworthy than the nonsexist counselor. The findings suggest that there is a decided advantage to the counselor in overtly and specifically outlining her orientation. The presentation of values within the counseling relationship, rather than by written announcement or description, may account for the difference in the results from this study and previous research (Schneider, 1985).

Overall the studies indicate that feminist therapy does have an appropriate and useful place in the treatment of problems. The populations served by traditional therapies do not appear to differ greatly from the populations served by feminist therapies. The studies also indicate the widespread acceptance of feminist principles and how direct and explicit communication of feminist values in therapy announcements and verbal explanation of treatment procedures can enhance the perception of the therapist. In addition, a strong case can be made for
matching feminist clients with feminist therapists to generate the highest level of consumer satisfaction for the client.

**Research in Client Experiences in Family Therapy**

Garfield (1978) has written a comprehensive survey of research pertaining to client variables in psychotherapy. In his chapter, he covers studies on client variables for acceptance of treatment, continuation in therapy and outcome. Repeatedly he notes conceptual and methodological problems that make research and the drawing out of conclusions rather difficult. He suggests that "more comprehensive, carefully planned, large-scale and coordinated research efforts will be required in the future. A host of idiosyncratic studies of poorly defined populations with vaguely described therapies and exceedingly variable outcome criteria will not produce findings of any substance" (p.225).

Garfield's chapter reaffirms that most research on therapy is based upon the therapist's rather than the client's experience. Highlighted below are some findings, limited as they may be, that are of interest when examining the description that clients of feminist therapists provide.

Two studies (Cole, Branch & Allison, 1962, Dodd, 1970) point to the large number of persons who are offered psychotherapy and turn down the opportunity, and a related problem, the number of persons who terminate their participation and drop out of therapy relatively early. In both of these populations there appears to be a high correlation between the drop-out rate and the socioeconomic status of the client. In one study (Imber, Nash & Stone, 1955), only 57.1% of lower class patients stayed beyond the fourth interview, whereas 88.9% of middle class patients went beyond the fourth interview. The Hollingshead instrument and
occupational status were used as measures of social class. Interestingly, no note was made in Garfield's chapter about why this correlation might occur; difficulties with transportation, child care, employment conflicts and service hours or class background of therapists were not addressed.

Other demographic variables that do not appear to be significant are age and gender of client. The variable of sex does not show significant differences in premature termination. Likewise, age does not predict early termination.

The article continues with studies that try to correlate clients' participation with scores on various assessment tools. Rorschach, IQ and MMPI scores do not appear to have significant predictive value in therapy participation (Auld & Eron, 1953, Roger, Knauss & Hammond, 1951, Sullivan, Miller & Smelser, 1958, Whitely & Blaine, 1967). Few of the studies conducted pre- and post-therapy testing; most studies administered the tests just once. This methodology does not allow the reviewer to examine any change in score.

In addition to Garfield's summary, this section reviews two studies on client-based descriptions of family therapy. Both studies will be described methodologically, results will be given and a brief analysis of the research by the author will be offered.

"A Mini Ethnography of Family Therapy of Adolescent Drug Abuse: The Ambiguous Experience" (Newfield, Kuehl, Joanning & Quinn, 1990) describes clients' perceptions of the family therapy experience. The ethnographic interviews were conducted as part of a four year National Institute on Drug Abuse outcome study testing the effectiveness of structural/strategic therapy, family drug education and traditional group psychotherapy in the treatment of adolescent drug abuse. The focus of the ethnography was on family members who participated in the
therapy protocol. "...This study is limited to a discussion of the clients' [sic] construction of the therapy experience around focused domains of inquiry" (p. 61).

The interviews were conducted in the clients' homes. Interviews generally lasted 90 minutes and most families were interviewed twice. The sample was opportunistic. Interviews were transcribed and analyzed according to Spradley's (1979) Developmental Research Sequence.

Four primary domains emerged from the analysis. They include 1. expectations of therapy, 2. types of psychos and shrinks, [verbatim from study] 3. the setting, and 4. individual versus family therapy.

Results from this study that are important to keep in mind when analyzing feminist family therapy data include: adult and adolescent clients generally expected therapy to be a somber experience, and parents expected they were going to get clear answers and quick results from the therapist. What was experienced was a therapist who asked questions and looked to the family for answers. "Counselor" was the most frequently cited term for the professional. There were elaborate descriptions pertaining to different helping professionals and dimensions of their expertise. The dimensions included; caring, life experience, technical expertise in counseling, the ability to address serious problems and the capacity to dispense medication. The qualities of each dimension varied according to the profession and clients self-referred themselves based upon their associated need.

The authors conclude that family therapy might be thought of as an ambiguous experience. "...This study suggests that the definitions held by clients can be at considerable variance with those held by different disciplines, and these
differences may not become issues until well into the therapy experience” (Newfield et al., 1990, p. 74).

“A Client-Based Description of Family therapy” (Kuehl, Newfield & Joanning, 1990) describes what 37 individuals from 12 families had to say about their experience in family therapy. Ethnographic interview methodology was employed. This study differs from previous research because it uses clients as informants rather than therapists as informants.

The research was conducted with families in the Lubbock, Texas, area who had completed family therapy for adolescent drug abuse. Families in the study had completed an average of ten therapy sessions, with a range of 6-13. The final session had been 51/2 months prior to the first interview. Most families were interviewed twice.

The interviews were conducted in the client's home. The texts were analyzed according to Spradley's (1979) Developmental Research Sequence. A significant factor for comparison sake, with the goal of the feminist family therapy research, is that all of the families in this study had received therapy from male therapists. The extent to which this factor influenced the results of the study is not addressed by the authors.

This study provides an excellent synopsis of the therapeutic process, which is broken down into six steps. The following section will highlight results from these steps. The introductory meeting was described by clients as the point where the task was to learn what counseling was going to consist of. Clients were surprised by the number of forms to fill out and the use of intake staff that did not actually turn out to be their assigned therapist.
Phase two was assessment. Clients described this as the "getting to know you and draw you out" phase. Adolescents revealed feeling scared and parents revealed feeling relieved by sharing the burden.

Phase three was described as "getting down to basics and generating suggestions." Clients described this phase as the most emotionally intense and time-consuming phase of the therapeutic process. Therapists were seen as "drawing answers out" of the family, and "getting down to the cause of the problem." Clients stated they preferred a therapist who offered "suggestions" and "alternatives" rather than "trying to tell us what to do."

Putting suggestions into practice was phase four. Results indicated that when a family perceived the therapist was "just doing a job" or "did not really care" they were less likely to put a suggestion into practice. Adolescents reported becoming more active in this phase. "Bullshitting," an informant term, became more pronounced as parents tried to follow through with suggestions.

Sharing successes with the counselor is the fifth phase. Therapists move toward being "more of a confidant and friend" and "less of an authority figure" in the minds of the clients during this phase. Not all families got to phase five. If they did, parents reported feeling more confident and stronger.

The final stage was troubleshooting and follow-up. Offering suggestions for the future and generating possible courses of action were the primary tasks. This phase was relatively short.

In the discussion section, the authors note clues clients give about the therapy process. Caring and understanding and the ability to generate relevant suggestions were the most frequently cited characteristics of therapists. The most satisfied clients experienced all of these qualities in their therapy. Clients who did
not complete therapy, and stated they were satisfied with their experience reported the therapist to be caring, but not able to generate solutions. Dissatisfied clients stated the therapist did not understand them and therefore could not generate relevant suggestions.

The authors conclude that therapists who were viewed as personable, caring and competent were more likely to have satisfied clients. They suggest that, at times, it may be the therapist who is resistant to generating new ways of convincing clients to change. With a more cautious approach in suggesting change and greater tenacity, a therapist may increase her or his ability to influence change in a family.

**Conclusions from the Literature Review**

In this chapter the following topics were outlined; feminist theory and feminism, why feminist therapy is needed, a definition of feminist family therapy, chronology of feminism in family therapy literature and research in feminist therapy and client experiences in family therapy. This concluding section pulls together five arguments for continued research in feminist family therapy and sets the stage for a long-interview format that examines clients' experiences in feminist family therapy.

In the discussion of their findings, Marecek, Kravetz and Finn (1979) state, "...Despite the increasing interest in feminist therapy, little research has focused on the feminist approach" (p. 735). They continue, "Overall, clients of feminist therapists reported their therapy to be more helpful than clients of traditional therapists did" (p. 740). They expand by saying, "We need to investigate the nature of feminist therapy - its values, knowledge base, interventions and outcomes...."
With this knowledge, we might understand better its feminist therapy value for certain clients" (p. 741).

Gilbert (1980) uses the analogy that a comparison between feminist and traditional therapy is like comparing apples and oranges. She elaborates "...it is argued that research efforts should focus on what happens in feminist therapy, what client and therapist variables are important to what does or does not happen, and what positive and enduring effects result from feminist therapy" (p. 246). She suggests that the ideal method for investigating feminist therapy would be to observe the therapy, describe it in a systematic way and draw conclusions. She then notes that the problems with doing this kind of research are enormous.

Enns' and Hackett's (1990) research is described in their article "Comparison of Feminist and Nonfeminist Women's Reactions to Variants of Nonsexist and Feminist Counseling." In their conclusion they recommend five directions for future research on feminist approaches. Their first point is (a) focus on more naturalistic investigations of client's reactions to feminist counselors. Their final point in the article is "...one of the most crucial areas, we believe, is to continue efforts to articulate the philosophical underpinnings of feminist approaches while also beginning to examine what self labeled feminist counselors and therapists actually do in counseling" (Enns and Hackett, 1990, p. 40).

Mustin writes "Clinical analogues have failed to produce impressive evidence of sex bias, whereas naturalistic studies have produced supporting data...More sophisticated research designs are needed to deal with the complex factors in evaluating [feminist] therapy" (Mustin, 1983, p. 595). Chaney and Piercy observe in their conclusion that very little research has been conducted on the integration of feminism into family therapy (1988, p. 315).
This study examines how current feminist family therapy theory is being integrated into family therapy. To access this information, clients of feminist family therapists will participate in a long-interview method. The use of a long-interview method provides clients with a forum to talk about their experience in therapy in a broad manner. This addresses the nature of feminist therapy (Marecek, Kravetz and Finn, 1979) and the research need for clients to describe what happens in therapy and what variables they state as important (Gilbert, 1980). The format provides for the naturalistic setting which can provide some unique client reaction (Enns & Hackett, 1990). Thus the use of clients as the primary informants and the naturalistic method of a long interview combine to generate new data on feminist family therapy.
METHODOLOGY FOR LONG INTERVIEWS WITH
CLIENTS OF FEMINIST THERAPISTS

This chapter describes the research methods and decisions made in conducting the study. The chapter begins with a brief description of qualitative methods, qualitative methods and feminist research and the suitability of the method for the topic under study. The remaining sections of the chapter can be divided into the procedures of conducting the study and the methods of analysis.

In the procedures section there are descriptions of the long interview process, the interviewer as a research instrument, participating therapists, accessing participating clients, description of clients and the interview protocol. The analysis section details the process under the following headings, data analysis and the research cycle, elements of trustworthiness and progressive subjectivity.

Qualitative Methodology

Qualitative research looks for patterns of interrelationships between many categories rather than sharply delineated relationships between a limited set of categories. Qualitative methods are used because of their ability to capture complexity. Data that are broad and difficult to retrieve through a closed ended format is best researched qualitatively (McCracken, 1988).

Qualitative methods do not look for findings that are generalizable to a larger population (Moon, 1990). Rather, qualitative methods try to gain access to cultural categories and assumptions on how one culture construes the world. In other words, the research objective is to ascertain the categories, relationships and
assumptions that inform the respondent's view of the world in general and the topic in particular. Strauss and Corbin (1990) name this phenomenon of qualitative research the "representativeness of concepts." The purpose of qualitative methods is to specify the conditions under which particular phenomena exist, the action and interaction that pertains to them and the associated outcomes or consequences. The focus of the research is not to generalize, but to specify.

Aesthetically one can describe qualitative research as picture painting. Bodgan and Bilken state, "You are not putting together a puzzle you already know. You are constructing a picture which takes shape as you collect and examine the parts" (1982, p. 20). Another way to describe qualitative research is that it is an inductive methodology. Stainbeck and Stainbeck (1991) state it is the kind of research that begins through immersion and observing experiences rather than testing and measurement of discrete aspects. Glaser and Strauss (1967) propose that the discovery of substantive theory is the formulation of concepts and their interrelation into a set of hypotheses for a given substantive area based on research in the area.

Guba (1981) details the difference between scientific and naturalistic inquiry by specifying how the four aspects of trustworthiness are approached differently. Both methods have criteria to measure the rigor or adequacy of research. Naturalistic inquiry looks for credibility, transferability, dependability and confirmability as aspects of trustworthiness (see Table 1).

The first aspect is credibility. Credibility is ascertained by the degree of correspondence between the data of inquiry and the phenomena those data represent. "Preserving the holistic situation" (Guba, 1981, p. 84) is the desired goal
of credibility. Prolonged engagement, peer debriefing, persistent observation, triangulation, member checks and establishing structural corroboration are methods of achieving credibility.

The second aspect is transferability. "Naturalists eschew generalizations on the grounds that virtually all social/behavioral phenomena are context bound. It is not possible, they believe, to develop 'truth' statements that have general applicability; rather, one must be content with statements descriptive or interpretative of a given context-idiographic or context-relevant statements" (Guba, 1981, p. 86). Purposive sampling, descriptive data and developing thick descriptions are avenues for addressing transferability.

<table>
<thead>
<tr>
<th>Aspect</th>
<th>Scientific Term</th>
<th>Naturalistic Term</th>
</tr>
</thead>
<tbody>
<tr>
<td>Truth Value</td>
<td>Internal Validity</td>
<td>Credibility</td>
</tr>
<tr>
<td>Applicability</td>
<td>External Validity</td>
<td>Transferability</td>
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<td></td>
<td>Generalizability</td>
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<tr>
<td>Consistency</td>
<td>Reliability</td>
<td>Dependability</td>
</tr>
<tr>
<td>Neutrality</td>
<td>Objectivity</td>
<td>Confirmability</td>
</tr>
</tbody>
</table>

(Guba, 1981)

Dependability is the third aspect of trustworthiness. In this aspect, "naturalists are concerned with the stability of the data, but must make allowances for apparent instabilities arising either because different realities are being tapped
or because instrumental shifts stemming from developing insights on the part of the investigator-as-instrument" (Guba, 1981, p. 86). Establishing an audit trail and arranging for a dependability audit are two ways to address this aspect of trustworthiness.

