A Portfolio of Academic, Therapeutic Practice and Research Work

Including an investigation into the relationship between feminist philosophy and psychotherapeutic principles within the context of therapeutic practice with women.

By

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Introduction to the Portfolio

This portfolio represents a selection of work carried out in partial fulfilment of the PsychD in Psychotherapeutic and Counselling Psychology at the University of Surrey. It presents the three central areas of training; academic work, therapeutic practice and research based activities. A selection of papers has been included with an emphasis on the integration between theory, research and therapeutic practice.

The Academic Dossier contains papers concerning the theoretical underpinnings of Counselling Psychology, which arise from the following course modules: Theoretical Models of Therapy, Advanced Theory and Therapy and Issues in Counselling Psychology.

The Therapeutic Dossier contains descriptions of the three clinical placements and a personal account of integrating theory, research and practice.

The Research Dossier contains three research papers: a literature review and two empirical studies.

Due to the confidential nature of therapeutic work, related practice material has been edited throughout this portfolio in order to ensure that the anonymity of clients, service contexts and research participants has been preserved. The full reports and notes are available in the confidential appendix, submitted separately but not publicly available.
Academic Dossier
Academic Dossier

This dossier contains a selection of academic papers and one report that were submitted during the course. The first paper is concerned with the theoretical foundations of therapy. This paper examines anger as a theoretical construct from the perspective of two theorists. The subsequent two papers are taken from the module covering 'Advanced Theory and Therapy'. The first of these addresses issues surrounding the Therapeutic Frame, whilst the latter focuses on an investigation into the role of the therapeutic relationship in Cognitive-Behavioural Therapy.

Finally, one report from 'Issues in Counselling Psychology' explores the contribution that feminist philosophy has made to therapeutic practice, documenting its development as a therapeutic intervention, and drawing parallels between the growth of feminist therapy and counselling psychology.
Comparing the Theoretical Aspects and Clinical Implications of Anger as Conceptualised by Klein and Winnicott.

"Rage is a common clinical problem for which there has been little agreement on an effective therapeutic approach." (Nason, 1985, p. 167)

Indeed, as suggested by this quotation there has been a "dialect of psychoanalytic controversy" (Ortmeyer, 1984, p. 625) as analytic theorists wrangle with the various notions of anger in an attempt to explain and understand its existence. Within this arena it seems that three main themes emerge. Ortmeyer (1984) observes that these concern the instinctual origins of aggression, aggression as a defensive reaction to anxiety, and the embedded nature of aggression in the developmental growth toward separation and individuation. With this in mind this essay will explore these themes as outlined in the work of two theorists, Melanie Klein and Donald Winnicott. It will review their analytical positions and the implications that these have for clinical practice. As a result both commonalities and areas of divergence will be highlighted. At this point it should be noted that the terms 'anger', 'aggression' and 'rage' will be used interchangeably in this essay.

For Klein (1997), aggression had its roots in infancy, and the infant's earliest mental processes. She believed that from birth the infant experiences powerful conflicting and desires, and:

"Even if the early environment is perfectly good () the child will experience anxiety and fear, and will suffer aggressive and destructive emotions." (Frosh, 1987, p. 117)

She theorised that anger, rage and other feelings of aggression arose from a threat of destruction to the self or ego. As noted by Kraus (1997), Klein believed that:

"Feelings related to aggression and the mechanisms defending against feelings of aggression are central to the development of personality." (p. 131)
Expanding upon this concept, she suggested that persecutory feelings are conceptualised by the infant as an external threat, which are then projected outward onto significant others in defence. Central to her theory is the suggestion that feelings of aggression are dangerous. Consequently, in order to protect himself from this danger, the infant attempts to split off aggressive feelings whilst trying to hold onto feelings of love and understanding felt from these significant others. Within this category falls the primary caregiver, the mother, whose breast becomes the first object of desire for the infant. As a result of this splitting the object is then perceived by the infant as having two facets: a good and loving part and a bad and persecutory part. Incorporating the work of Freud, Klein mapped this onto his proposal of the Life and Death Instincts, with the good part being the early representation of the former, with which the infant aims to identify. However, the breast is also regarded as bad through a process in which the ego manages threatening feelings emanating from the Death Instinct by projecting them towards the breast. With regard to this, the Death Instinct operates at the core of the infant’s experience in terms of a battle between life and death and, indeed, love and hate.

Introjection and projection are the tools that the infant uses in order to deal with the perceived difficulties and threats, whereby the former allows him to take the goodness in making it a part of the self. However, more often than not this proves impossible and so the infant attempts to spoil the goodness of the object. Projection allows the infant to put badness into the object thus destroying it and so removing the source of envious feelings. The relationship between these processes forms the basis for, what Klein (1946) referred to as, the paranoid-schizoid position. She believed that that paranoia resulted from the perceived external threat of destruction of both the internalised good qualities of the mother and the positive aspects of the self. The schizoid nature of the ego derives from its defensive response to this threat with splitting. In practice this means that no good object can in fact be formed, as once the original object is spoiled it is dropped and another object is chosen, however, that also turns bad and is attacked, so that all the good is once again destroyed.

In resolving this position Klein believed that the infant would learn to feel more secure, developing a greater sense of internal strength. Thus he evolves increasing
capabilities with regard to containing the anxieties surrounding hostile feelings, no longer needing to project them outwards. Ultimately, he is able to recognise that the mother exists independently in her own right, as opposed to an object provided solely to respond to his needs.

Klein referred to this recognition as movement towards what she termed as the depressive position, which as Holbrook (1971) notes is “a pathological version of grief and mourning” (p. 117). Klein (1952) argued that the infant's aggressive impulses and desires towards the 'bad breast' would now also be perceived as danger to the 'good breast'. She suggested that this would intensify in the second quarter of the first year as the infant started to feel that he was destroying the whole object through greed and aggressiveness. Kavaler-Adler (1993) notes that in this position:

“Vicious cycles turn into developmental processes. This involves a growing capacity to love and to neutralise archaic aggression.” (p. 195)

However, she then goes onto explain that Klein doesn’t account for the necessary role of the external object in amplifying the infants capacity for love sufficiently for the depressive position to develop. In clinical terms this means that the therapist is not viewed in terms of her role as a loving external object. This is one area that Winnicott focused upon, which shall be explored later in the essay. Thus, although Klein’s theory allows the progressive developmental progress to become apparent, she attributes the whole transition in analysis to the power of interpretation ignoring the ‘holding’ nature of the analyst.

It is at this stage that Klein believed that the infant would attempt to make reparative overtures to the object that he previously launched sadistic attacks upon. This describes a variety of processes by which the infant’s ego feels that it undoes the harm in suffered through phantasy, and restores and revives the object through the formation of loving personal relationships. For Klein, the experiences generated by the depressive position could be surpassed, increasing stability and realism. However, as observed by Kraus (1997), it is important to note that the depressive position is never fully resolved:
“Some degree of ambivalence, idealisation, anxiety, insecurity and despair follow us all our lives.” (p. 134)

Before moving on it is essential to address some further aspects of object relations theory. Mendez and Fine (1976) suggest that Klein was:

“The first to describe internalised objects and see object relations as allies against an inherently destructive inner world.” (p. 359)

Thus for Klein, aggression would be conceptualised as an important expression of the quality of the object relations that a person is sustaining or has internalised from the past. She argued that aggression is a basic biological drive. However, this sits uncomfortably with Winnicott’s belief that “at origin aggression is almost synonymous with activity; it is a matter of part-function” (p. 204).

Klein, like many other psychoanalytic writers, assumed that destructive aggression was inherent at birth. Westlund (1988) argues that her assumption of ingrained aggressiveness, along with her acceptance of the Death Instinct and the inevitability of guilt, is unsupported speculation. Supporting arguments are found in the writings of Winnicott (1958, 1984, 1991). Indeed, he posited that the Death Instinct, according to Freud and accepted by Klein, could be rendered redundant, as it failed to address the two sources of aggression as he saw them:

“That which is inherent in the primitive love impulse and that which belongs to the interruption of the continuity of being by impingement that enforces reaction.” (1991, p. 113)

Moreover, he goes on to acknowledge that there may only be frustration generated in the primitive love impulse, and that if that is the case then perhaps the contribution of the Death Instinct should be re-examined. As Goldman (1993) notes, Winnicott did appear to believe that it was not valuable to use the term ‘Death Instinct’ when referring to hate and anger.
When exploring Winnicott’s work, it is useful to note that others have found him difficult to follow. Nason (1985) suggests that other analytic theorists appear to have misunderstood and misinterpreted him. He goes on to observe that Winnicott’s “ideas on aggression are much less well known, partly because they are less clear” (p. 173).

In fact it seems that Winnicott had several theories of aggression. As mentioned previously he saw it as an intrinsic component of primitive love, believing that the id would never be fully gratified:

“We can say that in the primitive love impulse we shall always be able to detect reactive aggression, since in practice there is no such thing as a complete id satisfaction.” (1958, p. 210)

He also believed that the origin of an infant’s aggression existed in the phenomenon of motility. It is here that the terms ‘facilitating environment’ and ‘good enough mother’ are applied in order to determine the development of the infant’s aggression. In contrast to Klein, although he accepted that the infant has a fragmented ego, he stressed that this would adapt in a natural fashion resulting in its integration into the self. The presence of a facilitating environment allows for this through support and non-intrusion. Winnicott argues that it was a failure of this environment that gave rise to splitting, rather then the defensive reaction suggested by Klein.

The ‘good enough mother’ acts in a manner that mediates reality through functioning as a kind of mirror. This presents to the infant an image of the strength of his or her presence in the external world. Frosh (1987) notes that if managed this “leads to the formation of a ‘true self’ as the child discovers the power of his/her egoic desires” (p. 106).

The infant with the ‘good enough mother’ is able to amalgamate motility with eroticism for “a maximal experience of the true self” (Nason, 1985, p. 174). The residual motility must find opposition in the external world. Taken literally, this could mean the infant kicking out his legs in an attempt to meet resistance in a bid to differentiate between the true self, or ‘me’ and ‘not me’. Winnicott argues, it is this
that develops into the core of aggression, whereby an individual is either able to accept and enjoy his erotic impulses as self-gratification or feels most vital through aggression.

Nason (1985) outlines another of Winnicott’s more complex notions whereby:

“The fantasy of destructiveness and the impulse to destroy are essential components of the normal affective and cognitive developmental processes of self-object differentiation.” (p. 175)

Ultimately the destructive impulse is seen to create the infant’s sense of reality. Thus Winnicott maintained that aggression was manifested by active opposition and only reinforced through feelings of persecution. Therefore the impulsive gesture reached out only becomes aggressive when opposition is met (Ortmeyer, 1984). This was a subtle shift from his view as aggression as a reactionary response to frustration. He justified this in his theory of the earliest feelings, asserting that “we need to be prepared for aggression that precedes the ego integration that makes anger at instinctual frustration possible” (1958, p. 216).

In his book “The Child, The Family, and The Outside World” (1984), Winnicott talks of the relationship between aggression and construction. He explains that this evolves in the infant wanting to do something for his loved ones. However, if he feels he is not taken seriously or is laughed at he reacts aggressively in response to a feeling of impotence or uselessness. He used this idea to explain the relationship between love and hate and, indeed, aggression and loving.

Overall it seems as though he saw aggression as an achievement; a sign of civility that showed the infant was creating alternatives to “magical destruction.” (p. 238), whereby:

“Aggressive ideas and behaviour take on a positive value, and hate becomes a sign of civilisation, when we keep in mind the whole process of emotional development of the individual” (p. 139).
By this he was suggesting that it was important to keep anger and aggression in the perspective of the developmental stages that the infant was working through, and that as such they represented a shift to a more mature state of emotional evolution.

This is not to say that Winnicott made a complete shift away from the work of Klein. Indeed, when mapping aggression onto his thoughts about the stages of ego development (1958) he notes that his ‘Stage of Concern’ is the same as her depressive position. Thus the individual’s ego integration is sufficient for him to recognise the mother as an individual in her own right. For Winnicott this was important as it resulted in the infant experiencing feelings of concern with regard to “the results of his instinctual experience, physical and ideational” (p. 206). Hence it appears that Winnicott incorporated some of Klein’s analytical concepts in to his own work, whilst also adapting and modifying them in order to fit in with his own clinical studies:

“Winnicott turns many of her original insights round and offers them in positive terms, as in his popular writing for mothers and those in child care.”
(Holbrook, 1971, p. 117)

For Winnicott, an infant needed to discover the limits of his rage, in that he felt that the infant would need to exert the ambivalence of both love and hate on his real, as opposed internalised, objects in order to distinguish between inner and outer reality.

What then does this imply for clinical practice? Klein’s analytical ideas can be identified in work with borderline patients. As noted by Kavaler-Adler (1993), these patients, unable to tolerate the low mood and guilt induced by owning ones aggression, regress to the paranoid fear of the paranoid-schizoid position. Even when the guilt accompanying this can be contained, shifts towards the depressive position can be accented by further regressions due to resistance. However as these shifts between the two positions continue they can become more grounded in the depressive position.

Ultimately, Klein felt that a neurosis could be conceived as a repressed inner world of internalised object relationships, including that with the mother, whereby anxiety was
created through danger situations of both a persecutory and depressive nature. As such through phantasy, the ego would attack orally, anally and genitally in order to protect itself, whilst also fearing attacks from the internalised mother in retaliation. In adults, Klein argued that false strategies of survival could be identified, whereby things had gone wrong at birth and early infancy, and the adult had adopted attitudes to life that perhaps demanded splitting in order to survive. Patients to whom this had occurred would seek to preserve these spits at all costs in order to protect their identity, and as a result would present to the analyst the “energy, tenacity and ruthless cunning” of the schizoid individual (Holbrook, 1971, p. 131). Thus the work of analysis would be to enable integration of the personality to occur through overcoming these splits. In order to do this, analysis of the disharmony of the early love-hate paradox would be required as engendered by its manifestation in negative and positive transference onto the analyst. It is argued that this would facilitate integration, through the introjection of the good analytic object (Frosh, 1987).

Winnicott worked with both parents and children believing in the importance of the ‘real’ mother from birth, as opposed to Klein’s ‘internalised mother’. He appeared to feel that when a patient with a false self problem, a borderline patient, was able to recall the original parental failures in adaptation, and to react to them with anger the patient was making progress. Thus for Winnicott, the expression of anger is a vital part of the therapeutic process. Through transference, the anger manifested demonstrates the real failure of the parents mirrored by a real failure of the analyst, who has perhaps made a mistake. As Nason (1985) observes, if the analyst can accept and make use of his mistake then the patient can “experience and accept his own anger and its source in his personal past” (p. 176). It is here, Winnicott believes, that reparations can be made. Consequently, the analyst must first allow for the patient to express what he termed as constructiveness, as a symbolic and reparative tool, before encouraging him to accept the aggressiveness. Winnicott made it clear that this encouragement should not be seen as retaliation for the aggression, and so therefore it would not be appropriate for them to interpret and confront at this time.

There is also the alternative view to address, that of the analyst’s hate for the patient. Winnicott defined this in terms of more than just a residual effect of
countertransference, but as something that emerged in reaction to the actual personality and behaviour of the patient. Again this was seen to be positive in that it had to be recognised and accepted by the patient in order for him to also experience the analyst's love. This perhaps reflects the mother's hate for her child. Harris (1998) points to Winnicott's view of this hatred as deriving from the damage done to her body in pregnancy and birth, its all-encompassing impact on her life, and the deferment of her own needs. Thus in therapy he believed that it would be failing a patient not to acknowledge this ambivalence between love and hate, and allow for its expression as a normal part of the parenting process. As noted before, Winnicott believed that rage supported the process of individuation in an infant. However, in contrast to what has just been suggested he felt that this rage was not aimed at the analyst as a "parental imago" (Modell, 1993, p. 281), but rather as something more diffuse and less defined. Thus the analyst is equated to the environment, and as such becomes the target of the patient's rage against external reality. This rage may also be as a result of the envy that the patient feels towards the analyst for what she has and is, in comparison to their self-perceptions.

In conclusion, it is evident that the work of Klein and Winnicott offer areas of convergence and divergence. For Klein the central theme to her theories was the innate nature of aggression, and its existence as a component of the Death Instinct. Indeed, it was her argument that it must be deflected outward in order to enable the survival of the infant. Consequently, the infant becomes a victim of his own projected aggression towards the internalised mother. In contrast, Winnicott viewed anger to be a more constructive concept allowing for the emotional development of the infant in a healthy and positive manner. He argued that the real mother played a vital role from the outset, allowing for an analysis of the developing relationship between mother and infant. This would then facilitate exploration into the part that the relationship played in allowing the infant to experience his anger productively through the appropriate responses of the mother. Nevertheless, whichever approach is adopted, it is vital to recognise that any psychoanalytic theory of aggression has a clear responsibility to consider the power and impact of real violence on psychic life and character. I would argue that it is here that the work of both Klein and Winnicott need to be considered.
Perhaps their theories still have applicability, if reactions to a perceived psychic threat can be mapped onto reactions to real abuse and violence.
References


Discuss an Aspect of the Therapeutic Relationship in relation to Psychoanalytic Ideas

Introduction

The therapeutic relationship is at the heart of all psychoanalytic work. As an essential part of the interaction between the analyst and patient, it is considered to be a means of helping the patient to address their difficulties. However, what differentiates the therapeutic relationship from any other, from that with friends and family for example? It has been suggested that the main difference is the presence of 'rules' or what has also been referred to as the 'psychoanalytic frame' (Cherry and Gold, 1989; Hoag, 1992). As Cherry and Gold (1989) note:

"The concept of the therapeutic 'frame' or 'structure' seems to have developed out of an ongoing effort to preserve the distinction between therapeutic and other encounters and to define critical components of the therapeutic context."