Confirmability is the fourth aspect of trustworthiness. Naturalistic inquiry shifts "away from the concept of investigator objectivity toward the concept of data (and interpretational) confirmability" (Guba, 1981, p. 87). Triangulation and practicing reflexivity are two steps to meet confirmability. How the aspects of trustworthiness were handled in this study is described in the section labeled elements of trustworthiness.

**Qualitative Methodology, Feminist Research and the Family Therapist**

"The fundamental principle in qualitative interviewing is to provide a framework within which respondents can express their own understanding in their own terms" (Patton, 1980 p. 205). Devault (1990) suggests that traditional research frequently uses language that is incongruent with the realities of women's experiences and thus a qualitative approach provides a methodological strategy to capture experiences that are difficult to articulate. Attention to language is important as the essential research activity is fundamentally grounded in talk. Thus, a qualitative strategy that uses an interview approach is well suited, in both content and process, to gather data on female clients of feminist family therapists.

The choice of a long interview design allows the researcher to formulate questions that give space for complex, multidimensional responses. It also allows
the respondent to refuse any assumptions in the questions, clarify or reframe them in a way that fits their world view. Through the use of this type of qualitative methodology, the researcher is able to ask specific questions of the respondents, but they, in turn, are able to detail and highlight other important aspects of their experience that the researcher may not have accessed through a more closed ended research process.

**The Long Interview Process: Emergent Design**

The methodology for this dissertation is modeled on McCracken's *The Long Interview* (1988). This methodology is related to similar ethnographic styles of research that are commonly employed in other social science traditions, like anthropology and education. The rationale for this methodology is succinctly put by McCracken,

> It is precisely because the qualitative researchers are working in their own culture that they can make the long interview do such powerful work. It is by drawing on their understanding of how they themselves see and experience the world that they can supplement and interpret the data they generate in the long interview.

... The long interview presented here is deliberately designed to take advantage of the opportunity for insight and minimize the dangers of familiarity. (McCracken, 1988, pp. 11-12)

Some of the key issues to observe in this methodology include developing the questionnaire, the researcher as a research instrument, balancing obtrusiveness with unobtrusiveness, and manufacturing distance. What these issues are and how they were handled in this study is described below.
In constructing the questionnaire, McCracken highlights the need to use both analytical and cultural categories. The analytical categories are those already documented in previous research and found in the literature review. Cultural categories are those drawn from the researcher's experience, observation and intuition. This combination allows the process to synthesize previous work and use the researcher as an instrument of inquiry.

Information from the literature review was incorporated in the development of the interview protocol. Particular attention was given to the feminist family therapy literature in journal articles and recent text books. To address the cultural categories, the researcher's experience as a trainee at the Family Therapy Clinic at Iowa State University, and observation and supervision of other trainees in the program were incorporated into the protocol. The protocol was read and edited by three committee members. Editing was done to improve the questions, avoid ambiguity and align the protocol with the research goals. The questionnaire was tested with one person. No changes were made after the test because the protocol was assessed positively by the informant for clarity and comfort with questions and the data generated were appropriate for the research goals.

Bodgan and Bilken (1982) describe qualitative methodology as evolving and flexible. Because the researcher-respondent relationship is critical to the data gathering process, the researcher must establish rapport with the respondents (Stainback & Stainback, 1988). As Hogan states in her thesis, "Conveying to respondents that all viewpoints are valuable paves the way for new viewpoints or themes to emerge. The flexible design of a qualitative study allows the researcher to pursue new themes that emerge. Input from respondents guides further inquiry."
These citations are similar to those from McCracken and point to the critical role the researcher plays.

Obtrusive/unobtrusive balance and manufacturing distance describe what occurs during the interview. These issues help insure that the informants can tell their story in her or his own words, yet allow the interviewer to have some control over the interview. The obtrusive/unobtrusive balance is the style of interviewing that prevents the interviewer from interpreting the informant's comments and organizing the thoughts in the researcher's own logic prior to the conclusion of the interview. In this methodology the researcher must constantly work at not directing the informant's thoughts or responses, yet manage the conversation so that the data do not become extraordinarily abundant. Manufacturing distance is the issue that helps the researcher address categories and assumptions the researcher may have previously held. By manufacturing distance through well-worded questions and the use of prompts, the investigator may be able to see familiar data in unfamiliar ways.

The long interview provides the respondent a way to engage in an unusual form of sociality. In some ways the interviewer is the "perfect conversationalist partner" (McCracken, 1988, p. 28). Such a partner makes the respondent the center of another's attention. With the informant at the center of the conversation, her or his description, perspectives and ideas are welcome, invited and form the data base.

**Interviewer as Instrument**

In qualitative research, the investigator must draw on her or his own experience, imagination and intellect. To gather data-rich testimony, the
investigator must listen with a combination of respect and prying, hearing what is both new news and anticipated news with equal interest. "Entertaining the respondents' assertions as unexceptional truths is the most demanding but also the most rewarding of the objectives of the self-as-instrument technique" (McCracken, 1988, p. 20). This interviewing skill requires allowing the respondent to tell her or his own story, in her or his own terms. It requires a balance of nondirection and yet control over the interview to develop conversation in the desired areas. This skill is different from active listening (Eagan, 1975). Thus the skill, style, experience and sensitivity of the researcher become integral factors in what data are generated from the interview.

The investigator comes to this project with experience in qualitative research as a graduate assistant on Joanning, Brotheron and McBride's (1992) research on the Individualized Family Service Plan State Contract, as a consultant to Sarah Hogan's qualitative thesis on Parent-Child Care Provider Relations and as the Project Director for Legal Services of Iowa, Employee Relations Ethnographic Study. She is a student member of the American Association of Marriage and Family Therapy. In addition, she has been active in various feminist and women's organizations over the past fifteen years. The researcher is 33, Caucasian and was raised in a suburban community in Minnesota.

The following is a personal reflection on the process of the investigator as a research instrument. The paragraph summarizes the two aspects of the research that influenced me the most as a person and professional.

In the process of conducting the interviews the investigator was impressed with and touched by the powerful stories of change, courage and determination that the clients told. The reports of the experiences, trauma and difficulties the
clients encountered prior to and during therapy moved the investigator to appreciate the persons and process of therapy even more deeply than she previously did. The investigator felt privileged to learn from the clients what aspects of therapy were helpful, positive and needing change. Overall the impression of the participating therapists was one of high esteem and regard. Hearing the details of how they conducted therapy has taught the investigator how to be a better therapist.

**Participating Therapists**

The participants in this study were female clients of feminist family therapists. Family therapy was defined as a therapist being a member of the American Association of Family Therapists (AAMFT). Feminist therapy was defined by Judith Myers Avis's definition (see page 8 in the previous text). In the research proposal the gender of the therapist was not specified. As the research progressed the researcher and two committee members decided that it would be helpful to specify the participants further by limiting the clients to only those of female therapists. This was done to create continuity among the participants.

In seeking therapists to participate in the study, therapists needed to qualify on two criteria. First, they had to be known by colleagues as practicing from a feminist perspective and, second, they had to identify themselves as feminist therapists. (See Appendice A. & B.)

The colleague referral criterion was achieved by asking university staff in an employee assistance program at Iowa State University and Marriage and Family Therapy faculty at Iowa State University, the University of Minnesota and Purdue University to give the researcher names of family therapists who worked from a
feminist paradigm. The original plan was to seek participants from four therapy practices. After the first round of contacts through the universities were made, enough therapist names were generated that the Indiana contacts were dropped from the study. When the initial list was prepared, the therapists were contacted by telephone to ascertain their interest in participation and if they identified themselves as feminist therapists.

For future researchers attempting a similar protocol, the following barrier is noted. In the process of seeking participating therapists, two therapists names on the initial contact list refused to join the study. One therapist had her business in a family practice medical clinic and felt the risk of exposing the confidential patient-professional relationship was too great to allow participation in the study. The second therapist rejected participation saying she was already too busy professionally to get involved and did not have the time to participate.

Gilbert (1980) notes that complications in identifying feminist therapists occur, but that "Self-identification is the most direct approach to determining who is a feminist therapist. Alternatively, identification could be based on therapist's attitudes toward the roles, attributes and behavior of women and men; membership in feminist organizations or consciousness raising groups; and awareness and/or participation in feminist issues" (p. 245).

The accuracy of self-identification of feminist family therapy was confirmed in the 1988 Chaney and Piercy study that developed "A Feminist Family Therapist Behavior Checklist." They found a statistically significant difference among the three groups studied (feminist, unsure and not-feminist) with self-identified feminist therapists performing a higher mean number of checklist behaviors (p. 311).
The Feminist Family Therapy Scale (Black & Piercy, 1991) is a seventeen-item psychometric instrument that reflects the degree to which family therapists conceptualize the process of family therapy from a feminist-informed perspective. The potential range for scores with this instrument is 17-85. High scores indicate a feminist-informed conceptualization. Low scores indicate a more traditional conceptualization. The normal distribution of scores is 40-85. The scale was filled out by the participating therapists. They scored 56, 71, 73, 74 and 82 as individuals and had a mean score of 71.2 as a group. In addition, each therapist filled out a demographic form (see Appendix). This form outlined the type of practice conducted by the therapist, education, years in practice and additional training or focus of work. (See Appendix C.)

Five therapists were selected for the final group of participating professionals. One therapist worked for a private agency, one worked for a United Way agency, and three professionals were in private practice. All five were clinical members of AAMFT and two were supervisory members. The years of practicing as a marriage and family therapist ranged from eight to twenty-one. In addition to practicing from a feminist paradigm, the therapists reported employing other kinds paradigms including; Bowenian, solution-focused, Ericksonian, developmental processes, Jungian analytical psychology and structural-strategic therapy. The location of the practices were in Ames, Des Moines, Minneapolis, and St. Paul. All of the therapists were Caucasian.

Procedure to Access Client Participants

Each participating therapist was sent twelve informant packets. The informant packet contained a cover letter describing the research project, a
demographic response form that inquired about the client, the nature of therapy, initial contact information for the interview process and a self-addressed, stamped envelope to the researcher's home (see Appendix). The therapists were asked to give the packets to the first twelve clients that would accept them. A total of sixty packets were distributed. This method of contact ensured the confidentiality of the client-therapist relationship until the researcher received the form.

Although there is no way to account for the difference between the clients who mailed the response form and those who clients did not, eight respondents were chosen from a pool of eleven response forms. Decisions pertaining to the selection are described under the client participation heading.

After two months into the study, one of the therapists decided to withdraw, as she had passed out nine forms and none of her clients had mailed them to the researcher. The therapist contacted her clients and discovered one had moved to the west coast, one was recently hospitalized and a third client's parent had recently died. The therapist's practice was focused on work with the recovery and survivor issues of victims of sexual abuse. The therapist felt that her clients were particularly reluctant to participate because of the sensitive nature of their therapy and a fear of being exposed in an unsafe or unfamiliar setting. Thus, she hypothesized that the clients' histories of vulnerability made them less inclined to participate in the study.

**Description of Client Participants**

The participants volunteered for the study. From this pool, clients were purposively sampled (Bogdan & Bilken, 1982; Guba, 1981; Guba & Lincoln, 1982). The goal of the criterion based sampling is to create as wide a scope of information
with the fewest number of participants. Diversity in the following dimensions was sought in the participants: age, race, education, occupation, type of therapy and presenting problem. Respondents were sought who had no special knowledge of the topic under study. Eight interviews was seen as the optimum number of interviews based on McCracken's (1988) long interview methodology.

The participants ages ranged from 25 to 48 years (see Table 2). Three were currently married, two separated, two never married and one divorced. The level of education attained ranged from a high school diploma to a doctorate degree. All of the women were Caucasian. Their occupations included two homemakers, a graduate student, computer specialist, biologist, anthropologist, editor and school guidance counselor. Three of the women were childless, five were mothers of either one or two children. All eight of the clients described themselves as feminists. One client said she considered herself a radical feminist. (See Appendix D.)

**Interview Protocol**

The long interview is both conversational and specific in style. The format is conversational in that it is introduced as "tell me your story as if you were telling it to a friend." The interviewer works to establish a rapport with the respondent that encourages an openness to expressing all opinions and views pertinent to the topic. The interviewer seeks responses to specific questions; if the respondent gives information that is vague or would be particularly useful to have elaborated upon, verbal probes are used to encourage more of a response.
Table 2: Participants in the study

<table>
<thead>
<tr>
<th>Age</th>
<th>Number of Sessions</th>
<th>Type</th>
<th>Presenting Problem</th>
<th>Marital Status</th>
<th>Education</th>
<th>Occupation</th>
</tr>
</thead>
<tbody>
<tr>
<td>25</td>
<td>264</td>
<td>I</td>
<td>sex abuse</td>
<td>S</td>
<td>BA+</td>
<td>student</td>
</tr>
<tr>
<td>38</td>
<td>23</td>
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Key  I: individual, C: couple, S: single, M: married, D: divorced, Sep: separated

The place where the interview was conducted was based on the preference of the respondent. Each person was asked whether she preferred to have the interview conducted in her home or at an office location. Six interviews were conducted in homes and two in office locations. The location option was given to
help the respondent feel comfortable, relaxed and secure in the interview process (Stainbeck & Stainbeck, 1989). (See Appendix G.)

At the beginning of each interview, an informed consent statement was read to the participant, the opportunity to ask questions was given and the participant signed the consent form. (See Appendix F.) All interviews were conducted under the guidelines approved by Iowa State University under the Review of Research Involving Human Subjects Committee. The interviews were audio taped and transcribed verbatim.

Over the course of the interviews, the protocol remained the same. The greatest variance was the degree to which the researcher used prompts and probes and how verbal the client was. A comparison of the development of the data could be achieved by examining the full transcripts of all the interviews, with special attention paid to the interviewer's comments.

The protocol used was influenced by McCracken's (1988) outline and the guidelines suggested in Stainbeck and Stainbeck (1989). Factors not previously noted include the interviewer's attempt to respond in unbiased ways to the participant, to be flexible in the interview and use recursive language or the informant's phrases to help clarify the responses given.

The Research Cycle

The process of data analysis is circular with data gathering. A diagram of the process is presented in figure 1. This model is based on the Developmental Research Sequence proposed by Spradley (1980).
In a circular process, the researcher is able to develop a grounded theory that is derived from the data then illustrated by characteristic examples of data. Glaser and Strauss (1967) describe the joint collection, coding and analysis of data as the underlying operation of the development of grounded theory. They state, "The generation of theory, coupled with the notion of theory as process, requires that all three operations be done together as much as possible. They should blur and intertwine continually, from the beginning of an investigation to its end" (Glaser & Strauss, 1967, p. 43).

The research approach is phenomenological. According to Spradley (1980) the first step attempts to uncover the structure of the experience. This stage is characterized by scrutinizing the respondent's report and uncovering its meaning. Construction of analytic categories that emerge from the themes identified in the first stage of analysis is the second step. Third, descriptions of the relationships among the various categories are developed. The intention here is to identify the "patterns" or "structure" of the experience.

The first round of the research cycle consisted of conducting the pilot interview, making field notes, transcribing the audio tape and reading the data.
From this initial round, the data generated were sufficient to merit keeping the original interview protocol for subsequent interviews.

The second round in the research cycle involved conducting seven additional interviews and categorizing responses to the research questions. Categorizing was achieved by creating new files on a computer and placing all the responses from a particular question into the file. In order to create the files, answers were culled directly from the responses to the questions. Next, additional information that pertained to the topic, but was described in a different location, was also included in the categories. Selection for data that was moved was based on obvious clues to the topic, such as: use of the same words, an answer given to another question that described another phenomenon. Often these remarks were moved from second hand comments given by the respondent, or from a wandering remark that fit a previous topic discussed later in the interview.

Once the initial files were created, a second reader read them to highlight statements she felt were either of interest, importance or showed some insight. The section on trustworthiness describes this process in more detail.

The researcher then began to look for themes that emerged from each category set. Repeated topics, similar stories or experiences, unique or opposite patterns were all noted. After this early phase, narrative sections were written to describe each theme and the analytical and cultural categories (McCracken, 1988) were examined.

The data were then set aside for three months. Two members of the committee read the themes and provided feedback. The feedback involved questioning the construction of themes and asking for data that supported them.
In the second round of working out the themes, the topics emerged with greater clarity and the characteristics naturally built domains and themes. Again, repetition, similarity, contrast, expected and unexpected data, familiarity and freshness were used as clues in developing the domains from the data.

The evolution of the themes and domains is highly researcher dependent. While the data are constant, because they are unchangeable responses and recorded verbatim, where they fit and how they are organized depends a great deal on the researcher's sensibilities. A small example of this occurred during the first round of the data analysis when setting the agenda and pre-session work were separate domains. When the researcher returned to the data after a couple of months of rest, she realized they were pieces of the same cloth and were not so unassociated as previously thought. This is when the domain client-directed therapy emerged.

The emergent quality of the themes and domains points to the human factor in the research. While the data are unchanged, there is an organic process simultaneously occurring. The investigator's increasing familiarity with the data and the variations in how one's interest is piqued by the data influences how the results are organized and reported. This human factor thus demands even more careful attention to the need for safeguarding the trustworthiness of the data. Capricious or disproportionate highlighting of the transcripts can cause errors in the findings. The steps taken to insure the rigor of this study are detailed in the following section; elements of trustworthiness.
Elements of Trustworthiness

Naturalistic inquiry has four aspects of trustworthiness (Guba, 1981). The aspects combine to form rigorous research. How each aspect of trustworthiness was addressed in this study is detailed below.

Credibility was addressed through procedures of peer debriefing, member checks, and triangulation. Peer debriefing occurred at regular intervals throughout the research cycle. The primary format for debriefing was with the co-chairpersons of the dissertation committee. These meetings occurred bimonthly and monthly.

The second step in building credibility was the member check process. Three participants in the study volunteered to be contacted for follow-up information after the initial interview. Each represented a different participating therapist's practice. All three were sent some form of member check assignment. Only two of the participants responded. The first reader was given a summary of the themes and domains, the second reader was given the entire findings sections to read. The readers were given an evaluation and critique form to respond to the data. The first reader responded by mail. The second reader met with the interviewer for an unstructured conversation in which the reader commented on themes and domains.

Triangulation can be achieved by the use of a variety of data sources and a combination of different investigators. The variety of data sources was addressed by having a participant pool of eight respondents. The multiple number of participants allowed for patterns of similarities and differences to emerge from the data.

Triangulation by different investigators was met by the use of independent readers. The co-chairpersons of the dissertation committee read one transcript. One chairperson read through an entire transcript and underlined with a highlighter
pen important phrases and data she felt were meaningful for the analysis. A second reader, Barbara Gaddis, a doctoral candidate in the Marriage and Family Therapy Program, read transcripts that had been combined by responses to questions. She then proceeded to underline phrases with a highlighter pen that she felt were important or relevant data. The degree of agreement of highlighting similar statements by the researcher and the second reader was over 90%.

Transferability was met through purposive sampling and collection of thick descriptive data methods (Guba, 1981). The details of the sampling procedure are described under the client participants section. To summarize this section, clients were selected to represent as much diversity as possible within a small pool of respondents (Bogdan & Bilken, 1982).

Collection of thick descriptive data was achieved through the long interview format. Participants were asked open ended questions and were prompted to elaborate on their responses. Verbatim transcripts were made from the audio tapes. No synthesis statements or paraphrasing was done with the transcripts. The commitment to thick descriptive data is evident in the findings chapter, which contains lengthy quotes to illustrate the characteristics of the domains.

Dependability was addressed through the use of an audit trail. The use of audio taping and the full transcription of the interviewer and respondent remarks was one procedure used. The second procedure was the recording of field notes. Following each interview, field notes were recorded pertaining to important nonverbal observations and the researcher's subjective experience of the interview.

Confirmability methods include triangulation and practicing reflexivity. The triangulation procedures used were described above under the aspect of
credibility. Practicing reflexivity occurred through the recording of field notes, in conversations with committee members and in the write up of the investigator-as-instrument and clinical implications sections.

In summary, this chapter introduces qualitative methodology and the research methods used to conduct this study. The naturalistic approach used is based specifically on McCracken's (1988) The Long Interview. The procedures and decisions made for interviewing and analyzing the data were detailed. The next chapter lays out the findings from interviews with clients of feminist therapists.
FINDINGS FROM LONG INTERVIEWS WITH
CLIENTS OF FEMINIST THERAPISTS

From long interviews with female clients of feminist family therapists; three themes emerge from the transcripts, respect for the client, integrated feminism and mechanics of therapy. Each theme and domain is described with a narrative section. Characteristic quotes and an elaboration are reported for every domain.

Respect for the Client Theme

Respect for the client is the first theme. In the interviews, the clients enumerated a number of ways they felt respected by their therapist. The nonjudgmental attitude, genuine caring, significant sharing of information and willingness to construct a process that was sensitive to the client's needs was heard throughout the interviews. Client directed, affirming and empowering and sharing of the therapist's self are the three domains of the theme, respect for client. The domains describe how the theme was experienced and detail it through characteristics via the use of quotations.

In the quotations, the letter "I" is used to denote interviewer and the letter "R" is used to denote the respondent. All of the italics are actual quotes from the interview transcripts. Parentheses are used to substitute a relational term for the personal name the respondent gave. The grammar has not been altered in the quotations; [sic] has not been used, however, because it would be disruptive to the flow of the conversational reading style. Quotation marks are used to designate the response of one person. Thus, serial paragraphs without quotation marks can be understood to belong to one speaker.
Domain: Client directed therapy

This domain includes those characteristic descriptions of the work clients did relating to the therapy outside of the session itself and how they were able to influence the course of therapy. Two recurrent topics appear; they are presession work and setting the agenda.

Characteristics of client directed therapy

"I usually prepare what I'm going to do ahead of time. I keep all my notes. Generally, there might be a few things from the week that have come up related to the work that I'm doing. Primarily, we get right into the things that I'm working on as far as the sexual abuse. I'm pretty much the one that directs that.

If she does have an agenda, she says there are some things she needs to take care of with you before we go on. Then we talk about what that is. If she really has something left over from the session before, she really checks that out right away. That feels really good.

I really like that I'm the one in charge. I really love that. That I'm the one choosing what direction we'll go in. Not that she's totally excluded from that. I think that if she didn't agree she would obviously tell me. But I love being the one in charge.

Usually on our anniversary, I prepare kind of a summary of what we've done during the year. This is a way for me to kind of look back. I like anniversaries a lot and it's a way for me to kind of honor our anniversary date."

"Usually, (husband) and I will talk in the morning of the discussion if either one of us has a hot topic for today's discussion. And...there may or may not be one at the time in the morning. But I think one of us thinks of one during the day. Or
they may be one that one of us thinks of. I usually discuss it with him briefly. We'll usually get into it, you know, while he's getting ready for work or something. And sometimes, it ends up that he's getting out the door late because we're talking about it. And we leave it saying that we'll talk about it more later. Sometimes we don't talk about it until we're in the car on the way over there. And...that's just a real brief kind of thing. We've walked in there already arguing on the way in. ... But we usually have an idea of what we're going to be talking about."

"Generally, I'll have something specific, this is, of course, after being with her for a while. But, from our last sessions, coming home and mulling it over and pigeon holing everything and letting it sink into your consciousness, then it opens up all these other tidbits of things that you always wanted to get rid of. I'll have something specific that I can't quite tie into what I'm learning....Pretty much just me talking and trying to get the questions answered.

She'll (therapist) say, 'What's been going on?', something to find out why I'm there. And I usually know, I have my issues laid out. They may not be everything, but at least my first, 'what's it called?' issue."

"Usually, we'll sit down and say hi and (therapist) will ask what's on the agenda today. And one of us will tell her what we've been talking about or trying to figure out and a lot of times it seems like the first half hour we're doing a lot of talking trying to explain how we got there and she'll ask questions. If she doesn't understand she says can you tell me more about that or can you tell me what you mean or so we end up talking a lot about how we got to whatever we're talking about."

"She asks how I've been doing. I respond with some comments. The later sessions, I've been putting a list in my appointment book of things...at first, it was
like this giant pile of things...needed to address which kind of started and one thing would go to something else. Through that, we came upon some commonalty type of things. I like structure and yet, I would like structure in the session where you go in and say Okay, we're going to talk about that, that, that. But I'm so delighted about what comes up as we meander and go off on tangents. In things that I might not see as related. I don't want to request a structure. It's different than how I work. I kind of like this. Let's try this. So maybe we're kind of between that in that if I have some specific issues, I'll make a list of things."

"Yes, she has asked, particularly early on, are we on the right track. Is this where you want to be going? Is this where you want to heading? Are we covering the things you want to cover? Then now that I'm bringing a list of the things I want to address, she certainly knows that I'm bringing in what I want and she follows up and says are you getting to the things you wanted to on your list."

"She will encourage me to write things down, of course. I have done that recently and found that it was real helpful in getting a lot more into the session the next time. You know, just like when you go to the doctor, they say to write the questions down, because once you get in there, you have a tendency to forget because you're intimidated."

**Elaboration**

This domain can be organized around two major points, presession work that clients do prior to therapy and setting the agenda when they meet with the therapist.

Presession work is described by the clients as having written agendas, keeping notes in an appointment book and making lists to discuss. Words used by
the respondent to describe the thought processes include; pigeon holing, mulling over and trying to apply what was learned.

Therapists respond to this pre-session work by asking the client to state "What is the agenda for today?" or "Who wants to go first?" as opening questions in the sessions. These remarks demonstrate how the client has the opportunity to influence the course of therapy.

Clients say explicitly, "I like being in charge" and choosing the direction of therapy. Being able to address the issues as the client names them and feels their relevance is important to the client. Working on a particular aspect of retrieving memories or dealing with a perpetrator are examples of clients setting the agenda. The client speaks of progressing at a rate she can handle or are ready for. Self-determination as a domain points to the respect the therapists have for their clients. The stylistic approach of the therapist asking the client the topic, agenda or issues for the day is one demonstration of the therapist's affirmation of client-directed therapy. Often the report is that the client directs the discussion and the therapist acts as a clarifying agent. She will ask questions, note patterns and themes, or connect material from one conversation to another. To do this the therapist must genuinely accept the topic and expression that the client offers. My therapist "seems very supportive, but she lets you feel your own strength and then be guided by it" stated one informant.

**Domain: Affirming and empowering**

This domain is about how the therapist works with the client. It is described in part by what the therapist does for the client and how the client responds to the therapist.
Characteristics of affirming and empowering

"Well, I think (therapist) doesn't have any pre-conceived ideas about how it's going to work out or anything. Which I appreciate. And it might work out some very different way. Or we might think about things a totally different way. I don't think she has anything prepackaged. I guess the other thing is I probably trust her. There is more personal anonymity. At least more than I had here. Which I think gives her a particular slant on how things should turn out. At least I felt that way.

I have a strong feeling that she cares about what happens...and that she has a perspective. She's not trying to fit me in a little box. At least I feel strongly about that this time. More than I did before. I also guess I'm increasingly aware that she's a smart person. An insightful person. She doesn't say something really off the wall. You can tell when someone is listening and can understand."

"Nonjudgmental. Support. She's the first adult that validates my feelings. I don't know whether to say that's to her credit, but if we didn't gel, she couldn't do that to me. The safe environment she provides probably is what's helping me get rid of a lot of this. I know I'm not going to be judged or criticized or dismissed. She makes that conducive to open all the windows. So, she's really good that way. Laid back but not laid back to the point where you feel you're not accomplishing anything. She just provides enough spark to get my talk flowing."