(p. 162)

It is this idea which will be outlined this essay, exploring the context in which the therapeutic frame exists, and the contributions it makes to the therapeutic relationship. In discussion it will become evident that the frame, whilst serving in this rather indirect manner, is also one of the main analytic interventions that can be implemented during the course of therapy (Langs 1981a). However, in discussing this material it will also become clear that this is not a standpoint that all theorists accede to, and thus a critique of the frame will be noted. One particular area that will be explored will be the concept of deviations from the frame (Langs, 1981b), how these arise and their influence on both patient and analyst. In conclusion, it will be argued that the frame minimises the opportunity for self-indulgence on the part of the analyst, allowing for maintenance of a therapeutic stance, and creating an atmosphere that fosters growth in the patient. In consequence, the frame will be shown to serve functions for both analyst and patient.
The Frame: Functions and Components

The frame built on adherence to ‘ground rules’ is an essential component to the analytic encounter (Milner, 1952). It has been argued that the patient needs a framework that allows for transference to be recognised and attended to (Gray, 1994). For the analyst, this framework provides guidelines that enhances his or her ability to remain objective, allowing a focus on the patient’s own experiences (Cherry and Gold, 1989). Winnicott (1956) believed that it was vital to the treatment, arguing that the setting was of superior importance to any interpretation that the analyst could make, and that if not kept constant could lead to periods of stalemate and resistance. This view has been reiterated by Smith (1991), who argues that:

“Consistent unconscious reactions to the frame indicate that it does not function as a mere backdrop to the real business of psychoanalysis. The structuring of the frame, the management of the ground rules, is the real business of psychoanalysis.” (p. 164)

The frame has also been described as an essential ‘non-process’, the backdrop against which psychological activity and meaning can be perceived and comprehended, and an essential representation of the early mother-child union in the analytic relationship (Bleger, 1981). Milner (1952) first introduced the term, describing the therapeutic frame as analogous to an artist’s frame. Consequently, just as a canvas would be secured onto the frame in preparation for painting, the background of therapy is so secured, allowing for the process of analysis to occur. For Milner:

“The frame marks off the different kind of reality that is within it from that which is outside it; but a temporal spatial frame also marks of the special kind of reality of a psycho-analytic session. And in psycho-analysis it is the existence of this frame that makes possible the full development of that creative illusion that analysts call transference.” (p. 183)

Evidence of frame theory can also be seen in the work of other theorists, such as Lewin’s (1946) earlier concept of the ‘dream screen’, a kind of mental framework, and
Bion's (1977) theory of the 'container and the contained'. Indeed as Robbins (1998) notes, “the frame is always available to mark off the boundaries of a therapeutic container” (p. 23).

In reviewing the literature it becomes clear that the idea of ‘rules’ originated with Freud (1959). In proposing the basic components of the therapeutic frame, he discussed issues such as therapist abstinence, anonymity, and neutrality. The rationale for this was to create an open arena into which the patient could project fantasy and feelings, whilst also imposing limitations on their behaviour and experiences. Greenson (1967) notes that this served two purposes. Firstly to halt the patient from moving to a ‘flight into health’ and a premature abandonment of therapy, and secondly to avoid a contamination of the transference, which at the time was understood to consist of guarded instinctual impulses directed toward the analyst (Cherry and Gold, 1989).

More recently, further suggestions have been made, with a more comprehensive structure being developed according to specific rules (Langs, 1981a, Casement, 1985, Cherry and Gold, 1989). Thus it is suggested that sessions are held at regular intervals, in a particular setting, at given times, for a set fee, with some discussion of arrangements for missed appointments and holidays. What goes on in the sessions should remain totally private and confidential, there should be no physical contact, and ideally the patient decides when to end analysis. However, it has been argued that this is more a statement of the necessary conditions for therapeutic engagement than a demand placed upon the patient. Consequently, all of these are matters for discussion, negotiation and agreement between the patient and the analyst (Meissner, 1992).

Vakoch (1998) talks of the frame as a “truly therapeutic space” (p. 336), as opposed to a rigid confinement. However, in his paper exploring the work of Foucault, it becomes clear that this may not always be liberating for the patient, instead becoming oppressive. He talks of transferring the power of domination from the space of the asylum to the consulting room in which the therapeutic space becomes a means for promoting the creation of compliance. As Vakoch notes, for Foucault:
“The analyst heard the madness, but remained silent. And rather than holding up a mirror of alterity by which the mad could recognise themselves, the analyst showed the mad themselves through reflection on their own past.”

(p. 340)

Foucault constructs analysis as being conducted in a disciplinary space that is enclosed, partitioned, ranked and functionally organised. Thus each analyst works in a specific office and each patient returns to each session to share this space with the analyst. Although thoughts and feelings discussed in this shared space remain confidential, it is only to a certain degree, with others - a supervisor for example - also entering the space. As Vakoch (1998) goes on to note, this will not be the only infringement on the space between the patient and the analyst, others being things like one-way mirrors, videotapes and audiotapes. These are all things that can lead to the analysis becoming confining and unsafe for the patient.

Nonetheless, it is suggested that this space, whilst perhaps being disciplined and isolating, can also provide a forum into which the imaginary can be introduced. Foucault (1986) talks of “heterotropias” (p. 24), that is other spaces that remain separate from the rest of the world. Translated into the idea of analytic space, it can be seen that the frame allows for the work of analysis to be conducted in a space that is differentiated from the external reality of the world. This space opens up a whole range of possibilities that can be liberating for the patient, but yet they are held safe within the therapeutic frame.

Thus, it seems that what goes on the analytic space is irrevocably tied in with the frame that bounds that space, indeed as Sabbadini (1989) notes “to know a country, you must become acquainted with its boundaries” (p. 305). He goes on to suggest that these boundaries act in a way that give the patient support. It is clear that this can be likened to Winnicott’s (1984) concept of ‘good enough parenting’, in which the growing child is provided with a holding, bounded and facilitating environment.

The frame has also been constructed as a means of representing a particular area of mental functioning that is never fully portrayed (Goldberg, 1989). Thus it becomes
more than simply based upon a contractual exchange model (Meissner, 1992). In this particular interpretation, Goldberg suggests that the frame is something that both the analyst and the patient hold internally. If this is true than it can be suggested that their individual constructions of the frame may in fact differ. However, he suggests that the opposite of this may also be true, whereby it provides a common ground between the analyst and the patient. From this it appears that the frame can be construed as engendering opportunities for a shared dialogue between them, whilst also allowing the analyst to assist the patient in overcoming his or her resistances.

Within this frame, shared contributions are repeatedly made to the therapeutic relationship, in that management of the frame becomes a matter for both the analyst and the patient. Thus the patient takes responsibility for coming to the predetermined sessions, arriving on time, and paying the fees on time. He or she also takes responsibility for producing the material to be explored in analysis, in terms of free association and openness. This aspect of the relationship highlights and reinforces the collaborative nature of the analytic work, what Gray (1990) refers to as the ‘work ego’ of the patient. For the analyst, his or her contributions to the relationship include being there, being on time, attending to the maintenance of the frame, preserving the integrity of the analytic situation, and consistently using their skills and knowledge in the best interest of the patient. It becomes clear that this modifies Freud’s early view - that the frame functioned primarily for the patient and was controlled by the analyst - to a model that pays attention to the collaborative nature of the work, with both parties being of equal status and responsibility. Consequently, therapy becomes more than simply a contractual transaction in which the patient is never quite sure of what he wants or of what he gets (Menninger and Holzman, 1973), with the frame allowing for these things to be made explicit.

**Deviations in the Frame**

Langs (1988) suggests that the maintenance of a secure frame and the provision of “secure-frame moments” (p. 148) can have a positive effect on a patient in therapy (Hoag, 1992), whilst also creating a safe holding environment that can encourage a resolution of conflicts and personal growth. I will now explore what happens when
this is challenged - when the frame becomes blurred or unstable - something that has been described as a ‘frame deviation’ engendering ‘deviant frame therapy’ (Langs, 1981a). In practical terms, deviations can occur following missed appointments, premature termination, the number of sessions attended, and other issues relating to the day-to-day running of the sessions. However, the most common trigger appears to be that of the presence of external pressures on the therapeutic encounter, for example, the setting, pressure for funding and waiting lists. With much therapy in the United Kingdom occurring in a national health setting (NHS), it becomes clear that infringements on the frame become much more likely as these are factors to which the NHS is particularly susceptible. Thus, it may be difficult for the patient and the analyst to meet in the same room every week, there is no fee, and there are very often other people involved in the dyadic relationship between the analyst and the patient, for example, receptionists, general practitioners, and other consultants.

As noted by Hoag, (1992) in settings such as these “the therapist’s goal is directed toward maintaining as much of an ideal secure frame as possible” (p. 419). Indeed, it has been suggested that this is something that the patient also actively seeks out and indirectly communicates to the analyst through their narratives. For example, the patient may ask to change the time of his appointment, however, in the narrative following this request he may talk about how a friend let him down by changing the arrangements that they had made regarding going out for a drink after work. If the analyst misses out on the implications of this narrative and accedes to the patient’s request, then it can be suggested that they are denying the patient of a ‘secure-frame moment’, either missing or ignoring a request to maintain the frame. Langs (1979) argues that this will elicit several predictable responses on the part of the patient, for example, they may develop a sense of distrust, begin to feel persecuted, find that their personal boundaries may become unclear, or experience perverse gratification. Continued violations of the frame may ultimately communicate to the patient that the analyst is more concerned with his or her own needs than with providing a secure environment for the patient (Cheifetz, 1984).

In her example of working in a primary care setting, Hoag (1992) demonstrated that although her working frame was deviant, she was able to take steps to improve its
security, such as taking over her own appointments diary and providing patients with access to a direct line to her. This appeared to result in fewer missed appointments and early terminations, and an increase in the number of sessions attended. Thus by trying to address the needs of her patients before the needs of the surgery, she was able to improve the level of service that she could offer. The frame that she adopted in this example can be regarded as a ‘fixed-altered frame’ (Oaten, 1999, p. 95) whereby it was impossible to adhere to the traditional construction of the frame from the outset. However, the alterations she made remained constant for her patients. Consequently, the frame although deviant, remained fixed and managed, apparently eliciting more positive results. Similar controlled modifications to the frame can be seen in the work of Warburton (1999), who has applied them to her work in a student counselling service, a context in which the ground rules for therapy can not always be assumed. One deviation she refers to is the ‘three person’ therapeutic relationship, involving not only the therapist and student but also the student’s tutor (Noonan, 1986). Again, attempts to secure this altered frame included taking charge of the appointments diary and providing students with direct line access to the therapist’s answerphone.

In spite of all this positive press for the frame, it becomes apparent that not all theorists hold it in such high regard. For example, Gale (1999) argues that the boundaries created by the frame make it difficult for the patient to grow up, and compares it to school rules. In this construction, the frame is seen as unsupportive and isolating. He also contends that there is no such thing as a value-free relationship between two people, as it becomes impossible to keep politics, class, and finances out of that relationship. He regards frame management as something that increases the power of the therapist as opposed an analytic technique, concluding that the inflexibility of the frame, “kills innovation and provides no space for genius. So in trying to protect the client from the unscrupulous we deprive him of her of genius.” (p. 131). In acknowledging the potential for unscrupulous behaviour on the part of the analyst, Smith (1999) outlines an evolutionary hypothesis which suggests that we have developed an evolutionary bias to deceive and exploit both our patients and ourselves, in order to further our own gains. Consequently, he argues that potential for the frame to provide a vital protective boundary in limiting our chances for deception is perhaps more important than any costs that this could engender.
Summary and Conclusions

In concluding, it needs to be noted that until the work of Langs (1979, 1981a, 1981b, 1988), the management of the framework, and the boundaries of the patient-analyst relationship had been relatively ignored, or at least not conceptualised as a therapeutic intervention. However, it appears that frame management is inherently linked to the therapeutic relationship, influencing the development of the working alliance, providing a safe environment for the patient, creating a means for eliciting transference reactions, and shielding the analyst from indulging in their own countertransference fantasies. In exploring the importance of the frame, this essay has also attempted to show the effects of modifications or deviations in the established ground rules and boundaries of the therapeutic setting and relationship. As noted, these can have a wide range of deeply significant consequences that will be manifested in the behaviour, and conscious and unconscious communications of the patient. These deviations may impact upon the therapeutic relationship, with the patient feeling that it is unsafe, unequal, and lacking in barriers and separateness. However, it has also been observed that there will be settings where deviations are unavoidable right from the start of therapy. In investigating this, examples have been given of how these deviations have been incorporated into the frame, whereby although it is altered the alterations remain fixed. Attention has also been paid to the potential limitations of the frame with regard to its risk of constructing a restrictive environment and a dynamic of unequal power in the analyst-patient relationship. In responding to this issue our evolutionary biases have been mentioned with attention paid to role that frame management plays in protecting both our patients and ourselves from them.

The management of the frame - in terms of ground rules, therapeutic space, and boundaries - performs an integral function within the analytic encounter, the interaction between the analyst and the patient, and the relationship that develops between the two. As such, the frame should be regarded as an analytic tool that will enhance the potential for change and growth in the patient, and differentiates the therapeutic relationship from others that the patient might have. In short it is the frame that makes the relationship therapeutic.
References


In Cognitive Therapy, Therapeutic Change is not dependent on the Therapeutic System of Delivery but on the Active Components which directly challenge the Client’s Faulty Appraisals. Discuss.

Depending upon the primary source that once chooses (Beck, 1970; Ellis, 1958), over a period of three or four decades, cognitive therapy has now become firmly established as a recognisable form of treatment for psychological disturbances. This has been reflected by its increasing incorporation into the gamut of treatments offered by mental health professionals (Dobson and Craig, 1996; Hawton, Salkovskis, Kirk and Clark, 1998). With regard to the treatment of depression in particular, much evidence has been documented for its efficacy (for reviews see Hollon and Beck, 1994; Robinson, Berman and Neimeyer, 1990). However, despite this it appears that there is still very little empirical evidence as to the precise mechanisms of therapeutic change (Hollon and Beck, 1994). According to Beck, Rush, Shaw and Emery’s (1979) original proposal, cognitive therapy reduces depressive symptoms by modifying the clients’ cognitive processes. Therefore, through a process of cognitive mediation the supposed unrealistic or dysfunctional thoughts are challenged and re-framed through objective evaluation, with therapeutic change shown through clients’ development of coping skills that they then can generalise to situations outside of the therapeutic setting. In a similar vein, Ellis (1971) described therapy as didactic and skills-building, viewing change as an incremental process requiring the tenacious disputation of irrational beliefs, or faulty appraisals as they are referred to here. Thus the therapeutic focus would be on addressing beliefs such as ‘I must be perfect’, or ‘I must obtain love and approval from significant others’ (Cave, 1999). However, several authors have proposed that the therapeutic alliance and other non-specific factors also play important roles in the mechanism of cognitive therapy (Burns and Nolen-Hoeksema, 1992; Dobson and Khatri, 2000; Ilardi and Craighead, 1994). Despite this, it appears that these factors have received less attention in the literature, with developments in cognitive therapy interventions continuing to focus on strategies that promote cognitive change (Beck, 1995; Rector, Zuroff, and Segal, 1999).
This essay is intended to address this issue, exploring the role that challenging faulty appraisals has in assisting therapeutic change, whilst also assessing the impact of these other factors in the light of empirical evidence that has supported their significance. Themes that will be highlighted include the importance of cognitive conceptualisation and homework as therapeutic interventions, the role of the therapeutic relationship, and the impact of therapist competence, as well as the active techniques involved in cognitive therapy. As these are explored it will become clear that although the active components of cognitive therapy may be instrumental in promoting therapeutic change, there are possibly other factors involved. In conclusion it will be suggested that it is these in combination that result in the most successful outcome in cognitive therapy, and that as a whole they can be viewed as inherent to the therapeutic system of delivery.

In order to understand the role that challenging faulty appraisals has in cognitive therapy it is first important recognise the theoretical principles that the technique is based upon. Cognitive theorists take the position that both the internal understanding that a person has of the world and their external behavioural adaptation to the world, are components of adaptive or maladaptive functioning. Thus, the fundamental proposition of cognitive therapies is that cognitive processes can mediate behavioural change in both a positive and negative manner (Dobson and Khatri, 2000). But what are faulty appraisals, and from where do they originate? Beck et al. (1979) suggested that they could be manifested in a number of ways, but that the most common appeared to be overgeneralisation or drawing a general conclusion from a single instance; selective abstraction, in forming conclusions on details out of context; magnification or minimisation, either over- or underestimating the importance of an event; and arbitrary inference, with clients making interpretations of situations and experiences according to little factual evidence.

It seems that a client’s predisposition to make these errors in thinking stem from childhood, where beliefs about themselves, others, and the world are formed (Hawton et al. 1998). Beck (1995) explains that it is these beliefs which are perhaps unchallenged, and more often then not unarticulated, that come to be viewed by clients as “absolute truths” (p.15) on which they base their assessments of the world and
ultimately themselves. From this, cognitive theorists have posited that if one can access the appraisals, the automatic thoughts, then it is possible to locate the core beliefs that fuel them. If this is achieved, the suggestion follows that this creates the potential to modify the belief, as the thoughts are themselves modified. This is where the importance of the therapist and their therapeutic expertise becomes essential, as it is their role to educate the client, teaching them to be their own therapist in order to address this (Beck, 1995).