"I like her candidness. I like her honesty. I like her openness. I like her...I like the fact that she's not afraid to [say] something even though it might put me into my shame if that's what's going on. But she'll usually see that in me and she's the first one I think that has been able to pick up when I'm going into my shame big time or even small time..and she'll ask me point blank, '(client), are you going into your shame about this?' Usually the answer's yes, so what else is new?"
"I think I've worked out most of my anger with her and have become comfortable with anger. Some of that's been her modeling it. Like when she gets angry at me, it's not disrespectful. She never crosses the line when she gets frustrated with me. I was just terrified of it. The first time I started getting angry with her, I was terrified of it. It was really nice to feel like I had really worked through that. And practice it with her in a way that has never gotten disrespectful or never been explosive. It's always been constructive. So, yeah, I would that I really learned that from her. I don't think I've done that work with either of my other therapists.

We've (therapist and client) come up with..I have a checklist of things I do when I'm upset or whatever. It's a way to try to nurture myself. It's specifically for women because we have a hard time comforting and nurturing ourselves. I love..this is the compulsive part of me..there's a checklist in there, you can look up what your symptom is and it will tell you what page to go to. And what activity to do to help...

"I: ...describe for me a typical session or the last time. Walk me through what one is like. R: You mean like when she tells me I'm full of shit?  I: Yeah, what goes on when (therapist) tells you, you are full of shit? R: Well, I have a problem with accepting the talents I have because I classify my life as..I survived..so I become cognitive about many things because of survival not because of talent..but because you had to survive. If you don't know how to open the refrigerator, it's pretty hard to get in it. So to me that just meant that if I could do it anyone could do it. She gets on my case because everyone can't do. She says she can't believe the things I can do. I say anyone can do it. She says no, anyone can't do it. I don't see myself as being that special. She gets on me for minimizing and filtering my
talents. If somebody gives me a compliment, I have a real hard time accepting it, because how could I be good? Some days I do better than other days but a little voice inside my head says yeah, but you put your slip on upside down or, you forgot it or you did this. I'm right away chopping at myself because that's where my background came from. So she's telling me that in time when I start perceiving myself as a more whole and okay person that is the type of personality I'm going to emit and that's the kind of person I'm going to draw to me instead of hey, I'm a sick-o and if you want a sick-o, here I am (conference presenter) was going today radar..radar..there's a sick-o for you. That's what (therapist) and my sessions are like. We kind of bounce things back and forth. Yeah. That's been very helpful when she does acknowledge the certain things that I do well. It's probably because I looked to her for something. But also because she's really a neat person. It means a lot to me when she does and I know she's being honest about it. Giving me a message and trying to encourage me. It's legitimate that she really likes whatever. That's been very, very helpful. I mean, I think it's helped my self-esteem. It's helped give me a little bit more courage when I do go out and do things with that.

Yeah, and she's a real good ego booster. Most people I only let see pieces of me because I'm afraid they won't like me if they see all of me. She has a way of uncovering of me and I'm not always comfortable with that. It's good because I've been through so many therapies and I worked psychiatric and had it thrown at me. My father was a psychologist. Towards the end of my years at home, I could analyze things into almost rational behavior. She sees when I'm rationalizing and minimizing because it's less hurtful for me if I just rationalize it. So, she really focuses me.. which I need a lot of times.
I thought about this for awhile and when I was back to see her, I was really kicking myself in the ass again because I set myself up. Think of me as the plumber and you've got this bad leak. And every so often you drip. And (ex-lover, male) the drip. He didn't come on overnight. I wasn't going to get rid of him overnight. So every now and then I have to be a leaky faucet and I'm slowly healing myself. So my comment was would you please get me a big washer and we'll fix it once and for all. I don't like drips. She said it's not that easy, I'm only the plumber. She's there to...she makes me feel not so bad when I do stupid things like that. I do have to do them every so often. Consciously, I can be a very rational person. But it's the unconscious part of me that keeps screwing me up. She's helping a lot.

I told her I just love coming in, because I just sit here and babble and she makes sense out of it all and she can put it into themes. She shows me where the patterns are that I don't always see. I leave there feeling like I have another tool in my bag for coping with things. A session might meander through several topics. Even when it's more of a one issue session, the time goes by so fast. I love her sense of humor, her sense of style. She seems to be comfortable in the...sometimes my analogies get kind of...so there may be some comments on the analogies. We'll talk..she'll ask..usually I'll start babbling..she ask questions sometimes to provide focus or sometimes to look at it at a different angle. Offer suggestions, comments, what if, have you thought about it in this way. Is it possible that this could be in there? I guess kind of unlike me, she focuses on what's going on. We just talk and something always comes out of it.

"I feel like she understands things about me. She just doesn't listen and then say okay, I hear that you're... I really feel like she understands. That the
feedback she gives is more than just reflective thinking but its more in-depth understanding or pondering what I said. I like it a lot."

"One thing that has come up is there are places where I will not ask questions to gain information that I need or want because I'm uncomfortable doing so. She's helped me see how important it is for me to get the missing pieces of information and encouraged me to look sometimes to a discussion that needs to happen and to initiate that discussion. That might be called being more assertive in a specific situation."

"She has encouraged me to touch base with people. Like where I think something is happening in a situation and I don't trust my judgment, to ask someone else what do they think. Kind of a reality check."

"Someplace in my head..I have learned that fun is like bonus. She's helped to see that it's important to me. It's helped me to shift my thinking from bonus to nope, it's one of the daily food groups. We've got to get fun in there. It's important to me. More important than bread. I could probably live without bread, but I couldn't live happily without fun.

We have talked about that it's okay to feel these kinds of things. I know that I'm an emotional person. I believed that it wasn't okay to show emotions as a professional. There are times when I think I shouldn't be feeling angry. She's encouraged me to own those feelings. If someone steps on you and you feel angry. That's okay."

"I: Has your therapist ever discussed how your situation might be different if you were the opposite sex? R: Probably not and probably for good reason, because I've always wanted or thought I should be. She's more reinforcing that it's
good for me to be a girl. I brought it up and said that I would have been better off had I been born a boy and that boys got treated this way."

"I appreciate that there's no social, that it's all work. That we come in there and we start right away. That there's no socialization kind of stuff because it would be very easy to do that with her because she somebody that I feel that I could have a friendship with..that I have a lot in common with. But that never gets mixed up. I appreciate her thinking. I think she's very smart and she's not quick to make any kind of..this is it..just to cover it over and get on with it. I think she's really able to see the issues a lot. When we go through a lot of political..she cut through that and she has a way of doing it that doesn't put anybody down. She does not..she's very fair with both of us. I've never felt like there was never..she's right in the middle there. And it would be easy with me because of my own stuff to feel like she was siding with me being a woman and..I don't feel like that..I think she's very there for (husband) and hears him and respects him and respects where he is and his opinion. Very respectful of both of where we're at. There are almost always an insight or a suggestion that I can come away with or something that I can remember that sort of guides me in my process. It might be..you need to remember that this is something you can't do anything about...something maybe I couldn't have gotten myself that helps me when I need it."

**Elaboration**

This group of quotes consolidates what the client state as a positive gain from therapy. Encouragement, validation, focus and support are some of the qualities clients report as affirming acts by the therapist. Skills and insights that
contribute to empowerment are; assertiveness, ability to handle anger, increased self-esteem and clarity of priorities.

The clients stated that the working relationship with the therapist was enhanced because the therapist exhibited the following qualities: nonjudgemental, smart, trustworthy, unafraid, and ability to provide a spark. The therapists were also noted for working in ways that did not make the client feel like she was being put in a box or that the therapist had a preconceived notion of the outcome of therapy.

The therapy itself was experienced as affirming clients. When a client states her therapist was the "first adult that validates my feelings," the client is affirmed. "She's a real good ego booster" also demonstrates the domain. Modeling anger, clear respect for both partners in a marriage, providing a safe environment for discussion all are factors that empower the client.

Domain: Therapist shares herself

This domain describes a variety of ways that the therapist reveals herself to the client. The domain encompasses more than just verbal self-disclosure of personal information by the therapist. Everything from how the therapist shares her values, to her sense of humor and how she uses her body is described by the clients.

Characteristics of therapist shares herself

"She tells me what she has found to be true. But not so much her personal feelings. More fact based things. In her own mind, if it applies, she'll say that she found that...Some of the things I'm struggling with, she'll show me, how in a different way, she is struggling with the same things. Putting it into a whole different
perspective but deep down, we all basically fight the same things. The demons. Just a matter of occupation. We're all just the same under the skin."

"The times when she says what her values are, yeah. She's been real clear. I'm trying to think of specifics, but, and maybe there's only been a couple of times where her values would come into play with what's going on with us, but the times that has come up she has definitely stated how she feels about it. You know, and maybe that's not okay for somebody but this is how I feel about it. She's been real clear."

"She's real. She's not a person that comes across holier than thou. She's very relaxed. She might sit on one leg for a half hour and then she might sit on the other leg for a half hour. She might have one shoe on and one shoe off. She's real. She doesn't try to put herself in the position of well, I'm here to help you. Talking to her is like talking to a friend. Just a person that you're looking to and saying hey, I'm having problems with this and she says why don't you look at it this way. So, it's constant feedback. It's very comforting. For one, I know she has the education behind her and I know she has all her shit in one sock. At the same time though, she doesn't hold it over you. Very comfortable, very real. I like that."

"She tries to stay objective but yeah, I think she does. She does a really good job at being objective. I think part of her being such a good therapist is because she is real and she comes across as real. She has to be subjective in that respect. She presents how she thinks and how she feels but objectively so that it's not like her condemning me or putting her values on me. She's just stating her own views so that I have...which is nice so I can see what another person's view is without feeling like."
"Sense of humor. I feel very comfortable. That's very important to me. I mean, I'm baring my soul here. I know that I have to be honest with her. If I make up a person to tell her about, the only person she's offering suggestions to is this made up person. I'm selfish enough and determined enough to really get some stuff out of this. I'm baring my soul so that I trust her and feel an affinity with her that is very important to me. Some of that may be ways in which her style echoes mine. Makes me comfortable. She definitely has a sense of humor. She's very intelligent. She's laid back. I sense that there's a very strong woman in there. Although, she's not assertive or aggressive at least not in our therapy sessions. She listens to me. She seems to believe what I say is true. That's a very important thing."

"At times as we're chatting, she might use an example of something from her life which I find incredibly valuable. In terms of that everything doesn't go okay for therapist either. Life still dumps. Because I respect her so much as a person. Realizing that she copes with things as well helps me to realize that I need to learn to cope with things and that I'm okay. I think in some ways, pieces of (therapist's) value system has come through. It has never been in I value this and you should too."

"I think I picked them (values) up from working with her. Especially about choice and people having power. That's a huge value of hers. I've definitely heard that. I think that was a good one to hear. I think she does in a way but not in an imposing way. I think I know who she is and what she thinks and feels. She doesn't feel like some kind of vague, out there type of person. It feels like I know who she is in many, many ways."
I like that she's not afraid. That she expresses that in the therapy that she doesn't get scared easily, because I think I do. I like that...to have that kind of a model. What's rightful to be afraid of...she shares that piece of her with me. She's got...she keeps a lot more secrets than (name of other therapist), my first therapist did, about her personally. She shares a lot at the same time about her kids...her raising kids. When I get into thinking of ways about her kids, that's been wonderfully helpful. To get that developmental piece of that there are a lot of times that I'm thinking like a three or a five year old because that's kind of where my thinking has been at. Having the hopefulness that maybe I can grow out of that. I didn't have the chance before and maybe now I can. So that's been neat. Her sharing some pieces about her process. Not in any detail but about what who's worked on. She had been in therapy and she remembers those feelings. She has shame attacks, people have shame attacks so it kind of normalizes it for me. It feels more equal. I respect her a great deal. She's earned it but she also expects it. At the same time she expects it, she doesn't hold it over. It's not this kind of an up/down thing. That's been really wonderful. The fact that she expresses it she likes me. That's very important to me. Really, really important."

"She doesn't cram anything down my throat about what her perspective is."

**Elaboration**

This domain describes what clients know about their therapists, based on what the therapist explicitly told them or has been gathered through the course of therapy. Clients report that hearing the therapist discuss similar situations or difficulties they have handled as being a normalizing experience. One client says she appreciates the humanness of the fact that the therapist gets"dumped on" too
in life, and that she is still okay. When an incest survivor hears that her therapist has shame attacks and went through similar steps in therapy, she is reassured.

There are also points in the data that state the therapist does not evangelize her values. "She doesn't cram them down your throat" and "she is very respectful" are statements made. What is reported is that therapists do share values, have opinions and make statements. Subjective and personal aspects are revealed by the therapist and the client is given the freedom to respond in her chosen way.

**Integrated Feminism Theme**

This theme explores the ways feminism is incorporated into the practice of therapy by this particular group of feminist therapists. Feminism is the perspective that values women and women's experiences and promotes the advancement of women (Humm, 1990). Three domains emerge from the data to show how feminism is integrated. The domains are contextualization of the issue, support of women's full development and nature of the therapeutic need.

**Domain: Contextualization of the issue**

This domain illustrates how the therapist takes a therapeutic issue and connects it to a wider context. Traditional therapists have focused most of their therapy on individuals, nuclear family structures and generational patterns (Gilbert 1980). The participants report their therapists as considering gender patterns, societal norms and stereotypes. These considerations are examples of the wider context feminist therapists take into account when doing therapy.
Characteristics of contextualization of the issue

"I thought of her as a feminist. I'm not sure. I might use the word feminist. I might also use the word intelligent just from things I heard from her that she was very good. I'm not sure it was because of her being a feminist but that she was a good therapist and she was a woman and that she understood both issues of males and females."

"She definitely speaks her mind about feminist values and the role that society has put on women. If I think about it that way, she's real outspoken about that. I mean it doesn't come across as where (husband) has ever said anything about it and I know he would say something and he hasn't said anything yet. She's helping us to see the ways society has screwed around with women's roles and that kind of stuff. The roles that we've grown up with and the stereotypes of the females in our generation. Everything from how we grew up to how it is now. It wasn't just our family but the churches and the TV and all the other medias portrayed the role."

"I: Does (therapist) ever discuss your situation in terms of larger social issues? The society, cultural context or socialization? R: Yeah, a lot. Usually in the context of school or something. An important point in my therapy is learning that sometimes it can seem like you are the problem. It can happen in the family. It can happen in you work place, wherever. It can seem like you're the problem. If you buy into that and believe that you're the problem, people will be more than readily and willing to dump that on you. So it's been helpful to me to learn to check with other people about what's going on. Is there something else going on? So it might just not be me. Maybe more dysfunction in the system than within me personally. That's been very, very helpful in my checking with reality. Maybe it's
not just me. Maybe I'm not as bad as I think I am sort of thing. In terms of roles in society as a female, it's probably been more of my initiation."

"Not other than they are different and that the perceptions are different and that they are very evident and my hang ups are coming from those roles. Those preconceived on how society puts them on and I have assumed them because of my background. It's not necessarily that they are to be. It's just that the evidence is there. It's almost a rationalization of where they are coming from because a lot of my problems are from the roles. Whether, I've always tried to battle them instead of being me. I don't have to be a guy. My father always wanted a guy. That type of thing.

Oh, she definitely has an understanding of my family. Just about everyone in my family. It's hard for me to remember if she initiated a lot of that or whether I brought it up just as part of (therapy). When we did the transferring [changing from previous therapist to current therapist], I did a piece about informing her about the different people in my family. That may have been a question she asked me at that initial transfer session."

"Yeah, we do deal with the role differences. A lot of the things I have natural talents on are not typical female roles. I came from, I have seven brothers. My full blooded youngest sister was raised by my grandparents. My half sister is eleven years younger than I am.

I'm sorry, but I worked on the railroad for ten years and that job is no harder for a woman than it is for a man. Anybody can walk and anybody can kick. If you're a little weakling..there's men that couldn't do it either and there's women that couldn't do it. It's just because of your physique and mind set. It has nothing to do with sex. So the roles do play into our discussions a lot.
Yeah, and that becomes a whole part of the whole because we can narrow it down but that is kind of the abstract picture of it. Through my evolution, I can come from this invisible female to being okay with myself and then I can be okay with it and the world will be okay with me. That way I can interact with both the males and females and probably be better off...I can already function very confidently in the male world. It's the female part that once I can get comfortable with that I can then get intimate with the male part. They are very different no matter how we try to make them the same. An x and a y are just not the same thing."

"There are some places where we have talked about gender differences, but she places no value or judgment on roles in any way, shape or form. More of a style than a value."

"I get the sense that as we're talking about things, and the way things are, it's just in the sense of my world. The world of which I live in. Which of course touches society and the bigger cultural stuff."

"We talk about how women have been taught this or whatever. Kind of re-education, a feminist kind of perspective, you know, you don't have to be stuck in rigid roles. You don't have to be (or) think a certain way."

"Well, yes, but she talks about stereotypes..that's the way she encompasses it, that's the way she talks about it as a stereotype. ...Yes, I guess but not in the typical Reagan/Bush time of scenario. I think she speaks a little more fluently about old stereotypes and what versus reality potential. If that makes sense?"

"I: Would there be direct questions about your parents generation?" R: "Yeah, yeah, but more..yeah, but more 'how was it in your home? How was it when you were growing up? Also, just ethnically. Where we come from as far as our ethnic background as far as this is how it is in a German background and this is
sometimes how it is in an English background. We also have ethnically different backgrounds. And that has been..more at the very beginning of our therapy."

**Elaboration**

Clients report that their therapy has included discussing stereotypes, role expectations, and gendered family patterns. The source of these messages was labeled as coming from the church, television, the media and ethnic and family backgrounds. In the interviews, clients stated that narrow sex-role stereotypes influenced them negatively in the work place, their self-esteem and in current relationships. Therapists were described as providing re-education, confidence and new perceptions, these things were achieved by discussing the ramifications of gender issues.

**Domain: Women's full development**

This domain is about how the therapy has challenged the client to grow. The pursuit of the full potential as women is noted. Shifting domestic responsibilities, broadening careers and finding support in someone other than a male partner are actions encouraged by the therapist as avenues to expand the client's potential.

**Characteristics of women's full development**

"What I like mostly is that she's really supportive of women's issues. She's really, I guess she's just been very supportive. I realize this is part of the nature of the business, but very nonjudgmental and very supportive in the avenues that I've been looking..going down."
"We're just starting to get into that seeing as I'm going to be a single parent and need to get out and work. But we're really haven't picked up on that because the marriage is kind of a dead issue. We found that out rather early. So we concentrate more on myself and what I need."

"Well, you know, we did talk about that in the beginning when she suggested (husband) take over some of the household stuff so I didn't feel like a slave and that why don't I take care of finances and then I'd feel more in control of that.

I: Has she encouraged you find support in someone other than your husband? R: Uh huh, yea. She keeps telling me that's what my calling list is for. When he's not around."

"I don't have a female figure. My mother died when I was six. That is where I'm having some problems today because (daughter) will soon be the age I was when my mother died. I'm panicking because I have no model to give her once she hits six. Well, maybe she should live with her father because I won't be a very good mother. (Therapist) tells me no, you know, you're doing fine. But I really panic on that. I'm uncomfortable with it.

She has encouraged me to try to connect with single parents groups and to go out more with friends, female friends, she says I should put myself on hold where men are concerned until I heal a little more. Which I agree with. I just, your hormones cry out every so often. Just run (daughter) around the house and then I'm tired and can go to bed.

A lot of mine presently is a lot of introspection. She encourages me to do things with people and to get away from (daughter) every so often because it does drive me up the wall. I'm a list person because if you put 10 things on the list, you'd better accomplish them today. Tomorrow you can put 15. She encourages me to
minimize what I expect out of myself. Instead of so much outside, it's more like looking at myself. I'm real good at looking at the outside and getting involved with the outside because then I don't have to look on the inside. Kind of a 180 degrees on that one."

"Well, she always makes me feel like I'm a lot better than I perceive myself. I don't know, I'd have to give that one some more thought. I feel like she really collaborates to bring me forward. She bites it in the bud when I want to stay stagnant. She might veer off another direction, but she comes back to it. I've been blocking something when I was there this week and I still can't put my finger on it but it's like..it's almost like she went gotcha..and yet, I know she got me and I know it really hit me where I wanted to..I cannot..I've blocked it for some reason. She really pulls me where I want to go. I can't really say she's pushing, but she has a tendency to draw me there. Afterwards, I feel much better for it."

"Her saying I know you need this but at the same time you have to make a choice. I learned about choice from her. I never knew about choices before her. And that's been essential. I like that a lot about her. It's really emphasizing that I'm making choices about how I think or about what I do, you know, not just subjects. Which is a very victim, kind of powerless position.

I'm in charge of this. If I'm not going to be doing the work, why am I there? It's really not her responsibility to bring everything out because then it's kind of disempowering. It's giving me a message that I'm not capable of doing it. It's just more of my work under her. It's not her work. She's just there to help me through this kind of stuff is how I see this relationship."
Elaboration

In this domain, clients describe actions taken by themselves or suggested by the therapist in the course of therapy. Developing personal resources was cited several times. Using calling lists, being more social, getting together with female friends are examples of encouraging development.

The therapist addressed relevant issues in this domain. Helping a woman to feel like she is not the family slave by sharing household tasks with her husband is reported. Recognizing the changing economic and employment needs of a newly divorced mother is another example. The frustration of single parenting is acknowledged.

In this domain, the significance of verbal affirmation by the therapist is acknowledged. Clients note how the therapist tells them they are doing fine or well in certain aspects of their lives. They state the importance of these comments.

One client described her view of therapy as being her job, not the therapist's. This comment points to the client's experience that both the content and process of therapy work to empower women. Other examples given as ways clients moved toward their full development were by learning about making choices, understanding their consequences and abandoning victim behaviors.

Domain: Nature of therapeutic need

This domain illustrates the characteristics of the therapeutic need or dominant metaphor of the therapeutic conversation. This domain is largely an imposed domain because of the question that asks clients why they are in therapy. It becomes part of the theme because of unique feminine concerns or because of the feminist approach taken by the therapist in addressing the need.
Characteristics of nature of therapeutic need

"Well, yes. Just to give you an idea of why I left my former employment was because I'm in the middle of a law suit for sexual discrimination. So, and harassment. So that's like society. As a whole, I think that is a reflection or it became a part of it."

"She was good with female issues. A lot of it was, my hang ups are very female oriented, I believe. Just because of my lovely social status of being, with sex, is where most of mine have developed. So she seemed to be a ringer for that."

"Termination of relationship. Being very helpless. Feeling to blame and not knowing why. Very guilty. In a nut shell, and bluntly, I fucked up again because this is the third relationship I had. I come from a very dysfunctional family. Very co-dependent. Dry alcoholic father. Mother dies when I was six. So all my life I've been abandoned. Living in abandonment is where it started and I knew I need more help. It was bottoming out and it wasn't fair to (daughter).

Yeah, and that becomes a whole part of the whole because we can narrow it down but that is kind of the abstract picture of it. Through my evolution, I can come from this invisible female to being okay with myself and then I can be okay with it and the world will be okay with me. That way I can interact with both the males and females and probably be better off, I can already function very confidently in the male world. It's the female part that once I can get comfortable with that I can then get intimate with the male part. They are very different no matter how we try to make them the same. An x and a y are just not the same thing."

"The reason that brought me to see (therapist), it was through the employee assistance program. Initially, I guess the question is why did I go to the employee
assistance program. It was like a crisis situation at work and hopelessness and I needed to turn somewhere so I went to the employee assistance program.... A number of things over the years. Unresolved issues building up that you don't really realize are there. The pile getting bigger and bigger and bigger and finally the last straw comes on it. The last straw and finally I could see a pattern here. You know I'm sick of this. I don't know what to do. I don't know how to get out of this. I know I don't want to live this way. Because the crisis was work related, the employee assistance program seemed like a place to turn. I guess I must have been really desperate or really reaching out for help. Because when I saw the therapist I was like all right, I'll do whatever you want me to do. Just make it better. In retrospect, I think I should have sought help years and years ago. In my close family there is mental instability. My mother is hospitalized several times. There was a nervous breakdown a long time ago. I think my test for 'Am I okay?' was I've never been in therapy. I've never been hospitalized. I can make it on my own. I'm all right. I thought it was a sign of weakness. That probably kept me out of therapy for a lot of years when someone else, not using that as their badge of honor, might have sought help. Until finally, I was just sick of living this way. There was a lot of changes in the last year. There was a marriage. There were step kids. There was an ex-wife who hated me. My husband and I moving apart and having a long distance relationship. My mother died very, very suddenly in September, over Labor Day, which really took a lot out of me. I had really had stressed myself over the summer, working and said okay and said summer's gone, I'm going on a vacation. Then my mother died and I'm planning a funeral, so I never got my down time. I never got my escape. There was some family turmoil associated with the funeral and has continued on through Thanksgiving and on into Christmas. Some
things at work with my boss. I can't do anything right. She's always right. Some really big crisis things came up and I really pushed the issue. I went and talked to her boss and said these things are just not acceptable. Really kind of pushed into doing something. He talked to her and we all got together and talked about it. It took about six weeks and that said to me that I wasn't really important. After the first meeting, I just left there and thought okay, this is hopeless. Everything I say, she tells me I have no right to feel a certain way. It doesn't matter how many times we meet, I'm just going to get slapped down and that kind of sent me into the dive of I've got to talk to somebody. So, that took me to employee assistance and that took me to (therapist). I was basically very depressed over a lot of things. The actual diagnosis is transition problems or something because the doctor said the insurance company doesn't like to see depression on there. I suppose that could mean hospitalization and it could be a year long therapy project. So she put it down as transition therapy. Whatever works. Just get me help. I don't care what you call it. So, that's what brought me around to (therapist)."

"Primary reasons were that I had sexual abuse in my background. I hadn't recalled it before that. I was working on that. We've worked a lot on sexuality stuff, relationships with people in general and dating type stuff. We've worked on trying to recall memories. Spent a lot of time working through memories. I had several abusers. Probably about six. Five or six abusers in my life. We worked on the pieces that I did remember with those people. I'm still in that process."

"I had gone to (County) Victim Services meeting one time for Incest Survivors and found the meeting, the support group to be too intense for what I needed, those women had all had recent memories and I had never forgotten, so we were at different levels. I needed one on one so I could get on with things.
I have a lot of anger with the way the sexual abuse was handled in my family. I knew I could not unravel what needed to be unraveled on my own, by myself. It just appeared at a time in my life when I needed to do something about it. All the signals were there and just to try to make some sense out of things and to see what needed to be done. I've seen in my family a lot of, in their 40's and 50's all of a sudden facing crisis or breakdowns or something and I just didn't want, I wanted to nip it in the bud. It was starting to affect my life. Anger always does. I just thought if there's ever any help, it's going to have to be with a professional."

"Initially, I went with (husband), soon after we were married with just some kind of nuts and bolts things, when we were living together. When we were just living together, there were some things that were problematic. Actually, I think it was (husband) who initiated it. In fact I'm quite sure it was. That has been relationship, primarily the reason for seeing her. Over the four years. But then of course my own issues have come through. Then more recently I have seen her (pertaining to) personal issues have come through, this is the second year of a new job. I have needed help with some things that were more difficult relationships and just logistical in the new job. So that's why I saw her. Then (husband) and I still see her ongoing for relationship."

Elaboration

This domain collapsed four different content areas in regard to the therapeutic need characteristics. These content area include harassment in the work place, relationship with partner, sexual abuse and mothering issues.

Two clients noted harassment in work place as a central therapeutic issue. One client was involved with a pending sexual discrimination suit. The other client
cited conflict with the supervisor as the precipitating event that led her to the employee assistance program.

Relationship issues emerged for four clients. Involvement in three failed relationships, couples therapy and a new marriage into a blended situation were noted.

Sexual abuse was the dominant concern for two clients. Surviving six perpetrators as a child was one client's story. Another client discussed the need to deal with adult anger that stemmed from childhood abuse.

Death of a mother was part of the issue for one client. A second client wanted assurance of her parenting skills, as her mother had died when she was six years of age.

This domain may be described as an imposed domain because it comes directly from the response to the question, "What is the central reason for your being in therapy?" It was the decision of the researcher to place it in this theme because of the critical way the therapist handled the content in a feminist perspective. This quality will be discussed further in the following chapter.