It is this that embodies the dynamic nature of cognitive therapy, as both identifying and challenging the thoughts and appraisals are active processes on the part of therapist and client. In approaching this, the most basic method suggested is the use of questioning to evaluate the thought, looking for evidence looking for alternative explanations, and exploring how believing the thought affects emotions and behaviour (Beck, 1995). For example, the client who talks of failing an impending exam as they will never be able to learn all of the material would be asked for the evidence that supports this belief, i.e. how do they know this to be the case? Or a client who is isolating him/herself for fear that others will reject them would be encouraged to think about the likelihood of that. The use of this method - or Socratic questioning as it is called - is also a tool that may assist the therapist in accessing underlying core beliefs (Beck, 1995). Thus by asking the question, ‘and what if that were true?’ to each statement that the client makes, it may be that the therapist is able to guide the client to a core belief that they are helpless or unlovable. Again, it would then be possible to encourage the client to assess the evidence for this and to develop alternative explanations (Overholser, 1994; Walen, DiGiuseppe and Dryden, 1992). However, although the literature provides endless accounts of this questioning process as the cornerstone of cognitive therapy, it appears that little has been written describing or defining the process (Padesky, 1993).

Nevertheless, this is where the importance of a comprehensive case conceptualisation becomes apparent. The case conceptualisation provides both a framework for understanding the client’s difficulties, and a basis for developing an appropriate treatment strategy (Liese and Franz, 1996). Describing the relationship between core beliefs and negative automatic thoughts, it provides a “map of the patient’s
psychopathology” (Beck, 1995, p.138). Indeed, this has also been promoted as another active tool for therapy, giving voice to the faulty appraisals and providing a source of material about the client to be hypothesised and evaluated (Padesky, 1996). Additionally, it is viewed as a means for clients to understand their cognitive profile and how their core beliefs shape their interpretations of reality (Beck, 1996). Subsequently, the case conceptualisation may facilitate a focus on modifying these beliefs, allowing client’s to recognise when they are processing information in a distorted way and thereby reinforcing a negative core belief.

However, it seems that there may be more to cognitive therapy than simply accessing the thoughts and beliefs and then changing them. One issue to consider is the role that homework plays in the therapy, and whether it is purely an extension of the work undertaken in the sessions. Addis and Jacobson (2000) suggest that both in-session interventions and between-session homework assignments reduce the impact of thinking errors, and encourage clients to focus on the faulty beliefs that they may have developed over the years. The rationale given for this is that it allows clients to practice skills and behaviours learnt in the sessions, thus cementing new ways of coping and dealing with negative thinking and problematic behaviours (Bryant, Simmons and Thase, 1999). With regard to negative thinking or faulty appraisals, a commonly used technique is the Dysfunctional Thought Record or Daily Record of Dysfunctional Thoughts (Beck et al., 1979). This is a tool that allows for clients to evaluate and respond in writing to their automatic thoughts, whereby they are asked to record the details of specific situations that they encounter in their week and specify the automatic thoughts and emotions associated with it. As in the sessions, the client is asked to note alternative explanations which challenge the original thought, and then to evaluate to what degree it can now be supported in the face of the alternatives (Beck, 1995).

However, it should be noted that although this relationship appears to exist between homework and treatment outcome (Neimeyer and Feixas, 1990), it is perhaps a more complex interaction than some theorists have suggested (Bryant et al., 1999). This is where issues such as the therapeutic relationship and the client’s acceptance of the treatment rationale may be influential in terms of encouraging compliance both during
the sessions and in completing homework tasks (Addis and Jacobson, 2000; Raue and Goldfried, 1994; Rector, Zuroff and Segal, 1999). If these are indeed factors, then whilst a cognitive shift may be a cause of improvement in some treatments, it may also be a consequence of change in others (Hollon, DeRubeis and Evans, 1987). This suggestion is strengthened when one takes into account the number of studies that have called into question the role of cognitive change in determining cognitive therapy outcome (Gortner, Collan, Dobson and Jacobson, 1997; Jacobson, Dobson, Truax, Addis, Koerner, Gollan, Gortner and Prince, 1996; Whisman, 1993). As noted by Addis and Jacobson (2000), “taken together, these studies do not provide definitive evidence that CBT works by changing dysfunctional thinking. Nor do they indicate that cognitive change is always necessary for successful CBT outcomes” (p. 314). Indeed, Padesky (1993) in reflecting on her own cognitive work notes that it has been her experience that few clients undergo lasting change purely because their thought processes have been shown to be illogical. For example, one alternative suggestion is that with regard to homework, clients who complete the tasks set are more likely to have accepted the rationale of cognitive therapy as presented by the therapist (Addis and Jacobson, 2000). This level of compliance may be indicative of clients’ openness to change and hopefulness, contributing to a positive outcome of treatment independent of the interventions conducted in session (Ilardi and Craighead, 1994).

Stemming from this, the question arises as to what influences the clients’ acceptance of the rationale for treatment? This again may reflect a theme of therapist competence and their ability to develop a positive therapeutic relationship (Raue and Goldfried, 1994; Shaw, Olmsted, Dobson, Sotsky, Elkin, Yamaguchi, Vallis, Lowery, Watkins, and Imber, 1999). Raue and Goldfried (1994) note that cognitive therapists typically view the therapeutic bond between themselves and their clients as a necessary prerequisite to the application of cognitive techniques. Indeed, given the collaborative nature of cognitive therapy, this would appear part of what makes it possible for the therapist and client to work together as a team. However, various studies have argued that the therapeutic relationship may be something that facilitates therapeutic change regardless of cognitive change (Alexander, Barton, Sciavo, and Parsons, 1976; Lambert, Shapiro, and Bergin, 1986; Miller, Taylor and West, 1980; Ryan and Giznyski, 1971). In more recent study, Casonguay, Goldfried, Wiser, Raue and Hayes
(1996) generated empirical evidence for the primary importance of the working alliance. Interestingly, the study failed to provide evidence for the predictive power of the active techniques conducted in cognitive therapy, finding an inverse correlation between the process of cognitive mediation and clinical recovery. In addition, other research has indicated that clients who have undergone cognitive therapy place a greater weight on the therapeutic relationship in accounting for their improvement than on cognitive interventions (Seibel and Dowd, 1999). One explanation given for this is that in creating an environment of warmth and empathy, the therapist may help to correct the client’s negative cognitive distortions about relationships, thus promoting a greater shift in underlying dysfunctional assumptions about the “self in relationships” (p. 326, Rector et al., 1999).

Issues arising from this imply that there is, at the very least, more than one change mechanism operating in cognitive therapy apart from the process of challenging faulty appraisals. As such, perhaps more importance needs to be paid to the therapist, the role they play in developing the therapeutic relationship, and the more secure environment that this provides (Bishop and Fish, 1999). Dobson and Khatri (2000) note that therapist variables have not yet been well evaluated as predictors of change in cognitive therapy, but that this could provide valuable information about the typical characteristics of more- and less-effective therapists. They expand upon this, suggesting that research into the interactions between therapist and client could provide further evidence purporting to the mechanisms of therapeutic change, and the qualities of the therapist that perhaps mediate the level of that change. Consequently, simply adhering to the techniques of cognitive therapy may not be effective in isolation. Therefore, incorporating the skill, subtly and sophistication of the therapeutic relationship - as offered by a competent therapist - may contribute towards a more positive treatment outcome (Bryant, et al., 1999; Bright, Baker and Neimeyer, 1999; Dush, Hurt, Schroeder, 1989).

Shaw et al. (1999) suggest that therapist competence incorporates a “skilfulness of the therapist in providing a therapeutic milieu, in conceptualising the patient’s distress and problems within a specific theoretical framework” (p. 838). This appears to refer to the entire system within which therapy operates, rather than the specific techniques
implemented (Dobson and Khatri, 2000). Indeed, even Beck and his colleagues (1979) recognised that the manner in which the therapist implements each technical aspect of the therapy determines whether collaboration is enhanced or reduced, and the degree to which collaborative empiricism will facilitate active participation on the part of the client. This greater strengthens the argument that there may be a degree of reciprocity between the technical and nontechnical aspects of therapy that encourages therapeutic change, as opposed to technical specifics alone (Rector et al.). Accordingly, it may well be that both cognitive techniques and the therapeutic alliance positively influence therapeutic change in clients. However, it should be acknowledged that this idea is based upon studies that have showed correlational and not necessarily causal relationships between the variables (Addis and Jacobson, 2000; Tang and DeRubeis, 1999). Therefore, although perhaps contributing to a successful outcome, a positive therapeutic alliance may not necessarily predict one (DeRubeis and Feeley, 1990).

What then can be concluded from this? Although various theorists have called into question the necessity of eliciting cognitive change to promote therapeutic change, it seems that for the most part the importance of challenging faulty appraisals is widely acknowledged within the cognitive tradition (Cave, 1999). Thus as part of the cognitive mediation hypothesis, this process acts as both a source of direction for the therapeutic work and also a tool for implementing change. However, there are a number of other factors that will be overlooked if this is the only explanation that one accepts. As suggested, other possible triggers for change include the working alliance, therapist competence, and client acceptance of the treatment rationale, which can be considered as inherent to the therapeutic system of delivery. In consequence, although they are not necessarily the active components of cognitive techniques, it does seem that they have a role to play in facilitating clients’ movements towards therapeutic change. Indeed, it may well be as suggested, that it is the interaction between these technical and nontechnical factors that facilitates the process of change (Dobson and Khatri, 2000).

In summarising, it is also interesting to note some criticisms that have been levelled at this approach to working therapeutically. The main one revolves around the nature of the faulty appraisals themselves, and whether they are perhaps less dysfunctional and
more accurate than those made by most people. Thus, it has been suggested that people suffering from depression may in fact make more rational appraisals of the world around them, particularly with regard to negative events (Cave, 1999). This implies that defining what constitutes an irrational belief may become problematic, generating difficulties in choosing on which thoughts and appraisals to work. In addition, it appears widely assumed that psychological problems develop in a straightforward and linear pattern stemming from a single factor, in this case cognitions (Keeney, 1983). In contrast, alternative suggestions - most notably those arising from the systemic tradition - have pointed to a need to account for the complexity of interacting elements in clients’ lives (Bishop and Fish, 1999). Therefore, it may be that focusing on cognitions alone may not be as effective as incorporating a more holistic approach to the therapy. This approach would perhaps place a greater importance on the therapeutic system of delivery.

A final comment relates to the cognitive tradition of viewing rationality as the “hallmark of mental health” (Safran, 1996, p. 121). As a result, it appears that therapeutic change has been viewed as possible only through changing thought processes to increase their rationality. Thus, in the traditional cognitive approach, rationality becomes conceived of as a set of unequivocal universal rules for measuring objectivity of which the therapist becomes the keeper (Guidano, 1991). This seems a contradictory view to the collaborative spirit that cognitive therapists have argued is essential to the therapy and the relationship between therapist and client. Guidano (1991) goes on to suggest that in this light the therapist becomes the “enlightened sage” or “devils advocate” (p. 73), trying by any means to convince the client of the irrationality of his or her problematic beliefs, while constantly giving instruction how to strengthen more adaptive behaviours. Moreover, it has been suggested that although changing beliefs is often very therapeutic it may become more of a therapeutic liability if belief change by any means becomes the goal (Padesky, 1993). Overall, it appears that with regard to inducing enduring therapeutic change, challenging clients’ faulty appraisals will only be a part of the cognitive puzzle. This seems especially true if it is the aim of therapy to encourage clients to think differently or, perhaps more importantly, feel better not only for that session but for the rest of their lives.
References


Feminism and Therapy with Women: Implications for the Practice of Counselling Psychology

Introduction

In recent years, female therapists and their clients have wrestled with the problem of how to reconcile traditional psychological theory with the real-life experiences of women (Laidlaw and Malmo, 1990). It can be suggested that this has led to attempts to integrate feminist ideology with psychotherapeutic principles. Despite this, and despite the significant role played within psychology and psychotherapy by female theorists and practitioners, psychotherapy and feminism appear to have had an uneasy relationship. Cardea (1985) argues that therapy dilutes feminist political analysis, whilst other feminist thinkers have suggested that it has become an institutionalised way of life “creating and perpetuating false needs” (Daly, 1991, p. 280), that replace mutual relationships of friendship between women (Kitzinger and Perkins, 1993).

As one area that has been highlighted by my own research, this report will explore some of these issues in terms of the development of feminist therapy, before conceptualising it within the context of counselling psychology. In addressing this matter, it will be suggested that feminist thought can contribute to the practice of counselling psychology by allowing for an exploration of interpersonal and political issues as well as individual intrapsychics, whilst also empowering the client to take charge of their life. It will be argued that just as counselling psychology can be seen to have grown out of a desire to move away from a medical model of treatment, feminist therapy has also attempted to address the same need (Brown and Liss-Levinson, 1981). In conclusion it will be suggested that as both feminist therapy and counselling psychology continue to filter into mainstream practice, they need to reinforce their original ideologies in order to avoid being compromised or diluted by the medical establishments within which they operate.
**Feminist Therapies**

In the past two and a half decades of feminist practice and research various attempts have been made to create therapeutic ways of working with women (Brown, 1992; Hill, 1990; Morrow and Hawxhurst, 1998; Watson and Williams, 1992). Early feminist therapy was founded on three basic principles (Butler, 1985; Cammaert and Larsen, 1988; Gilbert, 1980; Sturdivant, 1980). Firstly it made a commitment to equality within therapy, reiterating the importance of minimising the power differential in the relationship between the therapist and the client. It also highlighted a commitment to bringing the nature and effects of sexual inequality into therapy. Through a focus on ‘consciousness raising’, issues of dual causality i.e. personal and societal factors, were used to unpack women’s presenting problems. Thus the third principle advocated the view that personal change and social change would go hand in hand, making the personal, political (Morrow and Hawxhurst 1998).

Consequently, feminist practice was not developed from one particular theory of therapy, but from a whole new set of values, and a system for how they could be integrated into existing therapies (Watson and Williams, 1992). As such, it appeared to develop as more of a philosophical standpoint than a prescriptive technique (Sturdivant, 1980). Despite this, there does appear to have been a shift from feminist therapy as a philosophy, to a pluralistic view of what can be regarded as multiple therapies (Dutton-Douglas and Walker, 1988). As suggested by Tong (1989), “each feminist theory or perspective attempts to describe women’s oppression, to explain its causes and consequences, and to prescribe strategies for women’s liberation” (p. 1). Accordingly, feminist therapy defined as a therapeutic orientation involves “breaking away from traditional stereotypes, opening options and viewing sex-roles as fluid” (Rothberg and Ubell, 1987, p. 134).

Whether or not this is achievable in practice, it can be argued that one of the major challenges facing feminist therapy is how it can be made authentic, when women live in a society that is largely antagonistic to female reality (Hill, 1990). This is intrinsic to women’s existence, when most of what has been taken for granted in their lives has been based fundamentally on the experiences of white men (Belenky, Clinch,
Goldberger and Truie, 1986; Daly, 1991). Whilst also raising questions about the impact of ethnicity, this implies that even our assumptions of what is therapeutic must be unpacked and reconstructed in a manner that can be applied specifically to women (Krawitz and Watson, 1997). Brown (1992) argues that doing so allows for a construction of feminist therapy that is “political, radical and transformative in its vision” (p. 239). In these terms, feminist therapy becomes unique in the degree to which “political action, and behaviour promoting social change are seen as integral to the therapy process rather than a diversion from the ‘real’ intrapsychic work of therapy” (Brown, 1988, p. 224).

Questions arising from this relate to the expected role of the therapist. Indeed, what criteria should a therapist fulfil in order to describe herself as feminist? In this instance I refer to the therapist as a ‘her’ and shall continue to do so throughout this paper. This is based upon my acceptance of feminism as fundamentally grounded in and informed by women's relationships with other women, not their relationships with men (Ermarth, 2000). As Ermarth (2000) explains, this definition means:

“Men cannot be feminists, not even those men who really do sympathise with women's struggle to assume full cultural and economic partnership; men who really do their share of domestic work; men who really do rejoice in seeing a woman succeed.” (p. 113)

However, feminist therapy seems to be about more than gender alone. Therefore, it is not be enough to be a female therapist working therapeutically with female clients on issues surrounding their gender (Gilbert, 1999). Indeed, what defines a feminist therapist appears be the explicit integration of feminist analysis into their practice, forging a link between a client's individual distress and women's collective political struggles toward societal change (Brown, 1992, Watson and Williams, 1992). The catalyst that perhaps engenders this is the therapeutic relationship. Also considered a defining characteristic of counselling psychology (Clarkson, 1995, Ryder and Shillito-Clarke, 1998), it means that whilst focusing on the dynamics between the therapist and the client, movement is also allowed to a broader sphere. It is in this sphere that the context of culture and society can also be explored.
Feminist therapy: a paradox?

Psychotherapy has traditionally been framed as politically, morally and therapeutically neutral, and value free. Its emphasis on intrapsychic theory locates an individual’s difficulties in their own psychological make-up (Krawitz and Watson, 1997). Worell and Remer (1992) argue that this will always fail to account for the role of social and political factors in women’s lives. Indeed, Pilgrim (1998) refers to this as “psychological reductionism and political ignorance” (p. 225) on the part of psychotherapy. This has been supported by others, who have criticised traditional psychotherapy as not addressing the needs of marginalised groups, arguing that when working with women, therapists need to be grounded in feminist theory and practice (Krawitz and Watson, 1997).