**Mechanics of Therapy Theme**

From the data, domains emerge that are more technical, functional or matter of fact in nature. The domains can be described as "imposed" because they are responses to direct questions. Although the domains below do not fit neatly into a previous theme or domain, they are findings that have particular relevance for the practitioner. The three domains in this theme are barriers to therapy, referral to a feminist therapist and previous therapy experience.
Domain: Barriers to therapy

This domain represents an imposed domain, because of its direct relationship to the protocol question, "What would you change about your current therapy?" Some of the responses are simple, one word or sentences, others are more complex, nonetheless all have instructive qualities that point to what makes obtaining therapy difficult for clients or aspects they wish they could change.

Characteristics of barriers to therapy

"I: Is there anything you would change about you therapy? R: The times that anything has come up like that, we really talk it through. So it feels like we're really doing what feels right for both of us. You know, what feels right in terms of my therapy and her, I don't think I'd change anything, because I think what I want to change, we've (already done) - she's been open to us talking through and if she can do it, she'll say so and if she can't, she'll say that, too. Or she'll think about it and decide whether she can. I guess that's another thing I like about her is that she's open to that. I don't think I'd change a lot. I don't, no, I don't think I would."

"We both really liked her a lot. So, even though it's one heck of a haul over there from here and almost stopped us from going there because we ran into major traffic problems sometimes, but we were both impressed enough with her that we wanted to continue seeing her and we thought it was worth it to go through two hours worth of driving to get to her and back.

Well, it would be nice if there wasn't a clock. I mean this is unrealistic, but there are times when I wish that the clock didn't have to say this time is up. We might be in the middle of some feelings that...there are times when she might be working with (husband) and he'll say something that either I don't understand or I
don't agree with, something along those lines, and I don't want to interrupt but I end up leaving the session not knowing the answer or what might be what she's (therapist) thinking or meaning. I leave not knowing because we run out of time. That's in a dream but, there have been times when we've left and I was like, what did she mean by that?

I have a tendency to take things wrong sometimes or may be take them too literally or something and maybe I'll have a questions, but we don't have time for it. So, I think that's the worst part is that there has to be a time limit. I can't really think of anything else I'd really want to change or any way we could possibly work better. If the time was longer, possible what would happen we would be working on my issues but not just my issues but his issues, too. A lot of times his issues will come up at the end and we have to quit then and doesn't seem fair. We may say we're going to start with (husband) next week and then something will come up another hot issue between the two of us and we end up not starting with (husband's) stuff first and so, the time constraint there kind of puts a cramp on the whole thing.

"I: I want to know if that bothers you that the focus is more on you and not sometimes the focus on (husband) and finishing? R: Yeah, yeah, it doesn't seem fair and he understands and I kind of understand, but I don't know, maybe down the road further it'll turn around and it will be more on his stuff. A lot of times it seems like I'm more in crisis than where he's at. I don't know. There's sometimes I wish the final focus was on him. Leave me alone."

"I wish I could afford to go more."

"At times I've thought that I wish she would push me more, but at other times, I've wished that she wouldn't have pushed me as much. I think she's doing
everything just right. A lot depends on how I'm feeling that particular day and how I perceive it at that particular time."

"At this stage, I think it's working very well. Nobody ever can be perfect, the initial relationship...whether it's friendship, therapy, whatever it takes time. So it's just a matter of time. Time is the only thing I can say would make it better because then she'd know more of me. But I think that she's quite keen on that, too, and has really narrowed in, I feel like she has a very good picture of where I come from and where I need to go or want to go. It isn't so much that, she seems to direct me more in where I need to go or want to go rather than where she thinks I should go. A lot of people don't do it where they get this preconceived notion that you should be doing this so it's wherever I'm at in the present time is where we pick up and go. So, it might take four or five times for the whole picture to come together. She's self directed but without being so focused that you can't veer from the path. The path coming from many different directions. She's good.

I wish Principal, the insurance company, paid more of it. That does hinder the amount of help you can get because of the cost. They cover pretty well. You end up paying the first 10 bucks and they pay 90% of whatever is left over. If you're on a lovely women's wage, that isn't always feasible to have two people in treatment. You really have to slice out how often you can actually go in for help. You go into a doctor, they think nothing about it. He'll have you come back and charge you $300 a visit. You go into mental health...and I guess 20 years ago they didn't pay a dime for it. Five years ago, they just were starting to. It's still a big issue. Health care, anyway."

"I can't think of anything. I used to get so turned off by the clinical
atmosphere. It's just not what I'm used to. It seems sort of like a hospital. It doesn't bother me anymore. I guess I'm used to it. The first person I saw, I really liked. We were meeting in the living room of her house. It was more informal. It seemed more clinical with (current therapist). I guess I'd change that.

I: Clinical is a physical setting? R: It looks like a hospital. And (therapist) looks like a woman, in general, that I wouldn't be friends with. She looks more like a nurse or something."

"The only drawback is that she doesn't take insurance. And that's a problem. It's very expensive. There have been times when it's real necessary.

Just occasionally. Occasionally, she'll talk about a similar issue with herself and her husband and sometimes I'm not interested. Sometimes I am. She's done that with herself, too, when I've had issues. Like when I've had anxiety about presenting myself in public speaking and she talked about herself and that was extremely helpful. So sometimes it is and sometimes it isn't. Sometimes it is something I can hold on to and kind of help me. We also usually see her at 4:00 because of the last appointment of the day. A couple of times it's been on a Friday and it seems like she's been tired. It's been maybe only one or two sessions where, which is real understandable. I mean, I understand it but it's sort of, a little bit of a disappointment. It's...she's never yawned...or anything. There are times, especially over the years having seen someone that you know they aren't as insightful.

I wish she took insurance. I do think that would make a significant difference in the times that I'm able to see her. I would have gone to see her more and there have been times when I needed to see her more."
Elaboration

The high cost of therapy was cited by three clients. They said it influenced the frequency of therapy. The result was that they did not seek services as often as they would have preferred. One therapist did not accept insurance payments, so the client had to meet with a managed care therapist on occasions when she could not afford private payments. A second client had a high co-payment schedule for mental health service care, thus limited the hours of therapy to fit her budget. This particular client was a single mother and her daughter was also in therapy.

Other items mentioned as negatives were the great distance between the client's residence and the therapist's office, a tired therapist, who did not appear as engaged on Friday afternoon appointments and a dislike of the time constraint of the therapeutic, fifty minute hour. Finally, one client stated a dislike for the hospital-like setting of the therapist's office.

Domain: Referral to a feminist therapist

This domain describes the variety of ways that clients get the name of or make actual contact with the therapist. Formal, informal and unusual routes are explained.

Characteristics of How did you get to your current therapist

"I was seeing a therapist at (college) and knowing that I was going to need to transfer at some point during my junior year..actually it was my sophomore year when I decided to start looking, so my junior year, I continued to work with that therapist, so over the summer break she gave me the name of someone to work with during the summer session. Worked with her and we didn't have a very good
ending to that summer session. It just brought up all kinds of stuff. It probably wasn't a good time to work with her. She was pretty challenging for me. Initially I was going to go back to her and when spring came around I went back and talked with her and decided it wasn't working. She said why don't you go see this woman. I had seen (current therapist) do a workshop before and it wasn't that I didn't like her. It wasn't that there was anything particular about her, I just didn't know that I wanted to work with her. So I went to the interview anyhow. I liked her so much. It was really wonderful. Met with her and she was really neat. In fact, she said that she wished I would work with her. She really liked me too and the work that I was doing. That meant a lot to me and it just started after that. Did a few sessions where we kind of transferred over some stuff. Started up May 3rd."

"Well, my sponsee in AA, her mother is in a recovery program in Pennsylvania and it's for ECLA [client term, undefined] treatment. She works by the treatment center and her mom recommended a family therapy institute to her daughter and when I called and asked who she would recommend, she said that institute. [The institute is the agency the therapist works at] (Friend) also, my sponsee's, also been in a mental health field herself working in setting, therapy setting, so I was hearing a lot of negative stuff about therapists and people that she worked with so I was kind of leery about who to go to and she told me that these people were very good and highly regarded and so I got their names. And then whoever I talked to at the intake recommended (current therapist) for it. So I didn't specifically ask for her or anything. I just kind of told them the basic problems and she recommended (current therapist) and it worked out real great."

"I had gone to (County) Victim Services meeting one time for Incest Survivors and found the meeting, the support group to be too intense for what I
needed, those women had all had recent memories and I had never forgotten, so we were at different levels. I needed one on one so I could get on with things and after that initial meeting I had called back over there and they gave me several names. She mentioned (current therapist) and I just picked her.

"I had called through my previous company. Help through EAP (Employee Assistance Program). She was the therapist in the area."

"It was through employee assistance. In order for you to get..if you're sick you can go to any Ph.D. and you can get it on the insurance, but in order to have any mental health assistance, you have to go through employee assistance at the University. Then they see you and refer you to..she gave me a sheet of paper with about 30 names on it..(Current therapist) just seemed to be the one that struck me. I have always had better luck with people who have L's in their name if they're going to assist me so that kind of led me to her. I never told (therapist) that though.

I: So, it wasn't anything particularly that employee assistance said about her? R: She was good with female issues. A lot of it was..my hang ups are very female oriented, I believe. Just because of my lovely social status of being, (a woman). with sex..is where most of mine have developed. So she seemed to be a ringer for that.

I: So there's was something about female issues that employee assistance said that (therapist) is good with? R: She has a good knack with them. Something that I have found..oh, the woman that sold me the ring, she says oh, I know her, she's fantastic. I told her I'd seen her about four or five times now and she says oh, you'll really like her. So other people in the community know I'm seeing her, and they're women and they really like her."

"Through a friend."
I: Was the friend seeing (therapist)? R: Yes. She was also a feminist therapist who I would have gone to had she not been a really good friend."

"She was on a list of those recommended by a doctor at Iowa State University. I went to the employee assistance program, she suggested that I might consider seeing someone for some longer, on-going therapy. She had the list of people. She explained which ones were covered by insurance and maybe some of the strengths of them. Both what she described to me sounded good. I have this whole list of people. I have no idea who to pick from. I'm going to stay in. She sounds good. She's at the top of the list. We'll start there. So a combination of she was first on the list. She certainly fell into the group of people that sounded good. I thought that I would really like her. Plus she assured me that if it wasn't working out that I was free to change at any time. So with that flexibility, it was like let's get started. I hate to say it was a matter of happenstance and it has worked out wonderfully. I couldn't have made a better choice if I would have thought about it for a week."

"She was a therapist for several of my friends who were also therapists. And also, in fact, three other women in my support group have used her, she is a just a common name, and two of my friends who were going to her were also doing some training with her. And so I just heard about her a lot from friends."

Elaboration

This domain emerges largely from the response to the question, "How did you get to your current therapist?" The referrals can be divided into two groups, those that came from formal agency connections and those from informal connections.
The formal connections include the client seeking out helping services initially from another agency. The initial contacts ranged from a student counseling service on a college campus, employee assistance program and government services for victims. One employee assistance program gave a general list, another employee assistance program gave a detailed list with personalized information and suggestions based upon the therapeutic need of the client. In two of the employee assistance cases, the referring therapist gave substantive recommendations on the therapists, but the clients also choose therapists based on the alphabetical order of the names.

Informally, positive referrals were made through friends who had previous experience with either the agency or therapist. Two clients had friends who were former or current clients of the therapist.

The data show some variety in how clients finally engage in therapy. Intentional connections are made based upon the perceived "fit" of the therapist's expertise and the client's need. One client described interviewing a prospective therapist, another talked about the option of checking out the therapist before committing to long term work with her. In all eight cases the client was given either a specific name or agency to begin their search for a therapist.

Domain: Previous therapy experience

Similar to other domains in this theme, this domain is more imposed than emergent. Clients describe previous therapy experiences and remark on differences between the earlier experience and the current feminist therapy.
Characteristics of previous therapy experience

"(Initial therapist) was the first therapist I started with and I started with her right away when I went to college. They have similar styles as far as letting me guide kind of what I'm going to do. That would be essential for me. I would say (initial therapist) was much more supportive and (current therapist) a lot more confronting. Which I like now a lot. I don't think I could have tolerated it when I first started. That's why I think it's been a wonderful transition. I think when I did do the transition that's exactly what I needed and why we mesh so well. That was primarily the biggest style differences. Both of them have similar focuses on sexual abuses and what it means, feminist perspectives on that thing. My first therapist was a little bit more political about that kind of stuff. Which was nice at that time. I don't know much about that with (current therapist) so I really don't have a clue. In terms of, both of them do the same kind of work, longer term therapy. Although that was changing at school and that was part of my motivation also was to hook up with somebody else, long term. The continuity was another thing. I could see her all year around versus just the nine months of school with my first therapist. I think I've always sought out people like that. I've always paid for therapy myself without insurance and so I've had the opportunity to seek out the kind of therapist I want instead of having to be short term or something."

"I have been battling with depression for many years. I think my first experience was when I went into the doctor and said I needed something for depression and he said okay, I'll give you this pill, but you need to go see this guy. So, I ended up going to see a psychologist for a while until I felt myself getting strong enough, at the time, I was trying to get out of my second marriage I was in. My self-esteem was good enough to get out of that marriage. Since then, I've been
to two other therapist besides (current therapist) and I guess what's different about it, is two other times before this it was like I'd go in and talk and I wouldn't get any feedback. With (current therapist), it's different. She listens and then she gives us feedback as to what she thinks is going on. And it is real different in that aspect. But, I guess the reason that I've gone in has always been something with the self-esteem and depression stuff has gotten me there. But I ended up not being happy with the two other therapists before this. Just because I didn't feel like I was getting anywhere. Went in and talked and okay, fine, bye, see you next week. You know, not very much good. How do you feel about that? You know. That didn't help me a lot. It didn't help explain what was going on or why I came up with ideas in my head that I did. I guess those were the basic differences.

Yeah. She explains a lot of where she thinks stuff might be coming from, where we might get that impression or feeling or anger or whatever and then she checks it out with us.