The area which appears to generate the most controversy between psychotherapy and feminist analysis relates to hierarchies of power and the question of equality between the therapist and the client (Brown, 1992; Kitzinger and Perkins, 1993; Lakin, 1992; Lazerson, 1992). As previously mentioned, it was intended that feminist therapy made a commitment to minimising the power differential between the therapist and the client. However, it can be suggested that in practice this may be difficult if not impossible (Lakin, 1992). This seems to be a phenomenon inherent to the therapeutic situation, whereby the dynamic revolves around an individual coming to therapy and seeking assistance from a therapist with unique knowledge and experience. This may inadvertently put the therapist into a position whereby they unknowingly use their authority and position in a manner that recreates cultural gender dynamics (Gilbert, 1999). Gilbert (1999) observes that the feminist response to this is not to deny the existence of this power differential - but to openly acknowledge it - and actively work towards developing a more egalitarian relationship. Some have constructed this as a “compromise with reality” (Brown, 1992, p. 248), whereby those aspects of a power imbalance are offset by a recognition of and commitment to identifying the expertise of the client. Thus for therapy to be genuinely feminist, the goal of the therapist must be to make herself unnecessary in the client’s life by transferring power and knowledge to them (Brown, 1992). However, the question still remains as to how
effectively this actually works in practice, and whether this can be achieved purely by
the therapist acknowledging their own power.

In light of dilemmas such as these, it appears that even feminist theorists are not
unified in their support or indeed dismissal of psychotherapy for women. For example,
Chesler (1990) believes that women can and do benefit from feminist therapy, whilst,
Kitzinger and Perkins (1993) argue that therapy is individualising and privatising, and
that no ‘real’ feminist would be a part of it. They claim that “therapy is wrong [and] is
a fundamentally unethical enterprise” (p. 106), asserting that the inherent power
imbalance of therapy can never be harmonised with the egalitarian aims of feminism.
This is reinforced by the charge that any form of psychotherapy is as value laden and
sexist as the rest of society (Stock, Graubert and Birns, 1982).

Possibly counselling psychology can go some way to resolving this issue. This is
attributable to its apparent openness to various schools of psychological thought.
Consequently, it may not be restricted by some of the more traditional models of
psychotherapy which appear to be so difficult to reconcile with feminist ideology
(Worell and Remer, 1992). It can also be suggested that as counselling psychology is
still to a certain extent in its infancy, it can remain open to ways of working with
women that are informed by feminist analysis. Moreover, engaging with this and
unravelling the inherent tensions that appear to exist between feminism and
psychotherapy, acts to “open up the possibilities for further clinical and theoretical
understandings of gender and ‘woman’” (Seu and Heenan, 1998, p. 2).

Conclusion

As interest and research into feminist therapy grows, it can be argued that one of its
major challenges will be in terms of its increasing professionalisation. As it becomes a
more recognised form of treatment it becomes subject to more of the constraints that
dictate the running of the mental health services (Marecek and Hare-Mustin, 1991).
Increasing pressure from managed care providers within this context may place
feminist therapists in a position whereby they are forced to adhere to diagnostic
criteria in order to account for their work, thus running the risk of pathologising their
women clients (Morrow and Hawxhurst, 1998). In view of this, it can be argued that a return needs to be made to the principles of feminist practice and activism to avoid diluting the practice (Gilbert, 1999).

However, as previously mentioned it is not enough for psychologists to “do therapy with women” (Brown, 1992, p. 250). Moreover, it can also be argued that it is also not enough to only focus a feminist analysis on the literature that has been generated so far. It is clear that to a certain extent this has been based on the experiences and preoccupations of white women (Watson and Williams, 1992). Thus in the future it can be suggested that for practice to be considered truly feminist, it must wholly embrace the society and culture in which it operates, not just the popular aspects of that culture. This will allow for all aspects of women's inequalities to be accounted for. Examples of these could include those biases generated by race, class or physical disability. In short, the integrity of feminist therapy depends on both an adherence to its political roots, as well as the evolution of its theory and practice to account for these factors (Morrow and Hawxhurst, 1998).

In conclusion, it is suggested that this feminist approach can inform counselling psychologists working with women by allowing for them to fully access their client’s experiences from their perspective, thus strengthening the working alliance (Ryder and Shillito-Clarke, 1998). However, in exploring the literature it becomes evident that feminist therapy and psychology has generated a nexus of tension between a feminist insistence on social change and psychology’s focus on the individual (Marecek and Hare-Mustin, 1991). Mainstream psychology has appeared to perpetuate this discourse of contained individualism, and the risk for counselling psychology is that it will follow the same path. However, it is clear that counselling psychology and feminist therapy will both continue to develop over the years to come, whether they can be shaped to compliment one another or whether they will grow apart is up to the counselling psychologists who work with women.
References


Therapeutic Dossier
The Therapeutic Practice Dossier addresses issues relating to the practice of Counselling Psychology. It contains a short description of each of the one-year placements and the training that was undertaken at each. Attention is also paid to other professional and educational activities that took place in each of the placements. Finally, a paper is included that documents my experiences of integrating theory, research and practice, and the impact of this on my development as a Counselling Psychologist in Training.

Names and any other identifying information regarding the clients presented, placement locations and placement supervisors have been altered or omitted to preserve confidentiality.
First year placement: A community mental health rehabilitation unit

October 1998 – August 1999

My first year placement was located in a community mental health rehabilitation service, which functioned as a support unit for people diagnosed with severe mental illness and their families. It was the aim of the service to help these people to fully integrate with the local community, living as independent lives as possible. The Community Rehabilitation Team had a large multi-disciplinary contingent comprising of a Consultant Clinical Psychologist, Consultant Psychiatrist, Registrar, Family Interventionist, Occupational therapist, Support worker, two Social Workers and three Community Psychiatric Nurses.

In addition, I also worked as part of the Community Mental Health Team (CMHT) in order to ensure access to a range of clientele. Clients seen within this team were referred either by general practitioners or by other psychologists within the trust. These clients' difficulties ranged from mild to moderate mental health problems. The majority of problems related to depression and anxiety, stemming from issues such as low self-esteem, relationship difficulties, sexual dysfunction and physical illness.

The division of this placement into these two areas encouraged an awareness of how the needs of these two client groups differed as well as the individual needs of each client.

My responsibilities involved conducting individual therapy sessions and attending staff and trust meetings. I also had the opportunity to attend care plan meetings and case conferences for those clients within the rehabilitation service, and to visit the sheltered accommodation and community job placements provided within the trust.

Supervision for individual client work was provided by a consultant clinical psychologist, who ascribed to a cognitive-behavioural orientation. Therefore, clients’
difficulties were conceptualised from this perspective, which in turn influenced the
direction of the treatment plans devised. In addition, my supervisor also encouraged
the development and integration of a humanistic approach in working with this client
population and their presenting problems in order to facilitate a fully therapeutic
environment.
Second year placement: A university student counselling service

October 1999 – August 2000

For this placement I was based in a university student counselling service. This functioned as a support unit for undergraduate and postgraduate students. It was the aim of the service to help these people to fully integrate into university life, living independently and managing their academic and personal lives in a successful manner. The team at the service consisted of four full time counsellors and five part-time associate counsellors who were on advanced training courses. The service was closely linked to the university health centre who were able to provide nursing and medical support where necessary, this also allowed for client referral to psychiatric services.

Clients were either referred by the general practitioner at the university health centre or the tutor responsible for their pastoral care whilst at university. In addition, clients were also able to refer themselves. Clients’ difficulties tended towards mild mental health problems triggered by academic concerns and those arising from adjusting to university life. However, clients were also seen with more complex difficulties such as bereavement issues, suicidal ideation, eating disorders and coping with sexual assault.

Supervision of individual therapy sessions was provided by a psychodynamically trained counsellor. The therapeutic work was also monitored by the head of service who was a psychotherapist and clinical psychologist. During supervision, process notes were discussed with an emphasis on a psychodynamic approach. However, I was also encouraged to conceptualise my clients’ concerns from other perspectives, especially where a more supportive or directive approach was perhaps indicated.

The placement experience also included supervision at group level on a fortnightly basis, and the presentation of a seminar paper on the work of Heinz Kohut. In addition, I also undertook the role of second therapist in a stress management group set up for university students.
Third year placement: A statutory service for the treatment of drug and alcohol addictions

October 2000 – August 2001

My third year placement was at a drug and alcohol service in a city centre location. It was the aim of the service to help people with drug and alcohol addictions both in terms of moving towards detoxification and abstinence, and managing and regulating their habits. As such the services offered by the organisation ranged from a daily dispensing pharmacy to those on supervised methadone and tranquilliser programmes, to relapse prevention groups for those who were no longer taking drugs/drinking. For clients engaged at all of these levels, psychological interventions were offered in order to support and further facilitate their attempts to confront their addictions.

Referrals for psychology were either made by the key-workers for clients already engaged in the service, or by general practitioners external to the service but within the catchment area of the trust.

My role in this service was to devise specific treatment programmes aimed at preventing relapse or encouraging motivation to change current drug-taking behaviours. I also saw clients who presented with multiple problems in addition to their addiction such as personality disorder, mild to moderate depression, childhood trauma and anxiety. For this client group in particular, forensic issues and health implications were also themes that emerged in therapy. Consequently, space had to be made within the sessions to explore the impact of these on their recovery. I offered both individual and group sessions, at two sites. The groups consisted of a relapse prevention workshop and cognitive-behavioural support group, both run with an occupational therapist, and a psychological skills training group run with my supervisor.

The head of psychological therapies within the addictions service, a consultant clinical psychologist, provided supervision for all of my therapeutic work. In addition, other
clinical psychologists in the department provided peer supervision. Clients’ difficulties were conceptualised from a cognitive-behavioural standpoint. Consequently, treatment plans revolved around readiness to change and relapse prevention, motivational interviewing, and schema-focused work. The challenges of engaging with this client group in encouraging them to complete treatment meant that I was expected to adopt quite a creative approach to therapy. This engendered the possibility for integrative work in emphasising the use of the therapeutic relationship as a psychological tool.

Other activities included attending departmental meetings and joint supervision with another trainee counselling psychologist. I was also involved in developing a series of psychological interventions for clients undertaking a programme of drug detoxification and the audit procedure that accompanied this.
On becoming an Integrative Counselling Psychologist

Introduction

This paper is designed to demonstrate the way in which, as a counselling psychologist in training, I have negotiated the process of integrating theory and research into my therapeutic work. In demonstrating this, examples will be taken from case history material, client studies and process reports. (Personal details of individual clients in all instances have been changed in order to maintain their confidentiality).

Starting with some thoughts on integration, this paper will provide an overview of my theoretical approach to practice and the framework from which it has developed. Using clinical examples, it will also demonstrate how this approach has influenced my conceptualisations of clients, their presenting concerns, and how I conduct my in-session work. Additionally, I will address the relationship between my psychological knowledge and empirical research, its impact upon my practice, and the evaluation of my therapeutic practice in line with the current trend for a practitioner-scientist approach to therapy (Wilson and Barkham, 1994).

The theme running throughout this commentary will be the importance of the therapeutic relationship as a point of integration. I will argue that the construction of this allows for clients to be engaged in therapy in a way that prioritises their experiences, empowering them, rather than trying to fit them into pre-existing models of therapy or pathologising their concerns (Strawbridge, 1999). In addition, I will also point to the importance that I place on understanding clients from a social, cultural and political perspective, a theme that has emerged within my own research. In concluding, I will argue that the integration of theory and research into therapeutic practice is an on-going and flexible process, and can be open to a myriad of interpretations depending on the philosophy and working practice of the individual professional.
What is Integration?

As suggested by Ryle and Cowmeadow (1992), any theory of psychotherapy must “aim to encompass a wide field” (p. 85). This perhaps implies a need for it to provide some explanation of the relationship between thinking, feeling, action, and bodily function, and a mindfulness of the development of the self and of the individual’s relationship to others and the world. However, it appears that in practice no current theory can realistically hope to cover all of these facets of a person’s existence (Ryle, 1994). In addressing these limitations, attempts to cover and attend to all aspects of human functioning seem to be the source of what has now come to be regarded as ‘integration’ - endeavours to try and generate one theory or incorporate different theories into a multi-faceted psychotherapeutic approach. It appears that although these attempts have developed various strategies in devising integrative models of therapeutic work (for examples see Dryden, 1992; Messer, 1986), they all express the need for a wider understanding of human experience. Ultimately, the gamut of therapeutic services as a whole seem to be moving towards a pluralistic view of therapy drawing on many traditions and not adhering to only one ‘truth’ (Clarkson, 1994a).

In addition, it appears that theorists have endeavoured to identify the elements of therapy common to all theories, suggesting that these may inform an integrative therapeutic approach (Lister-Ford and Pokorny, 1994). One such element appears to be the therapeutic relationship, which seems to correlate with therapeutic change across modalities (Brady, Davison, Dewald, Egan, Fadiman, Frank, Gill, Hoffman, Kempler, Lazarus, Rainy, Rotter and Strupp, 1982; Garfield, 1982; Harvey and Parks, 1982; Howe, 1999; Raue and Goldfried, 1994; Shaw, Olmsted, Dobson, Sotsky, Elkin, Yamaguchi, Vallis, Lowery, Watkins, and Imber, 1999). Consequently, it has been suggested that this acts directly as a therapeutic tool (Alexander, Barton, Sciavo, and Parsons, 1976; Casonguay, Goldfried, Wiser, Raue and Hayes, 1996; Lambert, Shapiro, and Bergin, 1986; Miller, Taylor and West, 1980; Ryan and Giznyski, 1971), whereby incorporating the skill, subtly and sophistication of the therapeutic relationship may contribute to a more positive treatment outcome (Bryant, Simons and Thase, 1999; Bright, Baker and Neimeyer, 1999; Dush, Hurt, Schroeder, 1989).
Indeed, even Beck and his colleagues (1979), in referring to the technically driven model of cognitive-behaviour therapy, recognised the importance of the therapeutic relationship with regard to the degree to which collaborative empiricism could facilitate active participation on the part of the client.

It is with this view that I have approached my own clinical work, mindful of the fact that any attempt to conceptualise and work with a client’s presenting concerns will be hinged on my abilities to foster collaboration with them. Therefore, regardless of the differences between us, I have worked towards adopting an ‘insider perspective’ on their life (Conrad, 1987), whilst also drawing on my own experiences of personal therapy and what it is like to be ‘a client’.

In approaching this idea I have found it most useful to adopt Clarkson’s model of the therapeutic relationship (1990, 1994b, 1997a, 1997b). She separates it into five relationship modalities referred to as the Working Alliance, the Transferential/Countertransferential Relationship, the Reparative/Developmentally Needed Relationship, the I-You Relationship and the Transpersonal Relationship. She explains the relationship between them using the analogy of piano keys whereby:

“Some of them may be played more frequently and loudly than others, depending on the nature of the music. But they are always potentially there in every therapeutic encounter whether or not the pianist uses them, whether or not the composer acknowledges their existence in the written score.” (p. 28)

In adopting this model, I have endeavoured to incorporate elements of these relationships into a specific framework that informs my approach to the therapy undertaken with each client.

In providing a lens through which to conceptualise my clients, I have been aware that these relationships encompass the theoretical roots of a number of different therapeutic traditions. In exploring these further I shall first summarise each modality, before going on to reflect on case material where I believe it has informed my interventions.
The Working Alliance

The first relationship that Clarkson points to is the Working Alliance. Characterised by the client's willingness to engage in the reciprocity of a collaborative relationship, this modality seems best represented in the approach of the cognitive-behavioural school whereby the collaborative stance taken by the therapist can prove essential (Beck, Rush, Shaw and Emery, 1979). Relating to the acceptance of treatment rationale, it appears that this relationship may encourage compliance both during the sessions and in completing homework tasks (Addis and Jacobson, 2000; Raue and Goldfried, 1994; Rector, Zuroff and Segal, 1999).

Examples of this can be seen in work undertaken at my final placement, a drug and alcohol rehabilitation service. Here the collaborative relationship proved essential in terms of engaging clients at the most basic of levels with regard to securing their agreement to enter into a treatment contract and the commitment that this entailed. To illustrate this I turn to case material from a client who was referred for treatment for depression, and motivational work to encourage him to address his long-term addictions to drugs and alcohol. On a theoretical level, I felt that a cognitive-behavioural approach would be useful in order to focus on his thinking patterns and the relationship that they had to his behaviour and mood (Beck et al. 1979). I hoped that this would support the motivational growth necessary to facilitate his readiness to make and subsequently implement changes (Miller and Rollnick, 1991, 1995; Prochaska and DiClemente, 1986). Elements of this can be seen in the extract below:

1 C: He's out of it now, the 'curse of life'.

2 T: Do you feel that it's a curse?

3 C: Sometimes I do...

4 T: Yeah.

5 C: I used to talk to my friend about the 'curse of consciousness'
6 T: Oh right.

7 C: You know... 'Ignorance is bliss'... That it's 'folly to be wise'. Uhm... I think you can analyse yourself too much... you can overdo it...

8 T: Yes.

9 C: And er... and that expression, 'the curse of consciousness', is a humorous expression that I thought of... seems like the more you know, well the more I know, the less I want to know, you know.

10 T: Yeah... I mean it can be very difficult, especially with the work that we're doing, trying to make new insights, making meanings of the things that are happening to you...

11 C: Of course, yeah.

12 T: And that's not always going to be a pleasant experience...

13 C: Yeah, yeah.

14 T: Because as well as allowing you to have greater control and understanding of what's going on for you, you've also got that awareness of well, 'things aren't quite what I want them to be.'

In this extract it appears that the client was starting to recognise the impact that the new insights explored in therapy were having upon him. It is possible that this could have led to him believing that this was too difficult to manage at this time, with him considering the possibility of disengaging from therapy. In working with this rather than directly responding to his observation, in 10 T and 12 T I was attempting to acknowledge that this was a struggle for him, whilst also rolling with any resistance related to facing his difficulties (Miller and Rollnick, 1991, 1995). With his apparent acceptance of this, in 14 T I felt that it was important to acknowledge that there were
both positive and negative aspects to developing new understandings, and that I was not unaware of the dilemma he might be facing. In referring to him and myself as ‘we’ at this point, and throughout the session, I was also trying to strengthen the working alliance, the sense that we were both collaborating together to address his difficulties (Raue and Goldfried, 1994; Rector, Zuroff and Segal, 1999). It is interesting to note that work with this client concluded successfully, whereby at the termination of therapy he had stabilised on his methadone treatment regime and managed to abstain from alcohol for a period of three months, an achievement that he reportedly maintained.

The Transference Relationship

The Transferential/ Countertransferential relationship modality is perhaps the most well documented aspect of the therapeutic relationship having developed as part of the psychoanalytic tradition (Jacobs, 1999). This aspect of the therapeutic relationship recognises that there are links between the client’s intrapsychic and reality-based experiences of the world with regard to their interactions with other people. Jacobs goes on to suggest that these interactions are introduced and acted out within the therapeutic relationship, whereby the client may adopt former, often childlike patterns of relating with the therapist, blurring the reality of the relationship with exaggerated and distorted images.

A good example of this can be seen in the work undertaken during my second-year placement at a university student counselling service, with a client who presented himself as suffering from depression and anxiety stemming from academic underachievement and the recent death of his maternal grandmother. Additional difficulties related to his abilities to work through emotional conflicts, and parental separation issues. In-session, adopting a primarily psychodynamic approach allowed for a focus on themes surrounding the degree to which he related to others as ‘objects’, and his apparent projection of the parent-child relationship onto the therapist-client relationship (Hinshelwood, 1995). It seems that the latter of these was a particular characteristic of the work with this client. This may have been due to the stage of life that he was entering, with late adolescence being a time where he would
be expected to accomplish key developmental tasks of which developing independence from parents would feature (Grayson, 1989). In particular, in witnessing his parents’ grief following the family bereavement, it was possible that he was starting to see them as ‘real’ people, vulnerable in their own difficulties and emotional reactions. As such he appeared to think of them as less available to his needs, and that he could no longer turn to them for care. In therapy he seemed to look to me to fill this role, wanting to re-create the secure attachment between parent and child that he felt was potentially under threat.

Additionally he appeared to experience difficulties with regard to developing intimate relationships, and seemed to view our relationship as more than a therapeutic interaction, apparently projecting the image of the ‘ideal girlfriend’ onto me. In exploring this in supervision it was felt that this was a useful facet to the relationship in terms of facilitating the transference of more positive feelings onto his relationships with other women. However, subsequently this client ceased attending his appointments. This may have been a feature of his ambivalence towards forming attachments, with the struggle to form a relationship with me conceptualised as a repetition of his past relationship failures with girlfriends and parents. If this was indeed the case, it could fit with the more classical view of transference as being a ‘contaminating influence’ interfering with the cathartic process of therapy (Freud and Breuer, 1895), and destroying the working alliance.

The Reparative Relationship

With regard to another client seen during this placement, elements of the third type of relationship can be identified, that of the reparative or developmentally needed relationship. This relationship necessitates the therapist adopting a role in-session that focuses on providing a ‘corrective emotional experience’ (Alexander and French, 1946). It is informed by the client’s original experiences of parenting, which where dysfunctional are seen to be pivotal to their emotional distress (Alexander, 1982). The client to whom I refer attended counselling for help in managing an eating disorder and a pervasive low mood. Central to these issues was a very difficult and complex relationship with her parents, from whom she considered herself to be estranged. In
exploring this with her, it seemed that she was seeking to create with me elements of
the supportive relationship that she felt was missing from her parental attachments,
especially with regard to her relationship with her mother whom appeared never to
have been able to empathise with her. It seems that this experience left her feeling
very lonely and isolated, but also ambivalent towards relationships when it was
perhaps her expectation that she would ultimately face rejection. To illustrate:

21T: I wonder whether this fits in with what you have said about your
parent's? It seems that your Dad has plainly said that he does not want
anything to do with you, and it also seems to feel that your mother has let you
down in not feeling able to support you as you wanted, perhaps not being able
to mother you...

22C: I guess, but maybe not so much rejection as lack of acceptance. My Dad
has never been able to understand me and what I wanted. I just don't think
that I'm the daughter he wants, I was never able to do things his way... Even
when I was little Mum used to tell him to say nice things about the work that
we had done, some painting or other, he never thought to say these things.
Was he ever really proud of me?

In this session extract, in turning this issue of rejection around to focus it on her
parents, I was really trying to test out this hypothesis. In her response I was
particularly struck by her apparently choosing not to address what I had said about her
mother, focusing only on her father. I feel that this was quite symbolic of their
mother-daughter relationship, whereby she adopted a protective stance towards her
mother, wanting to keep her safe from attack. However in doing so it appeared that
she had idealised her to the degree that she could not feel let down by both parents.
The following extract further illustrates the importance that she placed on her
relationship with her mother despite its failings:

25C: A close friend would be enough. Just someone to have a girly chat with,
go shopping with, talk about boys with... I know it sounds kind of American,
but the kind of friend that you would invite to a sleep-over. I've never had that.
Especially someone to talk about relationships with, to complain about ‘my man’. I don’t want to end up with a husband and no one else.

26T: Like your mother?

SILENCE

27C: Yes, like my mother.

28T: But it seems that to a certain extent that she’s the one person who you’ve tried to create that kind of relationship with. What’s that about do you think?

29C: Maybe it’s because it’s safer, she won’t leave me, she already knows me, and if things got too much I guess that I’d like to think that she would mother me. I know that’s probably not realistic, but it’s better than being alone...

SILENCE

30T: So you create this relationship with her to feel less lonely?

31C: Yes, although I know it’s not the same...

It is interesting to hypothesise that in transforming her apparent need for a loving mothering relationship into friendship, on some level she was perhaps making links to the relationship that she was forming with me as both idealised friend and mother. In analysing my own countertransference reactions and interactions with this particular client I did get the sense that I wanted to look after her, a recurring theme throughout the therapy. However, rather than it interfering, I feel that I used it to focus on this theme of re-parenting and ‘holding’ her (Winnicott, 1958). Consequently, throughout therapy I actively tried to encourage her and congratulate her on her achievements in the same manner that a parent could be expected to adopt. Examples of this included me becoming involved in practical solution focused work revolving around her funding her course and devising plans of action that would enable her to continue to
afford to finance her studies. Although in traditional psychodynamic work this would possibly have been considered outside of the therapist’s remit, with regard to her need for a reparative relationship with an other and with the support of my supervisor it did not seem at odds with my temporary role as her ‘parent’.

The I-You Relationship

The I-You relationship modality appears to most reflect elements of humanistic and existential schools of thought. This aspect of the therapeutic relationship mirrors the lived experience of human contact, or the ‘real relationship’ (Clarkson, 1994b; Jacobs, 1999). Also known as the I-Thou relationship (Buber, 1970), it involves relating to the genuine ‘otherness’ of the other person (Jacoby, 1984). In therapy it is manifested in a shift from the client interacting with the therapist as an object used to meet his or her own needs, to a separate person in their own right. Thus the therapist becomes a ‘You’ rather than an ‘It’ to the client. Jacoby goes on to argue that this shift represents a working-through of transference projections of past relationships, and allows for movement and change on the part of the client. However, at times in my own clinical practice this aspect of the therapeutic relationship has also increased its complexity, with some clients seeming not to want to see me as a person in my own right, preferring to maintain an potentially idealised image of me as the faultless object.

This appeared to become a feature of the therapy conducted with a client - Mr. Roe - who was referred to the community mental health team linked to my first year placement. He was initially referred for treatment for a sexual dysfunction relating to his inability to maintain an erection during sexual intercourse. However, as our work progressed, it appeared that this was more symptomatic of general relationship problems and in particular an inability to form close and loving bonds with women. In therapy it appeared that the sensitivity of his material and the potential for embarrassment developed into a pattern of interaction between us whereby he constructed me as the expert, the impartial source of knowledge provided to tell him what to do to ‘make it better’. He appeared unable to relate to me as a woman, and although relationship difficulties were mentioned he appeared to be presenting himself as non-sexual person.
In attempting to work through this with him, following feedback from supervision, we developed a series of role-playing exercises where he would play himself and use me to represent a potential partner. Thus we explored ‘asking someone out’, ‘the first date’ etc. This appeared to prove fairly effective with him reporting that he was starting to feel more confident with regard to approaching women to the extent that he had considered asking out someone with whom he worked. Moreover, as our relationship developed it appeared that he was shifting from a view of me as a source of knowledge, to me as a person with whom he could fully interact. However, as part of this process it also seemed that he was starting to develop a more romantic attachment to me. Although this felt awkward, it did create the opportunity for other theoretical material to be integrated into our work. Relating to Winnicott’s concepts of the ‘good enough mother’ and ‘facilitating environment’ (1958), we explored the consequences of this attachment in-session. Thus, although he may have become disappointed by me being unwilling/unable to reciprocate his feelings, he had developed the ego strength to contain this disappointment, rather than reverting to beliefs about being unlovable.

The Transpersonal Relationship

In brief, this relationship encapsulates the idea of a body that ‘carries our need for being, meaning and connection’ (Clarkson, 1997a, p. 275). Referring to the spiritual aspect of the developing relationship, it requires the therapist to empty themselves of expectations of the client and how they should be, giving them space to be in the relationship. Creating a dimension that allows for creativity and insight on the part of the therapist - in terms of how they work with the client and the methods that they adopt - it can perhaps be regarded as inherent to any integrative endeavour that refuses to restrict itself to ‘Schoolism’ (Clarkson, 1997b). In thinking about my own practice, it seems that I have only recently started to use it to inform the approach that I adopt with clients. This may be as it requires a shift from seeking “explanations, interpretations, links, identification of defences or any of these aspects of the therapeutic relationship” (Jacobs, 1999, p. 138), to reflecting on more unconscious communications (Smith, 1991), a skill that appears to develop with time, training and continued client contact.
I now find that it is particularly valuable to my practice in that it allows for me to feel ‘safe’ with not ‘knowing all’. Indeed, in my final placement this was of great importance, as clients there appeared to have particular issues about trust and what they did and did not feel able to tell me with regard to their drug-taking behaviours. This may have been related to the illegality of their addictions and other forensic issues, and possible feelings of shame and guilt that they caused.

However, I believe that it is interesting to revisit work undertaken with a client seen on placement during my first year of training when my awareness of this aspect of the relationship was minimal. This client had been supported by the community rehabilitation team for four years following a diagnosis of paranoid schizophrenia, and was engaged in a behavioural rehabilitation programme that included psychological interventions. When I started to work with her it was envisaged that we would address an apparent increasing tendency towards angry outbursts and temper tantrums. In-session I adopted a primarily humanistic client-centred approach focusing on the quality of our relationship (Mearns and Thorne, 1997). I also introduced elements of cognitive-behavioural therapy into the sessions (for examples see Bishop and Fish, 1999; Padesky, 1993, 1994, 2000; Young, 1994), as informed through empirical research that points to the effectiveness of specific theoretical modalities for schizophrenic illnesses (Kingdom and Turkington, 1991). Specifically, this revolved around challenging her auditory hallucinations, whilst maintaining collaboration through peripheral questioning designed to ascertain ‘the facts’ of the delusions without threatening her core beliefs too soon in the relationship (Turkington and Siddle, 1998).

However, as we continued to meet it seemed that the persecutory nature of the client’s delusions challenged my attempts to develop a relationship with her, with me struggling to maintain a non-confrontational stance. In supervision it emerged that I would possibly need to abandon my expectations of how she should be and the improvements I felt that she should be making, thus distancing myself from pre-prescribed roles of me as ‘the therapist’ and her as ‘the client’. At the time I believe I had not fully developed the confidence to relinquish these roles, and it felt safer to rely
on theory and research than to allow space for the creativity and intuition that a transpersonal approach to the relationship would encourage (Rowan, 1992).

Despite this, it did seem that we were able to make some progress in the therapy, with positive feedback from both her and her carers. Yet questions still remain for me as to how this progress could have been amplified through integrating a transpersonal dimension into the therapy, and if I were working with her now what impact it would have on our relationship.

The Counselling Psychologist as Scientist-Practitioner

In addressing issues of integration, it is also important to attend to how any therapy works in practice as well as its theoretical underpinnings. Of particular significance are the therapeutic activities of the National Health Service which, placed under escalating financial pressures, is advocating an increasing requirement for evidence-based practice, encouraging therapists to be both scientists and practitioners (Corrie and Milton, 2000; Wilson and Barkham, 1994). Consequently, it has promoted a focus on shorter-term therapeutic interventions that have proven beneficial outcomes (Cowie, 1999; Kerr, 1999; Ryle, Spencer and Yawetz, 1992).

As a counselling psychologist in training, this has been integral to my development. Evaluating client work and implementing measures of change encourages confidence in abilities and skills utilised in practice, whilst also providing the security of being able to account for therapeutic interventions made when discussing client work with supervisors. In my own practice, I have adopted this perspective mindful of the tensions that appear to exist between academic scientists and therapeutic practitioners, and an apparent reluctance to admit that it can be a psychologist’s responsibility to adopt both roles (Goldstein, 1982; Woolfe, 1997). In reality it appears that abdicating from this responsibility is an untenable position to assume, given the opportunities that the scientist-practitioner model offers with regard to integrating and acknowledging the interdependence of practice, research and theory, and the provision of credibility to counselling psychology as developing profession (Barkham, 1990).
At a very simplistic level it could be suggested that my day-to-day practice constantly applies research methods in terms of generating, monitoring, and testing out hypotheses with individual clients. Additionally, this process of evaluation has incorporated standardised measures of chronicity, specifically with regard to work undertaken with clients who have been referred for treatment for depression. Thus in all of my placements I have made it standard practice to administer a Beck Depression Inventory (Beck, Ward, Mendelson, Mock and Erbaugh, 1961) at the start and conclusion of therapy. I have found that, as well as providing evidence for myself with regard to apparent changes made in clients' presentations, this has allowed for them to observe changes in their mood.

Additionally, I have also been informed by the findings of my own research activities. The remit of this research has been to explore the impact of cultural and sociological influences on the domain of psychotherapy as something that can either complement or hinder therapeutic work. Although the form of these influences has been narrowed to the ideologies of feminism in this instance, it has proven impossible to ignore the effects of other social, culture and political factors that may shape the therapeutic encounter. In this light it seems that attending to these allows for the client to be viewed in a holistic and reflexive fashion. Consequently, I feel that in my own clinical work I have been able to remain open to a variety of influences in terms of making informed choices about which strategy to adopt with each client (Garfield, 1982; Smith, 1982; Norcross, 1986).

**Integrating Personal Research into Clinical Practice**

In exploring the ideologies of feminist therapy and integrating this into my practice, I have been mindful that research indicates is not enough for psychologists to "do therapy with women" (Brown, 1992, p. 250). For therapy to fully attend to women's needs it must wholly embrace the society and culture in which it operates, allowing for all aspects of women's inequalities to be accounted for; their race, class, possible disabilities and their gender (Krawitz and Watson, 1997; Morrow and Hawxhurst, 1998).
I would argue that this applies to the importance of the cultural and socio-political milieu that may impact upon all clients who enter therapy, not only women. In view of this, psychologists need to engage with issues relating to gender-based socially constructed behaviours and roles (Gilbert, 1999). To illustrate, returning to the example of Mr. Roe, it could be conceptualised that some of his difficulties around self-esteem stemmed from beliefs cultured by society about what it means to be a man, and the virility and powerfulness that are traditionally attached to this label (Levant and Brookes, 1997). In feeling that he did not ‘live-up’ to the stereotype, he perhaps attributed it to a failure on his part, so strengthening a core belief that he was weak and ineffectual. In exploring this with him it became apparent that although we could not change society’s stereotype, we could work around it by exploring ways that he could develop a sense of self-efficacy that would not be dependent on his beliefs about his masculinity (or lack of it).

An additional issue relates to the power dynamics potentially inherent to any therapeutic setting (Gilbert, 1999). This stems from the fact that therapy is a profession whereby vulnerable and distressed individuals seek assistance from persons with specialised knowledge and experience, thus setting up a power differential between those seeking help and those providing it. My research indicates that a feminist approach to therapy can highlight ways of acknowledging and working with this, further facilitating the therapeutic relationship (Brown, 1994; Ryder and Shillito-Clarke, 1998; Worell and Remer, 1992). This is something that I was particularly mindful of in my final placement. For both men and women using the service, it seems that potential power differentials in therapy may have reflected their identity as drug users who were powerless to confront their addictions. Feedback in supervision suggested that the creation of autonomy and a sense of power in client’s lives could be amplified through eliciting self-motivational statements in-session (Miller and Rollnick, 1991, 1995). Thus, encouraging my clients’ abilities make these appeared to facilitate a greater equality in the sessions which some were then able to generalise to other interactions, relationships with key-workers for example.
Summary and Conclusion

In concluding this paper, it seems fair to suggest that by exploring my current practice and tracing its development through training and experience, several core themes can be identified. First is the integrative relationship between theory, practice and research, and the links to wider definitions of integration across schools and client populations. Consequently, I would argue that although my training has been in 3 particular models I have now reached the stage where I would not think of myself as a client-centred, psychodynamic nor cognitive–behavioural therapist, but as a counselling psychologist, which in my view encapsulates elements of all three personas. Additionally, I now find myself in the position where, as illustrated in this paper, regardless of my chosen means of intervention, the therapeutic relationship in one or more or the forms described here is repeatedly fore-grounded as both a tool for change and a foundation for further therapeutic work.