And then we discuss it back and forth. Which is, you know, totally different than anybody else. And also, as far as the treatment part, one thing that is different with (current therapist) is if I ask her about a recommendation about a book or what I should be doing, you know, she'll give me one...She'll have some kind of idea. She usually doesn't give me homework. But, like I asked her about a book on self-esteem and she said, 'As a matter of fact, I do have one.' And she gave me a name and I just went out and bought it today. So she's real helpful as far as outside interests, other resources that I might be able to use or things that we might be able to work on at home here. So, that's different...you know, how do you know what the other therapist's philosophical view is when all you hear is well, 'how do you feel about that?' You know?
"My first husband was very physically abusive and at the time I was a psychiatric nurse....I went to counseling then and then when I was married a second time for about a year and a half (a former husband) tried to go to counseling. I was just very angry. He retired from the military and literally vegetated for a year and a half. Said that I was to support him and that was just all there was to it. I went into counseling with him and it turned out that he (social worker) at Lutheran Social Services of (northern Minnesota town) told me immediately to get away from him as fast as I could because he would eventually, a good tendency from his MMPI, would be to kill me.

I went to counseling then and also went into a group codependency counseling until I moved down here. It really seemed to help, once I got here, it seemed like I just lost everything. For all the confidence I gained from the codependent group I was in up there and the counselor I was seeing, and once I got away from all my support system, I got here (current town) and it was just like I crawled into a hole....It didn't take me but a year to start spreading out and realizing that I needed a support system and (husband) couldn't handle that. So, back in counseling I go again.

I: Could we talk a little bit about differences in philosophy or style between other therapists and (current therapist)? R: Let's see, the last two...well, this stems about 20 years though, too. The first ones were more, they were just initiating into the parent/child type therapy. So they always had to put somebody into a slot. It was always dealing with this imaginary person and a chair... As it progressed through the years, therapy had come to be where you work on yourself. The other person...you cannot even imagine that person in the chair. If you doing something that you need to spit it out, you still know that's an imaginary person. You're not
waiting for that person to talk back and you're not hopping back and forth between chairs. Because the first time, they would literally have you play both roles. Well, now it's growth on your own. It's where you're at. So, I do like the way the therapy has evolved over the last 20 years. They work from a different point of view and they really didn't know what codependents were. ALANON was something that even scared a lot of people and they talked about it in kind of a circular fashion. They never hit it on the head that the person in ALANON was actually just as sick as the person that was drinking. They never pointed this out. They just said you were coping with this. You were coping with the problem. You weren't having a problem in your life that you had to cut the vicious circle and you had to go on with your life. You know, you either adapted to this drunk or you left the drunk. Now, it's look at yourself and where you're coming from and why do you put up with that drunk? What are you getting out of it? It wasn't always you're OK, I'm OK. Now you can see it from a lot of different aspects and you can see where you're hang ups actually evolved from."

"Yeah, I saw a therapist in 1983. Then I was in (another university town) for a year and was in a therapy group in. I attended that year. I came back just a couple times and saw the original one when I was back here. Must have been 1984. Then last summer, I saw someone in a clinic. Maybe three or four times. Not continuous.

I think (current therapist) is probably more cerebral than maybe some of them. She figures things out and thinks things through. Probably more cerebral."

"I went to student counseling in 1984 or 85. I'm sure I was carrying around some of the same issues. I was an older undergrad and I was living with someone in a long, long term relationship which was very unsatisfying. Working too many
hours. I was a computer science major so I spent a lot of nights up programming. As an older person trying to have a normal social life, I was overextended and stressed out. Plus carrying the weight of some family issues that I held on tightly to for many years. Finally went to student counseling and saw a counselor a number of times and we did some couple's counseling with another counselor. She was an enormous help in telling me it was okay to let loose of some things. It seems so stupid that I needed someone to tell me it was okay to think this way. It's okay to be selfish now and then. After a period of time...I went like every week for a few weeks, then it was like once a month, or if I needed to. By that time the script was in my head and if there was something I wanted to tell her, I could hear what she would say and I could hear what I would say. So the script was there. I liked her and I wanted to go to talk to her. I found that I could go work a lot of those issues we'd been dealing with out by myself because I knew how. Then I found the strength to say this relationship is not going anywhere and yet I couldn't stand to be alone. So, which I really think it was the best thing I ever did. I saw someone for a brief period of time. This was a special situation so it was okay for me to see a counselor here. Although I was real closed about it and didn't tell anyone. I kept it very private. I saw it as a weakness that I couldn't deal with it on my own. That would have been '84 or '85."

"I was in kind of group therapy/peer therapy which was called reevaluation counseling, and there were a lot of therapists in. It was more of a peer nature. So I've done a lot of workshops and individuals sessions. I was in that for 5 or 6 years. Um, I went to marriage counseling once before, when I was considering marrying someone. And during the time I've seen (current therapist), I've seen other people and that was primarily because of finances, because she doesn't take insurance.. It
was primarily because of grief counseling. I went to somebody who took insurance. My preference was to go to her, but I could not afford, $75-80 a week, at the time. So I have seen other people. And (husband) and I saw a man before we saw (current therapist).

I: Can I ask, in terms of, the person that you and (husband) saw together, was there a treatment or philosophical or style difference from (current therapist)?

R: Yeah, there really was. Yeah, nice guy. [laugh] This was real confidential. He was an ex-priest, he started off, 'I just think what you do is wonderful.' (said to husband) And I was just kind of going [laugh] what he does is part of the problem. That was hard. The session was not very helpful for me. It just, it may have been different, but right away, his initial approach, and some of the things he said where not what I needed. So at that time I needed to find somebody else. And I found (current therapist) and she's real helpful. And at that time I also wanted to go to a woman and wanted to go to a feminist, but was willing to see what that therapist was like, that was (husband's) choice.

Elaboration

The clients describe previous therapy experiences and contrast differences with current therapy in this domain. Six clients report previous therapy experiences.

The youngest informant has seen two therapists in her life and both were feminist therapists. The reason for transferring had to do with the first therapist working for a college and having limited client contact hours. A second client had also been involved with student counseling services. She found the previous experience to be positive also.
One client has suffered years of depression and seen several therapists. Her primary contrast was that the earlier therapist/psychologist gave no directions and asked mostly "how do you feel about that?" kinds of questions. This client regards her current therapist positively and describes her as more directive, more forthcoming with theories and opinions and equipped to share specific resources and ideas for change.

Three clients had been involved in group or peer therapy experiences. One client reflected on the evolution of the helping professions over the past twenty years from Transactional analysis, parent/child paradigms, to ALANON co-dependency models to her current therapy which emphasizes self-responsibility. In this group, one of the women had also attended couple's therapy with a former priest and remarked with humor how inappropriate and blatant his chauvinism was. This propelled the couple to find another therapist.

**Summary of Findings**

Three themes emerged from the analysis of the transcripts. They are respect for the client, integrated feminism and mechanics of therapy. The themes reflect both process and content issues that clients state have been significant in their therapy experience.

The findings represent a confirmation of information already in the literature, and new findings. These connections will be discussed in the final chapter.
The conclusion chapter covers four topics: an examination of the findings, limitations of the study, suggestions for future research and clinical implications. This chapter builds on the preceding material.

**Examination of the Findings**

From the findings chapter connections can be made between the data with both analytical categories, issues raised in the literature review, and cultural categories, issues raised in life experience. The examination of findings will look at each theme and domain and make the connections between the analytical categories and the findings explicit.

Respect for the client is the first theme and encompasses the domains of client-directed therapy, affirming and empowering the client and the therapist shares herself. From the literature review these domains could be expected to emerge from the data (Gilbert, 1980).

Libow, Raskin and Caust (1982) state that one of the hallmarks of feminist therapy is that clients assert more control over the therapy process and therapeutic relationship than in traditional therapies. Thus, the examples of clients making lists, preparing agendas, asserting topics or goals for the therapy are congruent with the literature. The presession work and setting the agenda noted in the findings were finding anticipated by the literature.

The affirming and empowering domain fit with the literature. Williams (1976) suggests that feminist family therapy increases the client's self-esteem, sense of power and autonomy. The findings suggest affirmation does occur and that it is felt
in a significant way, and that it is much broader than simple ego boosting. Williams also notes that feminist therapy should make the client more aware of victim behavior. This awareness is only demonstrated twice in the findings and may be more appropriately elicited in different therapeutic needs than were addressed by this particular client population.

The therapist shares herself is noted in the characteristics described by clients as the therapist displaying values, humor, personal stories, being physically relaxed and giving examples from her own life. Gilbert (1980) and Libow, Raskin and Caust (1982) state that a hallmark of feminist therapy is the egalitarian client-therapist relationship. The therapist shares herself is one expression of the egalitarian effort made by the therapist. Without exception, all participants reported this phenomenon occurring. In addition to the experience of equality, the clients reported that having a therapist who shared the female experience was a favorable aspect of the therapy.

Marecek, Kravetz and Finn (1979) discuss feminist therapy as being a therapy that is not so much about specific techniques, but about an underlying philosophy. The theme of integrated feminism reflects Marecek, Kravetz and Finn's view. The therapy described by the informants incorporates a feminist philosophy and feminist values, and the actions by the therapists are congruent with feminism.

Braverman (1988) states that a feminist therapist acknowledges the social and political context of the therapeutic need. Under the theme of integrated feminism, these characteristics are similarly described in the contextualization of the issue domain. Here the therapist is described as connecting issues to the culture, men's and women's expected roles, generational patterns and ethnic patterns. The practice of connecting personal stories and situations to a broader
context is reported in the literature (Avis, 1986, Goldner, 1985, Hare-Mustin, 1978, Lerner, 1989 & 1993, Simon, 1984). The participants stated the contextualization occurred both early in the therapy process and ongoing. Overall it was viewed positively and as educational.

Libow, Raskin and Caust (1982) suggest that feminist therapy is not just observation of cybernetics and not just observation of content; rather, attention is given to both. What was reported by the participants was that the therapeutic need or presenting problem included issues of: sexual abuse, sexual harrassment, relationship issues, depression, stress-related concerns, work place and career issues. Feminist therapy is described in the literature as being able to successfully address the diversity of these issues (Johnson, 1976).

Johnson (1976) states that clients of the Philadelphia Feminist Collective ranked the following three items as the most helpful aspects of their therapy; seeing the therapist as a competent woman, knowing the therapist shared the female experience and discovering other women as central and helpful. The findings clearly illustrate the first and second items as similar positive aspects. The third item is not as prominent in the data. One reason for this omission may be context in which the Philadelphia Feminist Collective employed group therapy as well as individual therapy. All of the women in this study were seen as individuals or couples and would not have experienced the bonding and support that a group context can provide.

The theme mechanics of therapy emerges more as an imposed theme because its correlation to questions in the protocol. The three domains are barriers to therapy, referral to a feminist therapist and previous therapy experience. Unlike the other themes, this theme was not examined in the literature and does not have
the same kinds of analytical categories to draw upon. What it does offer are some answers to practical logistics for any therapist and the feminist therapist in particular.

Most of the barriers to therapy reported have to do with physical and financial considerations. High fees, high co-payments with insurance companies and inability to receive insurance payments are the most frequently cited barriers to therapy. These may become more significant issues for clients and therapists as the national health care debate decides policies on mental health coverage and managed care options. Other factors influencing barriers to therapy include the distance the client travels to the therapist's office and the clinically sterile environment.

The referral theme demonstrated how critical of a role a good referral network is. Where an employee assistance program was involved in providing an initial screening of the client's needs, the referral to a feminist therapist was positively made. The second most common referral reported by the respondents was the use of therapist by a friend or colleague.

Finally, the majority of the clients reported previous experience with other therapists and therapy styles. Only one respondent specifically mentioned having worked with a feminist therapist prior to the current therapist. In the responses, when nonfeminist and traditional therapists were described, the outcome of therapy was generally reported as having been less helpful than the current therapy.

Limitations of the Study

This section describes the weaknesses of the study by design and weaknesses that were discovered in the process of the research. Careful reading
of the methods chapter will elaborate on the details of the method, which are only alluded to here. Sampling, cautious participation, quality of responses, type of therapy, and the race representation of the participants are noted.

The sample was based on volunteer participation, not a random sample. The sampling method was purposive (Guba, 1981) and attempted to generate as much diversity as possible within the small participant number. It is unknown whether this type of sample generated a representative population. The participants may be more highly motivated, verbal and satisfied than non-participating clients, but there is no means to test this.

Feedback from a participating therapist included the remark that most of her clients were survivors of incest and abuse and that they were cautious about participating because they did not want to reveal their history to a stranger. This comment may suggest that some data may be more accessible when the interviewer is not a complete stranger to the client.

Because this study was grounded in talk (Devault, 1990), the results were highly dependent upon the depth of the conversation and ability of the respondent to articulate her experiences. Like any interview research, this study was limited by the quality of data that was able to be generated through the interview. Examination of the transcripts show the diversity of the participants' ability to describe their experiences.

The majority of the respondents (6 of 8) were seen by their therapists in individual therapy. This may reflect the type of respondents who volunteered for the study, the extent that this represents the percentage of individual, compared to couple or family, sessions a therapist conducts is unknown.
The study was drawn from a sample of Caucasian therapists and their clients. All of the clients were Caucasian. This characteristic may be helpful in describing one particular population, but it is a limitation in that it does not include the experience and contributions of women of color.

**Suggestions for Future Research**

Suggestions for future research beg the questions, "What was left undone by this study and how can the study be improved?" Three areas stand out as possible variations that might generate data for interesting comparisons. They are gender, theoretical paradigm of therapist and racial background.

This study was focused on female clients of female therapists. The field can be enhanced by a similar research design that involves male clients of female, feminist therapists. While some debate exists whether a male therapist can be a feminist therapist (Williams, 1976). Research on male, feminist therapists may be a future area of research, and has the potential to generate interesting comparisons.

Likewise, a comparison study, using the same protocol with nonfeminist, or traditional therapists and their clients might highlight the contrast and similarities between the therapeutic paradigms. A comparison study, designed to limit extraneous factors may be one of the closest ways to compare theoretical and practical differences.

Finally, a study with greater diversity in the racial and ethnic backgrounds of the participating therapists and client participants will yield additional insight. With the combination of feminism and the Women of Color movement (Cole, 1993, Davis, 1981, Walker, 1983) and the international feminist perspective (Carter,
1992, Hindmarsh, 1993) influencing feminist family therapy more and more, a broader racial composition of the study will add significantly to the field of study.