Secondly, I have become increasingly aware of the importance of research that either supports or refutes the efficacy of interventions that are promoted as being ‘therapeutic’. Consequently, I believe that it is vital for me to continually assess and evaluate the tools that I employ in my therapeutic work, as both a scientist and practitioner. I would suggest that this is of utmost importance to a counselling psychologist - or indeed any practitioner - who works from an integrative perspective, whereby it becomes essential to demonstrate the therapeutic validity of any approach or intervention that is selected, especially when there is more than one to choose from.

Thirdly, in linking to the theme mentioned above, influential to my own development has been my own research and the body of literature that supports and informs it. This has highlighted the importance of attending to the impact of culture or society on clients in therapy (Krawitz and Watson, 1997; Morrow and Hawxhurst, 1998). I believe that this has added to the therapeutic repertoire that I have to hand in terms of providing material for integration, whilst also encouraging me to embrace a holistic understanding of my clients (Millon, Everly and Davis, 1994).

This last point would seem of particular importance if one of the aims of therapy is to
enable and empower clients (Strawbridge, 1999). Consequently, I would argue that it is integral to any construction of therapy that highlights a collaborative therapeutic relationship with regard to 'working with' rather than 'doing to' clients. Moreover, I would suggest that this will inform the epistemological, methodological and etiological foundations upon which I continue to develop and mature as a counselling psychologist.

Ultimately, as I progress in the profession in terms of my own theoretical understandings, clinical practice, and research-based activities, I hope to contribute to the ongoing debate as to 'what treatment, by whom, is most effective for this individual with that specific problem, and under which set of circumstances' (Paul, 1967, p.111). However, I remain mindful of the fact that my answers to these questions will continue to develop over time, and will undoubtedly differ from those of other practitioners.
References


Research Dossier
This dossier contains three research reports, one from each year of the PsychD course. The first report documents the relationship between feminism and psychotherapy, and the conflicts that are apparent between their differing ideological standpoints. These are examined within the context of women’s psychotherapy groups, with attention paid to literature that outlined areas of inconsistency and friction. In concluding it is suggested that on a theoretical nature reconciliation between differing feminist and psychotherapeutic philosophies does appear to provide a major challenge to the practices of women’s psychotherapy. However, this is qualified as difficult to substantiate in practice given an apparent lack of empirical research on the topic.

The second research project was designed to address this gap in the literature. A qualitative piece, it explores the experiences of women who had undertaken therapy in the context of a women’s group and who also ascribed to the philosophies of feminism as they understood them, and focuses on their attempts to negotiate a path between the two ideologies.

The final year research project expands upon this theme of feminism in therapeutic practice. A quantitative piece, it focuses on practitioners’ level of feminist identity development and its relationship to what is conceptualised as feminist practice. The implications of this are discussed with regard to generating support for practitioners’ opportunities to utilise their personal belief system, feminist or otherwise, as a therapeutic tool, and the potential role for this within the context of counselling psychology.
Women’s Group Psychotherapy: Towards an Integration of Feminist and Psychotherapeutic Perspectives

Feminism and psychotherapy have had a difficult relationship, with their apparent ideological differences proving a challenge to reconcile. In this paper these ideological differences are explored within the context of women’s psychotherapy groups, thus questioning the workings and indeed legitimacy of such groups. In reviewing the literature, attention is drawn to areas of inconsistency and friction, thus allowing for a discussion of concepts such as ‘power’, ‘neutrality’, ‘ethics’, ‘praxis’, and the role of the therapist. Attention is also given to the diversity of feminist therapies and other psychotherapies. In conclusion it is argued that feminist and psychotherapeutic perspectives do appear to be difficult to integrate in the practice of women’s group therapy. However, this is qualified by a discussion of the predominantly theoretical nature of the literature. It is suggested that until further empirical research is conducted it will prove impossible to generate a comprehensive resolution to the dilemma.
Women’s Group Psychotherapy: Towards an Integration of Feminist and Psychotherapeutic Perspectives

Introduction

In recent years, female therapists and their clients have wrestled with the problem of how to reconcile traditional psychological theory with the real-life experiences of women (Laidlaw and Malmo, 1990). It can be suggested that this has led to attempts to integrate feminist ideology with psychotherapeutic principles, particularly when working in psychotherapy groups with women. Despite this, and despite the significant role played within psychotherapy by female theorists and practitioners, it appears that psychotherapy and feminism have had an unsettled relationship. Cardea (1985) argues that therapy dilutes feminist political analysis, whilst other feminist thinkers have suggested that it has become an institutionalised way of life “creating and perpetuating false needs” (Daly, 1991, p. 280), that replace mutual relationships of friendship between women with ‘prosthetic’ relationships (Kitzinger and Perkins, 1993). It has also been interpreted as unethical due to the inherent power imbalance that may be generated between the therapist and the client (Lakin, 1991). Yet, if this is indeed the case, then how can we account for the existence of women’s psychotherapy groups that are apparently constructed as supporting women in an empowering and feminist manner? (Dutton-Douglas and Walker, 1988; Worell and Remer, 1992).

These apparent ideological differences seem to have been overlooked by researchers. For example, Marecek and Kravetz (1998) point out that the extensive literature
written by North American therapists rarely makes reference to the difficulties of merging psychotherapy and feminism. Indeed, Kravetz and Marecek (1996) note that group therapy is a means of personal change that is particularly suited to the goals and philosophies of many feminist practitioners, and Brown and Liss-Levinson (1981) suggest that only the most orthodox Freudian psychoanalysis is incompatible with these goals and philosophies. However, this apparent acceptance has been questioned (for example see Chaplin, 1998; Reed and Garvin, 1996a; Rothberg and Ubell, 1987). Moreover, it has been argued that attempts to reconcile the different ideological standpoints of feminism and psychotherapy have not really addressed the problems that initially led psychotherapeutic, and particularly psychoanalytic, approaches to apparently collude with and reinforce women’s societal subjugation (Frosh, 1994; Holloway, 1989).

Various constructions of these ideological standpoints have suggested that feminism acts in a manner that highlights liberal individualism, but which minimises the impact of gender differences, and is informed by both value-based and political systems (Enns, 1993). In contrast, psychotherapy has been constructed as politically, morally and therapeutically neutral, value-free, and rooted in intrapsychic theory (Krawitz and Watson, 1997; Stock, Graubert and Birns, 1982). In reflecting on this last point, Worell and Remer (1992) argue that any therapeutic practice so based will be essentially problematic with regard to introducing a feminist framework, given that it will always fail to account for the role of social and political factors in women’s lives. Indeed, Pilgrim (1998) refers to this as “psychological reductionism and political ignorance” (p. 225) on the part of psychotherapy. This has been supported by other critiques of traditional psychotherapy, which accuse it of not addressing the condition
of marginalised groups, including women, and suggested that when working with women, therapists need to be grounded in feminist theory and practice (Krawitz and Watson, 1997).

It can be argued that engaging in this debate, and unravelling the inherent tensions that appear to exist between feminism and psychotherapy, acts to “open up the possibilities for further clinical and theoretical understandings of gender and ‘woman’” (Seu and Heenan, 1998, p. 2). However, a challenge to this appears to be that even feminist theorists are not unified in their dismissal, or indeed support, of psychotherapy for women. For example, Chesler (1990) believes that women can and do benefit from feminist therapy, whilst Kitzinger and Perkins (1993) argue that therapy is individualising and privatising and that no ‘real’ feminist would be a part of it. They claim that “therapy is wrong [and] is a fundamentally unethical enterprise” (p. 106), going on to assert that the inherent power imbalance of therapy cannot be harmonised with the egalitarian aims of feminism. This is reinforced by the charge that psychotherapy is as value laden and sexist as the rest of society (Stock et al. 1982). However, it can be suggested that Kitzinger and Perkins (1993) are really promoting a utopian ideal of feminism, whereas in reality the egalitarianism that they talk about will always prove a challenge to facilitate. That is not to argue that feminism is riddled with faults, but rather on a more positive note it creates something to work towards, a goal to idealise. Regardless of this, it is apparent that the examples that they use of therapy in practice are extreme and rather bizarre in contrast to the standard that predominates. I would argue that this selectivity makes for a poor reflection of the reality of therapy.
Before moving on, it is important to note that various factors have influenced the ideological frameworks that have been brought to bear on the literature explored in this paper. These frameworks can be conceptualised as an individual ‘speaking position’ (Burman, 1994). My own speaking position is likely to have been shaped by my standing as a woman who has been influenced by critical feminist writing, and who is also a trainee counselling psychologist for whom psychotherapeutic theory and practice have played a major role in training. Therefore, when a reference is made to ‘I’ the implications of my speaking position must be taken into consideration.

Additionally, in supervision my own thoughts and ideas have been discussed with someone whose ideological frameworks perhaps differ from my own in terms of his academic position and personal interest in feminist approaches to psychology. In consequence, it can be suggested that this has allowed for alternative views to infiltrate my material, thus permitting the development of a more rounded argument.

The issue of speaking positions did, however, make it difficult to maintain a uniform stance with this particular overview of the literature, whereby some constructs appear to have been explored, whilst others are left unexamined. I am aware that this may be viewed as epistemological inconsistency, which appears to result in a deconstruction of constructs that I wish to oppose, and a preservation of those that I need to maintain (Edwards et al., 1995). I make no apologies for this, as I hope that it will perhaps encourage readers to consider alternative interpretations of the literature in order to judge the persuasiveness and credibility of my argument.
Feminism, Psychotherapy and Women’s Groups

Prior to the ‘grass roots’ increase in women’s groups the thought of same-sex psychotherapy groups was rarely considered (Lerman, 1987). This increase resulted in the Consciousness-Raising (C-R) groups created by the women’s liberation movement of the 1960s and 1970s (Marecek and Hare-Mustin, 1991; Sandage and Radosh, 1992). Developed from the belief that women need to be with other women in order to increase self-valuation and unity - a touching although rather naïve idea - these were groups of women who met to discuss their lives and their experiences of being women. The belief was that women’s therapy groups eliminated the unconscious sexism that predominated in mixed groups (Walker, 1987). Their focus was to identify commonalities derived from the external roots of existing in a society dominated by sexism. Ideally leaderless and egalitarian, it was their intention to work towards growth and social change. The most salient effect of these groups was in increasing women’s personal insights and improving relationships between women. From this, the goals and format of C-R were adapted by feminist therapists in working therapeutically with women in all-female groups (Benardez, 1996), supported by arguments that work in all-women groups would be a critical ingredient of a feminist therapeutic approach (Mander and Rush, 1974; Sturdivant, 1980).

However, with regard to this approach, it appears that feminist therapies have many permutations (Reed and Garvin, 1996b). Thus each therapy seems to differ from others (Walker, 1990; Lazerson, 1992; Heenan and Seu, 1998). Corsini (1981) questions whether such a thing as feminist therapy actually exists as a system of theory and practice, arguing that it is more a political/professional and ethical issue as
opposed to a theoretical/procedural one. Yet it does seem that feminist therapy as a philosophy has shifted to a more practice-based pluralistic view of these multiple therapies (Dutton-Douglas and Walker, 1988). As suggested by Tong (1989), “each feminist theory or perspective attempts to describe women’s oppression, to explain its causes and consequences, and to prescribe strategies for women’s liberation” (p. 1), whereby it may be that these ‘strategies’ can be conceptualised as therapeutic techniques. Overall, it can be suggested that feminist therapy can be defined in terms of a linear cause and effect model, whereby the targets for change are individuals in society and society itself (Rothberg and Ubell, 1987).

Although diversity appears exist between feminist therapies, they do share some level of heterogeneity as a result of their development from common tenets (Marecek and Kravetz, 1998). Worell and Remer (1992) suggest that three principles have remained central to the growth and development of feminist therapy in practice. Firstly, there the element of consciousness raising, whereby clients are helped to differentiate between the problems of societal and sexist politics, and which of those can be realistically controlled.

The second area concentrates on the relationship between the therapist and the client, and places an emphasis on minimising the power differential between the two. This would seem a point of convergence between feminist and therapeutic frameworks, with the role of the therapeutic relationship as a key component of both ideologies (Clarkson, 1994; Taylor, 1997). Worell and Remer (1992) go on to suggest that forming a relationship based on equality will challenge issues of dependency on the part of the client, who is encouraged to set her own goals. This process is facilitated
by the therapist, who whilst identifying with her female clients and offering respect and unconditional positive regard, is still able to maintain essential boundaries (Marecek and Kravetz, 1998; Taylor, 1991). The third commonality that Worell and Remer (1992) outline, relates to feminist therapies’ shared interest in self-valuation and self-validation; thus the importance of the individual is emphasised.

In consequence, although feminism and feminist therapies - like other forms of therapy - exist in many permutations, by discussing them in these terms, I believe that the whole spectrum of therapies can be drawn into focus rather than getting caught up in the specific minutiae of particular techniques. Indeed, as noted by Reed and Garvin (1996b), “feminist strategies with groups must be viewed through the contextual lens of multiple feminisms and multiple psychotherapies, at varying stages of development and transformation” (p. 15).

Returning to the theme of integration, perhaps one route of inquiry would be to look at the basic assumptions of feminism and compare them with the basic assumptions of psychotherapy. This could ascertain the extent of the differences that seem to exist between them, and whether or not they can be minimised to allow for reconciliation. A useful starting point for this is to look at how feminism and psychotherapy have been defined. The Oxford English Dictionary (1989) defines feminism as an advocacy of the rights of women (based on the theory of equality of the sexes), whilst psychotherapy is referred to as the treatment of disorders of the mind or personality by psychological or psychophysiological methods. As such it is hard to see why women’s group therapy could not incorporate both elements, working with the members’ psychological distress in a manner that supports their existence as women. However,
as this paper will now go on to outline, it is only when exploring the field deeper that ideological differences become more apparent.

**Neutrality and the Therapist**

I now intend to investigate the construction of the feminist therapist, before reflecting on the relationship of this to the psychoanalytic concept of 'neutrality'. One focus for this is the role of the therapist, and how her presence affects the rest of the group. As Krawitz and Watson (1997) suggest, should she also be an activist and politician, and if so how is this placed against her role as a therapist? In addition, can ‘she’ in reality be ‘he’? It is noticeable that so far I have referred to the therapist as female. Indeed, Cammaert and Larsen (1988) argue that any therapist who works according to the ideologies of feminism must be a woman. Kravetz and Marecek (1996) assert that a female therapist can provide the clients with a role model, or model of behaviour, whilst Reed and Garvin (1996b) note that all-women groups with women as therapists produce different environments for women than mixed groups or groups with male therapists. I believe that in practice it is more difficult for an all-women’s group to have a male therapist, due to the women’s preconceptions. It can be suggested that he would perhaps reinforce the women’s dependence on men for self-validation, or that his presence would restrict rather than encourage the discussion of gender-sensitive topics (Reed and Garvin, 1996b). On the positive side, interaction with a male therapist could provide a model of how different relationships between men and women can be. Underpinning this debate is the concept of therapeutic neutrality. Instructing a therapist to adopt a value-free stance, it could be argued that this would render any gender difference between therapist and clients as unimportant, with
gender constructed as independent from socio-political influences.

However, this is where a real nexus of tension exists between feminism and psychotherapy. Reed and Garvin (1996b) note that “all forms of feminism challenge the assumption that psychotherapy (or therapeutic work within groups) can be a neutral-objective endeavour but, rather, recognise it as a profoundly political and value-laden endeavour” (p. 33). This challenge to the notion of group psychotherapy as neutral and value-free is supported by Eichenbaum and Orbach (1982), who argue that “all therapies are informed by a political perspective. Many psychotherapists often make the mistake of offering up their clinical work as though it were value-free” (p. 69).

Despite this, it is argued that neutrality is central to the psychotherapeutic situation, and is an important aspect to the analytic ambience (Wolf, 1976). As noted by Leider (1983) this idea immediately raises questions. What is meant by neutrality? Does it refer to the therapist’s values, or does it refer to attitudes, such as “emotional coldness or avoidance of sympathy”? (Leider, 1983, p. 666). Sen (1998) argues that the construction of the neutral therapist, the ‘tabula rasa’, is little more than an ideological framework that serves to hide issues of power, a way of avoiding our responsibilities as therapists. Thus it can be seen that different authors construct the concept in line with their own ideologies.

Regardless of how neutrality is interpreted, the question still remains as to the possibility of maintaining it in the therapeutic situation. Indeed, this possibility has been repeatedly questioned as something that is recommended in theory, but difficult
to achieve in practice (Franklin, 1990; Leider, 1983; Shafer, 1983). In my own resolution of the dilemma, I understand neutrality to be a theoretical construct that has perhaps generated credibility due to its prevalence in the literature, and the contributions that it can make towards encouraging therapists not to judge their clients. However, to restate the original argument as to whether or not this is possible, the situation becomes more complicated by introducing the values of feminism into the frame. As a result, tension is highlighted between therapeutic neutrality and the adoption of a feminist speaking position to inform client work.

This speaking position, or ideological persuasion of the therapist, will be an obvious threat to neutrality. Lakin (1991) argues that instead of the beliefs and values of the therapist remaining controlled and hidden, they become almost the central focus of the therapy in “dictating its goals and its procedures” (p. 208). Feminists argue that these inspire the women in the groups to forge on and endeavour to change their lives (Cammaert and Larsen, 1988). However, Lakin (1991) refers to these personal values as destructive, which “may become the fulcrum of subtle coercion by therapists and emotional...exploitation to conform a client/patient to what we [therapists] think they should be or how they should act” (p. 200). Furthermore, it has been suggested that if we as therapists, whilst accepting our own values, challenge clients’ beliefs around their cultural and socio-political medium, we could be seen to be imposing these same values on them (Krawitz and Watson, 1997).

Despite this, it does seem that they can have a role to play in determining the therapeutic tools and techniques employed during the sessions (Enns, 1992). Therefore, in addressing this, I would argue that the question to ask is not how to
eliminate values and subjectivities, but rather which values and subjectivities should inform theory and how? I believe that resolving this issue would go a long way towards the full integration of feminism and psychotherapy, whilst also reinterpreting the concept of neutrality and its contribution to the therapeutic encounter. Consequently, perhaps the professional construction of legitimate therapy needs to be addressed, so that some acknowledgement is made of the impossibility of eliminating subjectivity and values and how they could in fact supplement therapy.

However, one challenge to the active integration of values into therapy, is the suggestion that even feminist values themselves are not immune to certain influences (Forisha, 1981). Forisha argues that feminist thought cannot be abstracted from “the backdrop of the patriarchal system that still dominates therapeutic circles” (p. 318). Thus, the accusation is made that in their work many feminist therapists still consciously or unconsciously conform to the mandates of a male-dominated society. This echoes the work of Chesler (1972), who charged psychology with being dominated by middle-aged, middle-class men, who treated, middle-aged, middle-class women, thus perpetuating the submission of women and the rigidity of society. In critiquing this, it should be noted that she was commenting upon psychology at the end of the 1960s, and as such this opinion is now dated and may be no longer relevant. However, as she writes in “Twenty Years Since Women and Madness” (1990) she believes that although the times have changed in some respects, with a virtual plethora of feminist therapists and feminist therapies, “the book... remains, unfortunately, quite up to date” (p. 315). She explains this in terms of things like the concept of the family, whereby women still experience childhood in a father-dominated/absent, mother-blaming context, where “women still behave as if they have been colonised” (p. 315).
She argues that these factors continue to shape and influence women both as clients
and therapists.

When looking at the concept of ideologies, it is argued that all psychotherapies have
historically been concerned with understanding, enlightenment and re-organisation of
the self, and as such have developed a preoccupation with how people should live and
behave (Drane, 1982). From this it can be suggested that all therapists, including those
who lead/facilitate women’s groups are working from their own model of how their
clients should run their lives. Consequently, the question must be asked as to how
professional, ethical and indeed therapeutic this actually is within this context.

Grunenbaum and Smith (1997) assert that psychotherapy has been hiding behind a
medical paradigm, in order to break away from its roots as a “cultural practice” (p.
56). However, in actuality this may be a reflection of the power of the ‘medical
model’, which has diminished the opportunity for psychotherapy to operate from any
other paradigm and thereby address the influence of culture. This is a position not
considered by Grunenbaum and Smith.

**Power and Ethics**

Returning to Lakin’s 1991 critique of women’s group psychotherapy, it appears that
he raises concerns that cover myriad ethical issues. These mostly revolve around the
inherent power he believes the therapist to be imbued with, and the challenge this
presents to any relationship of equality. Indeed, it seems that the concept of power has
been a central problem in feminist social theory (Marecek and Kravetz, 1998). Thus,
Lakin speaks of group-work as “‘indoctrination’ rather than therapy” (p. 213). This
could potentially create problems in the infancy stage of the development of the women’s psychotherapy group, whereby the individual members become subject to cohesion-based mutual influences which are directed and channelled by the group’s leader. If this is indeed the case, it causes problems for those of a feminist persuasion, due to the potential created for group members manipulate one another and the therapist’s orchestration of this. In addition, the possible existence of hierarchies between group members may contribute to this dynamic as a result of issues such as differing personality characteristics, resources, status and perceived expertise. Thus in the groups it is not so much the women dominated by men outside of the group, but dominance of stronger members over weaker members within the group. Lazerson (1992) notes that all theories of group psychotherapy have little to offer regarding power relations, including those informing women’s therapy groups. If this is indeed the case then the question ‘why?’ must be asked. Is it because this is a source of conflict that is difficult to reconcile?

Kitzinger and Perkins (1993) argue that psychology has shifted the meanings of certain ‘feminist’ terms, including those relating to ‘power’. They go on to suggest that resulting from this, when feminist therapy advocates the empowerment of women, it does not reflect the theme of power as political or patriarchal, but ‘psychological power’. If this is true, then it must be asked as to whether this supports and maintains the principles of feminist thought. I would argue that the examination of this dynamic is of vital importance, as it relates to the idea of ‘dependence’. This would seem something specifically relevant to women’s group therapy, especially if we take on board the idea of power differentials between group members, and dynamics of dependency that could develop between them. As such, these groups
could potentially create reflective cycles of reliance, which could weaken rather than strengthen individual group members’ struggles for autonomy and independence.

Lakin (1991) points to three tensions that characterise all psychological helping groups, including women’s psychotherapy groups, all of which raise ethical concerns for him. The first of these focuses on the intrapsychic or inner personal feelings that first led the individual to seek help. The second factor concerns the intra-group tensions that may be created from individuals’ competing needs. This competition has been constructed as being both healthy and destructive in terms of members’ ability to ask for attention in the group, give feedback, express desires and fears openly, and talk about feelings of greed and envy without enacting them (Wallach, 1994). The third pressure that Lakin discusses relates to aspects of intergroup behaviour, whereby the ‘us and them’ differentiation can be mobilised and emphasised to develop group cohesion. This point in particular would appear to fit in with the principles of feminism whereby the consciousness of women is rallied into fighting the oppressive demands made on them by ‘the other’ that is men.

These are all issues that may arise within the context of the women’s group. However, from the perspective of the apparently opposing principles of feminism and psychotherapy, what could potentially be a problem is the weighting that each of these issues is given. The utopian ideal would be that they are all given equal consideration. However, there are many variables that could interfere, for example the orientation of an action-focused therapist could mean that a greater emphasis is placed on the latter of these, which could minimise the potential for group members’ individual personal issues to be given space. Likewise, if the group had a strict analytic focus, then the
influence of the latter may not be considered, with the emphasis being on the individual psychological functioning of the group members. I would suggest that the decision as to which of these issues receive attention will be determined by the importance placed on the ideologies that inform them, in this case feminist and psychotherapeutic. However, as is being argued in this paper, this decision will be complicated by the apparent differences that appear to exist between these two philosophies in terms of which tensions are given more weight.

Lazerson (1992) directly challenges Lakin’s critique of women’s therapy groups, arguing that a feminist perspective is ethical and able to make significant contributions to the practice of group psychotherapy with women. She constructs the therapist as an “ethical advocate” (p. 543). An interpretation of her work indicates that she envisages no problem in considering the ideals of feminism and psychotherapy as compatible. Indeed, she conceptualises feminism as adding to and revising much developmental and analytic theory in terms the origins of role-playing behaviour. In contributing to, rather than detracting from psychological thought, she presents it as intrinsic to the effectiveness of women’s group psychotherapy. This position promotes the importance of women’s groups in terms of their ability to explore the impact of social roles and stereotypes on group members (Burden and Gottlieb, 1987). Burden and Gottlieb (1987) go on to observe that it is not useful to focus only on intrapsychic explanations of presenting problems, as these potentially foster self-blame and doubt. In addressing this, they seem to suggest a meeting of psychotherapeutic and feminist perspectives in the form of women’s group therapy. However, as noted throughout this paper, although this is all very well in theory, in practice it appears much harder to achieve without one of the principles being fore-grounded at the expense of the other.
The Relationship between Theory and Practice

The successful transition of theory into practice is something that can be questioned in light of the literature referred to in this paper, whereby the focus appears to be on how women’s therapy groups should work in principle. I would argue that perhaps a shift to conducting in-depth empirical research into how they work in practice would be more valuable. That is not to say that this has been totally overlooked (for example see McLeod, 1994), but when compared with the body of theoretical and philosophical literature, actual research conducted so far appears to be quite limited. Indeed, Reed and Garvin (1996b) point to the fact that although a variety of feminist therapies have evolved from the integration of feminist principles with multiple theories of therapy, little has focused on feminist group therapy in terms of documentation or exploration into its workings. Huston (1986) reinforces this suggestion, noting that there have been no quantitative data as to the efficacy of women’s therapy groups. Indeed in her critique of the literature on the topic, she remarks upon the fact that although logical, the statements and theories proposed are pure supposition.

In one of the limited number of empirical works, Donnelly (1986) carried out an interesting observational study of a particular women’s group. Talking to members of the group, the focus was on their reflections on their group experience. The findings of this indicated that a feminist perspective allowed for women to feel that the social context of their difficulties was explored, and that they were not made to feel personally inadequate. Additionally, there was a recognition of the necessity for group
leaders to continually challenge “the ideologies and premises of those treatment models which seek to rehabilitate women or retain women in certain socially defined, socially acceptable roles of femininity, and [] seek to implement less oppressive ways of working” (p. 38). Although a useful paper, the focus was on research from a feminist perspective, particularly in terms of social work. If we tie this in with the aforementioned possibility that some principles are adopted at the expense of others, then here the psychotherapeutic aspect of the group may have been sacrificed in order to focus on the social and political aspects of being a woman.

In another study, Johnson (1987) conducted a survey on feminist therapists and their views on working with women’s therapy groups. However, throughout this study, no reference was made to the therapeutic principles that the therapists who participated employed, or from what perspective they were devising their treatment plans.

So how do these studies inform the debate into the relationship between feminism and psychotherapy? From a critical perspective, it can be argued that these are only two papers, which raises issues as to how representative these findings are of all women’s therapy groups. Even if they are, questions remain as to the contributions they are able make to the process of reconciling feminist and psychodynamic thought in practice. This is something to keep in mind when exploring the theoretical side of the literature. Once again, does it refer to something that is possible in practice, or again are we returning to that utopian idea of how things should be?
Reed and Garvin (1996b) outline the concept of ‘Praxis’, which refers to the relationship between theory and practice. This can be regarded as one of the major underpinnings of the present discussion and its focus on how women’s group psychotherapy can work in practice. In order to frame this relationship, they discuss what are referred to as ‘the thirteen feminist practice principles’. These are effectively clusters of feminist thought. I believe it useful to outline these, as they provide a good summary of feminist philosophical perspectives with which to compare the framework of group psychotherapy. They also reiterate and summarise the main points that have been made so far.

The first principle concerns social justice and social change as major goals. For group psychotherapists this includes the need for attention to be paid to the dynamics of the groups that may be creating or reinforcing social inequalities. Secondly, it is considered essential to act from feminist theory, knowledge and values. In this case this would refer to knowledge about the construction of gender, and relevant feminist research and critique. However, as has been suggested this route of action may be at the expense of other principles, namely psychotherapeutic ones. In addition, Reed and Garvin (1996b) do not propose how this should be achieved in practice.

Feminist principles also emphasise the importance of engagement in ongoing self-reflection and consciousness raising. This may also reflect psychotherapeutic principles, perhaps echoing the concept of countertransference, whereby the therapist has to be aware of their own subjective responses and gender related assumptions (Lazerson, 1992). This notion of self has a role in feminism, as it allows for an exploration of how one’s gendered socialisation and identity formation shapes and
informs individual thought.

The fourth principle refers to the use of praxis. In terms of psychotherapy, this can be implemented through the approach adopted by the therapist, an approach shaped by psychological theories. This would appear to be at odds with other feminist principles which state that the individual experiences of women are all-important, and as such trying to fit them into existing theories would diminish this importance. However, this may prove inevitable in any therapeutic encounter. In addition, it can also be questioned as to whether this is something that can be achieved in the group, whereby it may become difficult to treat members on an individual level, particularly when part of the group agenda may be to explore wider issues such as those relating to the socio-political arena and the general oppression of women. Every good therapist should be able to focus on her clients in terms of their individual needs, problems, and concerns, rather than trying to squeeze them into pre-existing frameworks. However, I believe that working in a women’s group makes this quite a complicated operation, particularly where the group is run according to a feminist agenda.

The ‘personal is political’ is a concept that plays a major role in feminism, although it means different things to different strands of feminist thought. Conceptually, it revolves around the belief that everything that occurs in an individual’s personal life is related to societal factors; thus personal issues are always placed in the larger context of society. However, this does not appear to be an idea that all have accepted. For example, Chodorow (1989) does not agree that the central arena of gender oppression has moved entirely away from the personal to the public and social realm, and asserts that it de-individualises the individual to accept this. In critiquing this position, it can
be suggested that this may lead women to blame themselves for events which a political or feminist analysis would deem outside of their control (Seu, 1998). However, when placed in the context of therapy some have argued that ‘the personal is political’ is a principle that has become diluted. Kitzinger and Perkins (1993) suggest that in terms of therapy, “instead of oppression being understood as a political issue requiring social change, our oppression becomes a private issue requiring individual adjustment” (p. 106). Thus it seems that therapy is constructed as interfering with the ‘real work’ of feminism in challenging the source of women’s concerns and instructing on how to fix them.

The next principle is also one that causes problems for psychotherapy, in that it advocates a reconceptualisation/reexamination of power. In terms of feminism, this is constructed as the inherent power imbalance that exists in society between men and women. As suggested, in group psychotherapy this could be applied to the relationship between the therapist and other members of the group (Stock et al., 1982). As already noted, this raises the question as to whether the relationship between all members of the group can remain equal, or whether the presence of a therapist - although part of the group – evokes deference from other group members. Feminist therapists would perhaps argue that this could be minimised through a sharing of knowledge and self-disclosure. However, it can be suggested that this is only a theoretical proposition, and that in practice the power differentials that arise are perhaps more difficult to disperse.

The seventh principle relates to the suggestion that process and product are equally valued. For feminist practice, this would seem to arise from a concern about not recreating usual forms of power relationships. For group psychotherapy with women,
this would suggest that a focus would be needed on procedures and norms. This is where therapy within a group context can become essential, whereby learning from the group processes can be a way of accessing how larger society works and shapes the individual. Thus group processes become therapeutic tools, whilst also reflective of the group as a social microcosm of the outside world that re-creates the gendered roles of society, allowing for them to be challenged and re-worked (Bender and Ewashen, 2000; Yalom, 1995, 1998). Here again there are problems caused for psychotherapy, whereby feminist theory appears to advocate that the therapeutic nature of the group is guided by the impact of larger society upon group members. This deflects from the implicit psychological functioning of the individual that would perhaps be the main focus of the psychotherapeutic elements of the group.

The incorporation of mechanisms for examining gendering and other culturally based assumptions are also considered to be important. This echoes the main tenet of consciousness raising, whereby an exploration of the lives of all of the members, including the therapist, is promoted as a focal point. However, the question must be asked again as to whether this is purely attributing blame for the women’s problems to society, and denying them the opportunity to take responsibility for their own lives. As previously raised, is the personal always political, and if so what can therapy help to achieve?

The ninth principle relates to feminist ideas of wholeness and unity that reflect the importance of taking a holistic and integrative outlook. This would seem to be a concept that has a variety of applications, relating to intra-personal splits in the individual, whilst also promoting the notion of ‘the group’ as a single unified entity.
Again, in theory this sounds a very noble and desirable function of feminism, but when applied to women's group therapy it prompts a return to the question as to how attainable this goal is, when allowing for the possible power dynamics of the group that may challenge any attempts at unification. Turning again to Kitzinger and Perkins (1993), it can be interpreted that they regard psychotherapy to be a very individualising experience. If this is indeed the case, then how can it be fitted in with the collective tenets of feminist thought?

The tenth maxim indicates that the meanings of words need to be renamed and examined. This is in order to account for the natural biases that exist in language; labelling for example. It is apparent that this generates problems for both feminism and psychotherapy. In particular, for feminism it can be suggested that this would be a fruitless task, whereby it appears to be little more than talk as opposed to social change and 'revolution'. In addition, as previously noted, this could engender the infiltration of 'psychobabble' into feminist culture, with words signifying political action transforming into psychological terminology (Kitzinger and Perkins, 1993). Thus 'liberation', 'power', 'rights' and 'choice' become terms to describe the internal workings of the individual, rather than those used to describe the workings or non-workings of society. The consequence of this appears to be a dilution of the true meaning of feminist 'action' words into platitudes for reassuring one's mental health stability.

The eleventh principle would appear to lend itself quite well to the notion of women's groups, as it advocates the examination and strengthening of relationships among women. As noted by Kravetz and Marecek (1996), all-women groups evoke benefits
in terms of women helping women, the power of group processes, and the advantages of a woman therapist. The existence of a group of women, purely in the dynamics that it generates, necessitates implications for relationships. On a deeper level the question can be asked as to how these dynamics differ from those within friendships outside of the group. Moreover, it may be that women’s therapy groups encourage the forming of relationships with women in the group at the expense of their friendships outside of the group (Kitzinger and Perkins, 1993).