**Clinical Implications**

The examination of the findings has pointed out that the client description of feminist family therapy has strong parallels with the literature of the feminist family therapy field. This congruence affirms that clients appreciate the intentional and overt feminist process and feminist content of the therapy. In summary, the data affirms that feminist family therapy is doing what it claims to do.

At a glance feminist therapy might appear like some of the paradigms of therapy that have developed under the influence of constructivism and social constructivism. Examples of these might include Narrative Therapy (White & Epston, 1990) or other language and story based therapies like Collaborative Language Systems Therapy (Anderson, 1993). The constructivist era attempted to take the reality presented by the client seriously. Social constructivism incorporated these same notions only added the social or communal dimensions. Like wise, feminist therapy gives credence to the constructivist and social constructivist avenues of understanding the individual experience, but it does not stop at this point. The divergence is demonstrated in the theoretical discussion of feminism highlighted in chapter one. Like the other paradigms, feminist therapy has a profound respect for the way clients describe and tell stories about their lives. Unique to feminist therapy is the consciousness it always holds as a back drop and tool for analysis with the clients. The feminist consciousness includes awareness of patriarchy, heirarchy, misogyny and sexism, to name but a few. Feminist therapy also submits that no therapist works from an absolutley “neutral” position. Every
therapist has a world view and how she or he relays or promotes this to the client varies in its explicitness. Nonetheless, the therapist's construction is always present. Feminist therapy has a clarity about its construction and why it presents its theory and understanding in a particular way to the client.

It is hard to imagine a form of family therapy that does not conceptualize and express even the most basic principles of feminist therapy. These principles include respect for the client, sharing of the therapists self, empowering, encouraging the full development of women and contextualizing the issue. Yet the clients report many of the positive elements of feminist therapy have not been present in their previous experiences with nonfeminist therapists. To the lay reader in family therapy, the positive elements described in the findings may appear to be simply markers of good therapy. They are not. The markers told by the clients are explicitly about feminist family therapy.

Leupenitz (1989) asks the pragmatic question, "Does this [feminist] method work?" The answer from the informants is a resounding "Yes!" Leupenitz also states the "...traditional family therapists tend to ask feminist therapists how they 'do it' differently or better (1989, p. 7). The answer is in the findings. Traditional therapists need to examine their practice and compare and contrast the responses they might get from a similar conversation with their clients.

"Feminist therapy, to paraphrase Lillian Robinson, cannot be 'patriarchal therapy in drag.' The solution is to problematize the issues of mother blaming and father coddling - to put them on the table rather than condemn them to the dim corridors of common sense. If family therapy cannot be done well without devaluing women, we should know that. If it can, then we must ask why therapists choose to do otherwise" (Leupenitz, 1989, p.13-14).
REFERENCES


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Thank you.
Dear Therapist,

Thank you for your participation in the study on feminist family therapy. The therapist's role in recruiting clients to be informants is a critical piece to the success of this research.

Enclosed are ten respondent forms to give to female clients. The client needs to have met with you a minimum of three sessions. Stapled to each envelope is a letter describing the study and a demographic form that will be used in selecting respondents.

When you invite clients to participate in the study, I hope you will invite the full spectrum of your client base, this includes clients you feel have had positive experiences as well as clients that have been more difficult to work with.

Please take a few moments to fill out the enclosed form that describes yourself and your practice. In addition, there is a short instrument for you to fill out pertaining to your opinions influencing therapy.

The results of the study will be available this summer. You will be sent a summary of the results, which will both affirm and inform your current practice.

Thank you for your critical role in the success of this study. Please feel free to contact me at any time if you have questions or suggestions.

Sincerely,

Ane K. Fitzgerald
Ph.D. Candidate, Iowa State University
APPENDIX B. PARTICIPATING THERAPIST FORM

Name ____________________________ Date __________

Name of Practice ________________________________

Type of Practice ________________________________

Length of time in this organization __________________

Length of time practicing as a therapist _______________

Clinical Memberships and Licenses ____________________

________________________________________________________________________________________

Education and Training ____________________________

________________________________________________________________________________________

________________________________________________________________________________________

Major schools of thought, philosophies or paradigms influencing practice

________________________________________________________________________________________

________________________________________________________________________________________

Other identifiers to your practice or unique aspects to your work

________________________________________________________________________________________

________________________________________________________________________________________

2/93
The following statements describe different ways therapists might conceptualize gender, clients, and the process of therapy. Please put the number which best describes your opinion about these issues after each statement.

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Have mixed Feelings</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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</tbody>
</table>

Example: Family therapist should only see individuals 5

1. Traditional approaches to family therapy validate the uniqueness of women's experiences

2. In the family system, women have equal power to men.

3. The traditional nuclear family does not provide men with the experience of being emotionally responsive.

4. Special attention should be directed to what is unique about the problems of women.

5. Notions about masculine and feminine roles are major determinants of family rules.

6. The traditional nuclear family supports women's psychological health.

7. If therapists do not challenge traditional relationships, clients will perceive this as approval of these relationships.

8. Most women enter therapy with power equal to that of men.

9. The traditional nuclear family supports women's productive creative selves.

10. Family therapists should not influence the distribution of power in intimate relationships.

11. Families are structured by generational and gender hierarchies.
12. Therapist reinforce traditional sex roles by not addressing them.

13. The traditional nuclear family views the role of peripheral male as normal.

14. Interactional patterns within the family reflect our patriarchal social systems.

15. In dual-career families, women often have the primary responsibility for the emotional/psychological well-being of both their children and spouse.

16. Patriarchal values are not inherent in our socio-political system.

17. The traditional nuclear family conditions women to an inferior status.

APPENDIX D. CLIENT LETTER

2818 Rutland Avenue
Des Moines, IA 50311
February 20, 1993

Dear Client,

Your therapist and I have an interest in improving ways therapy services are delivered. We are asking you to help us by meeting with Ane Fitzgerald for an interview about your experience with therapy.

I am a doctoral candidate in the Marriage and Family Therapy Program at Iowa State University. The interviews are part of my dissertation research.

Participation in the study involves one interview, approximately sixty minutes long, and a brief follow-up telephone conversation or written response, one to three months after the interview. The location of the interview will be at an office in your city or your home, whichever is most convenient for you.

The study is completely confidential. The interview will be audio taped, your name will be substituted with a code number.

Participation in this study is voluntary. No compensation or fee will be paid to either party. If you are interested, the results of the study will be made available to you during the summer of 1993.

If you are willing to participate in the study or would like more information, please fill out the demographic form and mail it in the attached envelope. Thank you in advance for your cooperation in this project.

Sincerely,

Ane K. Fitzgerald
Participation Form I am willing to be interviewed.

Name_________________________ Date____________________

Address________________________________________________

Telephone home:_________________ work:_________________

Best time to call_______________________________________

Name of my therapist______________________________

Date current therapy began_________ Approximate number of sessions____

Type of therapy currently involved in, check the most appropriate:

individual_____ couple_____ family_____ other, describe____________

Please give a sentence or two describing the major goal(s) of your current therapy___________________________________________________________

__________________________________________________________

Date of birth_____/_____/____ Marital Status_________________

Race__________ Sex_________ Number of children___________

Occupation____________________________________________

Highest level of education completed_____________________

Please circle the time(s) when you would be available for an interview.

weekdays weekdays

daytime evenings

Are there any other considerations, you want me to be aware of?
APPENDIX F. INFORMED CONSENT

This research project is aimed at understanding the therapy process and experience from the client's perspective. The researcher plans to use this information to educate and train other therapists in how to better provide services to their clients.

The project consists of answering a series of questions about yourself, your therapy, your therapist and your perceptions about the therapy experience in general. After the initial interview, you may be contacted by telephone or letter and asked additional questions, similar to the first ones.

Your participation in this project is completely voluntary, and your therapy will not be affected in any way if you refuse to participate or decide to withdraw from the study at a later time. You may refuse to answer any question and can withdraw from the study at any time.

The information you give me will be completely confidential and your name will not be associated with your answers in any way. An audio tape recording will be made during the interview. The tapes and transcripts will be kept locked in a secure place. Your name will not appear on any of the information, and an identification number will be used to keep track of the data in the study.

If you have any questions about the project you may contact Ane K. Fitzgerald, Ph.D Candidate at (515) 274-1936 or Dr. Linda Enders, Major Professor and advisor to the study at (515) 294-8439, Iowa State University.

This project has been fully explained to me. I understand the procedures for obtaining information and am willing to participate.

Signed: ___________________________ Date: ________________

Witness: __________________________ Date: ________________
APPENDIX G. INTERVIEW PROTOCOL

A. Demographics - Introduction

1-How did you find your therapist? What was the process you went through to get her name?

2-How long have you been seeing this therapist? Number of sessions over what length of time?

3-Describe briefly, the reasons that brought you in to see your therapist. (individual, marital, family...other) Does anyone attend therapy with you?

4-Have you ever gone to a therapist before you went to therapist X (current therapist)? How are the circumstances similar or different this time in therapy, than your previous experience? (Are there any treatment, philosophical or style differences between therapist A & B?)

B. Grand Tour

1. Describe a typical session for me. i.e. The last time you met. Walk me through what this was like for you. (Start with what was important for you.)

2. What do you like about or especially appreciate about your therapist, how she works with you? What have you found most helpful in your time together?

3. Is there anything you would change about how you work together? Do you have suggestions for ways to make it better?

4. Does you therapist ever give you "homework assignments" or tasks to do in between sessions? Could you describe some of them to me?

The next series of questions addresses specific actions, attitudes, values or techniques some therapists might display. I am not looking to critique your therapist, rather I am trying gauge how frequently they occur among therapists and how clients respond to them.

C. Sex-Roles

1. Does your therapist ever talk about the differences between the value of men's and women's roles and place in society?
2. Has your therapist asked you about the female and male roles/patterns in your current situation? Your parent's generation? Any other significant relationship?

3. Has your therapist ever discussed how your situation might be different if you were the opposite sex?

4. Does your therapist ever discuss your situation in terms of larger social issues—i.e. the society, cultural context, socialization?

5. Does your therapist ever talk about how certain roles can be limiting to women and men? (i.e. stereotypes can prevent individuals from being their full potential)

D. Power

1. Does your therapist ever ask you/challenge/suggest any of the following items...
   - more equal distribution of household tasks?
   - split child rearing tasks differently?
   - non traditional role changes for you or your partner?
   - direct female client to become more involved in activities outside of the home, particularly things that give meaning, money or recognition?

2. Who would you say your therapist expects to change the most, or initiate the most change in your current situation? You, your partner or both equally?

   I want to shift a bit, to talk specifically about how your therapist works with female clients.

E. Empower

1. Has your therapist ever...
   - focused on the unique and positive contributions you make to the family?
   - encouraged you to be more assertive?
   - encouraged you to find support in someone other than your husband—male partner?
   - helped you to focus on ways to get your personal needs met in and out of the home?

F. Skill Training
1. Are there specific things your therapist may have taught you...

- skills on how to express anger-disappointment-disapproval effectively?
- teach male clients how to recognize and express feelings?
- teach male clients how to nurture family/others?

G. Hierarchy

1. Does your therapist communicate her own values clearly to you?

2. Does she work in collaboration with you, i.e. see you as the best expert on yourself?

3. Does she ask you where you are in the therapy process, i.e. ask if its going well, are you making the progress you want, meeting your goals?

F. Feminism

1. Please describe what feminism means to you? Do you consider yourself a feminist?

2. Therapist X advertises or is described to be a feminist therapist. Were you aware of that before you started meeting with her/him? How did you find this out?

3. How outspoken would you say your therapist is about feminism, feminist issues?

4. How does her feminist perspective influence your opinion of your therapist's work-practice-professional qualifications?

I. Closure - Wrap up

1. Are there other things you would like to tell me about your experience in therapy?

2. What question did you expect, that I did not ask? Your answer?

3. How has this interview-research process been for you so far?

4. Is there anything you would like to know from me?
-In 1-3 months I will be doing a follow-up to today's interview, after I have talked with a few more clients and begun to analyze the data. I will either send you something in the mail, or make a quick telephone call to you.

-Thank you !!!
Dear Confidential Respondent [substitute name],

Thanks for taking a look at this data. I think you will find it interesting.

Feel free to read the entire document or pick 3 or 4 domains that look the most interesting to you. If you could make a general response to the domains you read, that would be helpful to me. I am interested in things like, does the domain reflect your experience? Is there a gap or something I misunderstood from your experience? What rings a bell or is particularly true for you?

With the other respondents, I wanted to know if they could recognize themselves or their situation in the data. If you were quoted, are you comfortable with how the material is handled? Also, from your memory, are there any ideas, examples or key points that I may have missed?

Please jot your notes on the enclosed paper or directly on the transcript. I will call you after January 2nd.

Any and all comments and feedback are welcome. I appreciate your time on this.

Sincerely,
APPENDIX I. HUMAN SUBJECTS APPROVAL

12. Letter or written statement to subjects indicating clearly:
   a) purpose of the research
   b) the use of any identifier codes (names, #s), how they will be used, and when they will be
      removed (see Item 17)
   c) an estimate of time needed for participation in the research and the place
   d) if applicable, location of the research activity
   e) how you will ensure confidentiality
   f) in a longitudinal study, note when and how you will contact subjects later
   g) participation is voluntary; nonparticipation will not affect evaluations of the subject

13. Consent form (if applicable)

14. Letter of approval for research from cooperating organizations or institutions (if applicable)

15. Data-gathering instruments

16. Anticipated dates for contact with subjects:

   First Contact

   1/25/93
   Month / Day / Year

   Last Contact

   8/28/93
   Month / Day / Year

17. If applicable: anticipated date that identifiers will be removed from completed survey instruments and/or audio or visual
tapes will be erased:

   8/28/93
   Month / Day / Year

18. Signature of Departmental Executive Officer

   [Signature]

   Date

   1/14/93

   Department or Administrative Unit

   HDFS

19. Decision of the University Human Subjects Review Committee:

   X Project Approved
   — Project Not Approved
   — No Action Required

   Patricia M. Keith
   Name of Committee Chairperson

   11/14/93
   Date

   Signature of Committee Chairperson