Grunenbaum and Smith (1996) suggest that therapy groups provide an opportunity to explore and improve the capacity for intimacy. But what is meant by intimacy? Does it refer to any relationship that a member of the group may have, or to intimacy within the group? If it refers to the intimacy within the group then its relevance to ‘real life’, that is life outside of the group may be questioned. Grunenbaum and Smith go on to argue that the knowledge and importance of friendship has been also marginalised from the literature on the practice of women’s group therapy. Consequently, it appears that women’s group psychotherapy may be being accused of threatening this dynamic. This seems to reinforce points of contention between feminism and psychotherapy, whereby feminism is constructed as a unifying and bonding amongst all women in contrast to psychotherapy groups’ apparent dislike of women socialising out of the group, creating friendships external to their therapeutic interactions (Grunenbaum and Smith, 1996). In addition, it seems that this conceptualisation of feminism allows for difference and preference in friendships, whilst psychotherapy is constructed as demanding equal relationships that allow no room for personal choice. This demand appears to either overlook the development of particular friendships within the group, or more directly refers to them as “defensive sub-groupings” (Grunenbaum and
Smith, 1996, p. 70). Therefore, rather than these being the growth of bonds with other like-minded women who share common concerns and attitudes to life, they are viewed as anti-therapeutic. This is despite the fact that in reality this may enrich an individual’s social network, rather than damaging it. However, the argument still remains that the development of these relationships will be controlled by context of the group. Whether these relationships prove to have positive effects, it can still be suggested that these ‘friendships’ remain artificial to a certain extent.

The penultimate principle refers to the goal of seeking to discover multiple ways of learning, knowing, and practising. This would appear to fit in with the psychotherapeutic notion of the ‘practitioner-scientist’ (Wilson and Barkham, 1994), with a focus on research and its influence on how we work with clients. As such, the therapist also becomes viewed as a researcher, in terms of how she seeks to discover ways to help the client. Consequently, applying feminist thought to the group employs an understanding that different women have different styles of thinking, interacting, and changing, and that the approach adopted with them needs to be open and flexible to this. However, it can be suggested that this becomes difficult in practice when also trying to accommodate the ideologies of both feminism and psychotherapy into the arena, due to the pre-determined framework that they may impose onto any therapeutic agenda, whereby both of them vie for dominance over the therapeutic encounter.

The thirteenth and final principle that I wish to address calls for serious and regular attention to be paid to all sources of oppression. Although the focus here is gender-based, this also requires the inclusion of other sources of discrimination; examples of
which are those based on culture, religion or disability. It can be suggested that as individuals we all face our own sources of oppression that may differ from those of others. This prompts the question as to whether or not there can be space for these in a collective group, or whether we turn to the oppression of women as the only commonality shared between the group? This is not necessarily a negative thing, indeed as noted by Greer (1999) “to be feminist is to understand that before you are of any race, nationality, religion, party or family, you are a woman” (p. 7). However, when considering the therapeutic implications of this - and if accepting Kitzinger and Perkins’ (1993) argument that psychology has changed the meanings of language - it becomes evident that ‘oppression’ can be constructed as an internal psychological issue rather than an political one. Consequently, a discrepancy emerges with regard to the source of this oppression as internal as opposed to an external, independent of gender, and therefore something that needs to be attended to on an individual level rather than a group level.

Conclusion

So what can be concluded from this overview of the literature? Is it possible to incorporate the various principles of feminism into women’s psychotherapy groups? It seems that regardless of whether feminist ideals conflict with the psychotherapeutic orientation of the group, it is a fact that same-sex groups may be preferable for women, whereby it is more likely that women will be able to empathise with other women (Aries, 1976; Carlock and Martin, 1977). In addition, feminist principles posit that women in groups can share the experiences of their oppression and can undertake collective action. In view of this, it appears that on a superficial level there seem to be
few problems with this. Thus we see women undertaking group therapy which changes their lives (see DeChant, 1996). At least this is how it works in theory. However, this is where the problem lies, in that this is all theory. The body of the literature is written from a theoretical perspective of how it could work, and how therapy should be done. It is only when examining this on a deeper level that problems become more apparent.

As this paper suggests, any integration of feminism and psychotherapy within the context of women’s therapy groups raises ethical concerns, and questions about power relations and neutrality. In addition, integration also appears to prompt complications as to the focus of the group, whether inward and personal or outward and socio-political. It appears that the latter of these is what has made feminist therapies attractive to women, in that their demand for groups of special interest has been met, whilst the demand for dealing with interpersonal issues has fallen (Johnson, 1987). This is fair enough, as it shows that the needs of women are being heard and answered. However, can what these groups actually do be regarded as psychotherapy? I feel that this is part of the problem, in that perhaps the dilemma lies in how these groups conceptualise and present themselves, and what explicit and implicit agendas they adhere to. Moreover, questions remain as to what constitutes therapeutic practice and whether women’s psychotherapy groups do deliver this? I would argue that ultimately this relates to what actually establishes legitimate therapy, in other words, those qualities and attributes that make a situation therapeutic. I feel that these issues demand further attention, and that by investigating these it may be possible to address the integration of psychotherapy and feminism in practice rather than on a solely theoretical level.
Where then does this leave the therapist? Is she a leader, a feminist, a facilitator, a group member, or even a ‘he’? Another route of investigation for this paper, it appears that in raising these issues, questions have been prompted as to the potential for conflict between the therapist’s personal ideologies as opposed to her neutrality, and the role that psychotherapy and feminism play in this dynamic. These are complex questions to resolve, and for now perhaps we have to be happy either acknowledging ourselves as feminist therapists, or feminists and therapists (Ernst and Maguire, 1987).

So how should this debate be concluded? Without further empirical evidence, perhaps it is better to acknowledge that difficulties do exist, but suggest that until they are identified in practice it is almost impossible to do anything about them. This is not to say that therapy should be rejected in its entirety, as demanded by Kitzinger and Perkins (1993). Indeed, it can be argued that their call for the abandonment of therapy has no real basis, but it does appear to have encouraged debate and discussion into the area, as demonstrated by this paper. Ultimately, the nature of the therapy and what it is trying to achieve needs to be questioned, rather than just trying to combine psychotherapy and feminism to create a generic therapeutic intervention, oblivious to the problems that this engenders. At the end of the day there are only two choices that women can make: they can either change themselves, or they can change their environment. Currently it seems that psychotherapy links to the former and feminism to the latter. However, whether it continues to be the case that ‘never the twain shall meet’ remains to be seen.
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Feminism and Women’s Group Psychotherapy: Complementary or Contradictory?

Feminism and psychotherapy have had an uneasy relationship, with the apparent ideological differences between the two rendering them difficult to integrate into the practice of women’s group psychotherapy. In this study, 10 women, who defined themselves as feminists and had been in group therapy, were interviewed in order to obtain data on their construction of feminism and possible conflicts between this and the ideologies of their groups. Data were subjected to interpretative phenomenological analysis. In relation to the central research question, it was found that although there were instances where the participants had experienced conflict between their feminism and the ideologies of their group, this was not to the degree hypothesised by feminist critics of psychotherapy. For two participants in particular, rather than detracting from the therapeutic process, feminism appeared to provide an invaluable framework for their group experience. The implications for feminist theory and counselling psychology are discussed in light of the findings.
Feminism and Women’s Group Psychotherapy: Complementary or Contradictory?

Introduction

In recent years, female therapists and their clients have worked towards reconciling traditional psychological theory with the real-life experiences of women (Laidlaw and Malmo, 1990). It appears that this has led to attempts to integrate feminist ideology with psychotherapeutic principles, as seen by the growth of therapeutic groups for women. Despite this, and despite the significant role played within psychotherapy by female theorists and practitioners, psychotherapy and feminism appear to have struggled to form a positive relationship. Cardea (1985) argues that therapy dilutes feminist political analysis, whilst other feminist thinkers have constructed it as an institutionalised practice, “creating and perpetuating false needs” (Daly, 1991, p. 280) that replace mutual relationships of friendship between women with ‘prosthetic’ therapeutic relationships (Kitzinger and Perkins, 1993). Therapy has also been interpreted as unethical due to the inherent power imbalance that may be generated between the therapist and the client (Kitzinger and Perkins, 1993; Lakin, 1991; Stock, Graubert and Birns, 1982), whilst dominated by a framework of patriarchy that constructs the therapeutic arena as a gendered space, founded on principles of masculinity and femininity (Forisha, 1981). However, if this is indeed the case, how then can we account for the existence of these women’s psychotherapy groups, which are apparently presented in terms of supporting women in an empowering and feminist manner? (Donnelly, 1986; Dutton-Douglas and Walker, 1988; Johnson, 1987;
It appears that feminism has commonly concerned itself with the politics of gender, sought equal status and empowerment for women, and committed itself to action for social and political change (Griffin, 1995; Russo, 1999; Stanley and Wise, 1983; Walby, 1990; Worell and Remer, 1992). In contrast, psychotherapy has been constructed as politically, morally and therapeutically neutral, deterministic and based on intrapsychic theory, choosing to focus on medical or illness models which locate problems in the individual (Greenspan, 1983; Worell and Remer, 1992). Pilgrim (1998) refers to this as “psychological reductionism and political ignorance” (p. 225) on the part of psychotherapy, a criticism that has been supported by others who have condemned traditional psychotherapy for not addressing the condition of historically marginalised groups, of which one constitutes women (Krawitz and Watson, 1997).

However, it seems that theorists have overlooked these issues to a certain extent. For example, Marecek and Kravetz (1998) observe that the extensive literature written by North American therapists rarely makes reference to the potential difficulties of merging psychotherapy and feminism. Indeed, Kravetz and Marecek (1996) note that group therapy is a means of personal change that is particularly suited to the goals and philosophies of many feminist practitioners, whilst Brown and Liss-Levinson (1981) suggest that only the most orthodox Freudian psychoanalysis is incompatible with these goals and philosophies. This is not to say that this apparent acceptance has not been questioned (Chaplin, 1998; Reed and Garvin, 1996; Rothberg and Ubell, 1987). However, it has been argued that attempts to reconcile the different ideological standpoints of feminism and psychotherapy have not really addressed the problems...
that led psychotherapeutic approaches to be represented as colluding with and reinforcing women’s subjugation in the first place (Frosh, 1994; Holloway, 1989). In light of these inconsistencies even feminist theorists appear undecided about whether to unite behind or reject psychotherapy for women (see Chesler, 1990; Kitzinger and Perkins, 1993; Stock et al., 1982).

In this study it was felt that by looking at women’s experiences of group therapy, some common ground might be found between the individuality of psychotherapy and the collective motivation of feminism. The rationale for this reflects the idea that therapy groups for women arose out of an amalgamation of the characteristics of feminist consciousness raising into more traditional models of group treatment, thereby allowing a focus on both social and personal psychopathology (Marecek and Hare-Mustin, 1991; Sandage and Radosh, 1992).

If, as suggested, links are made between the work of the group the workings of wider society, this study could also be used to inform other societal issues, one of which is the growing demand for evidence-based practice (Wilson and Barkham, 1994). This reflects the emerging trend of evaluating therapy by seeking the views of its ‘consumers’ (for example, see Annesley and Coyle 1998; Milton and Coyle, 1998). Thus research into this area could inform training and provide psychologists with “a quality empirical base for their practice” (Milton and Coyle, 1998, p. 76), whilst also ensuring that the clients’ needs are being met on a psychological level and as consumers of a service. Indeed, with specific reference to counselling psychology, it was hoped that this research would demonstrate support for the construction of the counselling psychologist as a scientist-practitioner, one of the foundations on which
counselling psychology has developed in order to generate credibility as a profession (Wilson and Barkham, 1994; Woolfe, 1997). I would argue that adopting this persona allows for practitioners to focus on integrating past, current, and future research into their clinical work, whilst also attending to the influences of cultural, socio-political and theoretical issues in conceptualising their clients.

Mindful of these issues, this study involved exploring the views of self-identified feminists who had been in group therapy. It was felt that women who have feminist beliefs would perhaps bring this ideological commitment to the context of the group, consequently creating avenues for exploration about how they reconciled this with the ideologies of the group, whilst also highlighting any areas of incompatibility. In focusing on potential tensions and possibilities for resolution empirically, it was hoped that evidence could be found for how feminism and psychotherapy work together in practice within the context of women’s therapy groups.

**Method**

Feminism encompasses diverse frameworks, ideologies and attitudes towards inequalities between women and men (Russo, 1998; Russo and Dabul, 1994; Tong, 1998; Walby, 1990). This has given it a pluralistic flavour, highlighting the need for diversity in research methods when exploring the experiences of women (Russo, 1999). Although traditional research methods perhaps answer certain important feminist questions, Russo (1999) argues that there are others that need to be addressed that cannot “be answered with old fashioned methods” (p. ii). Other theorists have framed this in terms of a need for qualitative methods, which have been promoted as
allowing a real insight into the lived experiences of participants (Crawford and Kimmel, 1999; Grossman, Gilbert, Genero, Hawes, Hyde, Marecek and Johnson, 1997; Merrick, 1999). In view of this, it was felt that a qualitative approach would enhance the feminist framework of this research in exploring the “personal experience of the female” (Spender, 1978, p. 259).

Additionally, the research was informed by co-operative inquiry (Heron, 1996). The focal characteristic of co-operative inquiry, or participatory research as it is also termed, is that the researcher interacts reciprocally with those who would be constructed as passive research subjects within a traditional research framework. Elsewhere, this has been described as a way of empowering women to do their own research in what interests them, rather exploiting them as research subjects (Olesen, 1994). Heron (1996) notes that this makes for a unique approach to participative inquiry, in that a commitment is made to exploring participants’ realities through co-research, thus giving them a discernible voice.

**Participants**

Attempts were made to recruit self-identified feminists who had been in women’s group therapy within the last eight years. This time frame was decided upon on the grounds that participants’ memories of their group therapy experiences would maintain resonance, and that the impact of the therapy on their lives would still be in evidence. After all routes of networking were exhausted without success, a call for participants was placed on three Internet web lists (http://www.mailbase.com; counseltherapy@mailbase.ac.uk, group-analysis@mailbase.ac.uk and women’s...
studies@mailbase.ac.uk). These focused on counselling and psychotherapy, group analysis, and women’s studies, and had been set up as forums to offer support and discussion for people interested in those areas. Ten women agreed to participate.

**Interview Schedule**

The participants were interviewed by the researcher using a semi-structured interview schedule, where possible either in their home or at their place of work. The schedule began with demographic questions (see Appendix A), which were followed by questions on their construction of feminism; their expectations of the group and its relationship with feminism; the role of the group therapist; their relationships in and out of the group; and their thoughts on future practice (see Appendix B). Material for the line of questioning was taken from literature noting the complexity of the relationship between the two ideologies and calling for further empirical research into the issues that this raised (Horne, 1999; Worell, 1996; Worell and Remer, 1992)

Interviews lasted between one and one-and-a-half hours. All were audio-taped and transcribed verbatim (see Appendix C for sample transcript). Unfortunately, some of the participants lived overseas meaning that it was not possible to meet with them. Consequently, after contacting these women by telephone, each was sent a revised version of the interview schedule that had been modified to a questionnaire style format (see Appendix D). They were then re-contacted when it was expected that they had received this questionnaire to discuss any issues or concerns that they had with either its completion or return.
Ethical Considerations

In terms of ethics, and particularly matters of confidentiality, participants were asked to sign a consent form after reading an information sheet about the study (see Appendices E and F). These gave a brief outline of the research and explained what would be asked of the participants. When giving consent, it was made clear to the participants that all data including tape recordings would be kept confidential for the duration of the research, and destroyed at its completion. It was also impressed upon the participants that they were free to withdraw from the study any time, for any reason.

Additionally, given the nature of the research topic and the potential for distress on the part of the participants - with participants perhaps having to touch upon material that they explored during their therapy - a basic counselling-style format was adopted in order to approach their material with sensitivity (Coyle, 1998; Coyle and Wright, 1996).

Analytic Strategy

Although the analysis was conducted at group level, the first stage consisted of exploring each case individually. It was felt that in approaching the data this way, the importance and complexity of each woman’s experience could be highlighted in terms of differences and similarities (Price, 1999; Uzzell, 1995).
The data were analysed using interpretative phenomenological analysis (IPA) (Smith, 1996a; Smith, Flowers and Osborn, 1997; Smith, Jarman and Osborn, 1999). This method of analysis is concerned with developing an ‘insider’s perspective’ on participants’ experiences, focusing on their processes of making meanings of these (Conrad, 1987).

The analysis involved examining the transcripts in detail, with notes being made on each transcript regarding significant or interesting points that linked to the research topic. Within each transcript these notes, and those that emerged during subsequent readings, were condensed to produce initial themes summarising significant points. When this process had been repeated with each transcript, the resulting set of initial themes was examined to identify recurrent patterns across the transcripts. Where possible, these themes were then combined into increasingly analytic ‘superordinate’ themes. The links between these and the data set were then checked again to ensure that they remained grounded in the data. Throughout this operation, attention was particularly focused on the connections and associations that the participants were making, allowing for some exploration of their meaning-making processes. The themes were then ordered in such a way as to create a coherent narrative that captured the essence of the participants’ combined experiences.

Linking to the principles of co-operative inquiry, as part of the analytic strategy it was decided to offer the initial analysis back to the participants to explore whether it had any resonance with them. Feedback from this was incorporated into the final write-up. However, as noted by Coyle (1996), this method should not be adopted unquestioningly due its potential to become merely a “bumper sticker to trumpet the
‘authenticity’ of the research” (p. 74). Additional considerations are explored in the overview section of the report, where attention is paid to the influence of the power dynamics of the research situation and the impact that this may have had on participants’ feedback.

Evaluating the Analysis

The analysis that is offered resulted from reading the transcripts and from discussions between the researcher, her research supervisor, and the participants, as to which interpretations were most persuasive; in this sense it is not claimed that this analysis is in any way objective. One way of explaining this is in terms of IPA’s recognition that the research product is influenced by the interpretative frameworks brought to bear upon the data by the researcher (Smith et al., 1999), also termed as the researcher’s ‘speaking position’ (Burman, 1994).

The researcher’s speaking position is likely to have been shaped by her standing as a woman who has been influenced by critical feminist writing, and who is also a trainee counselling psychologist for whom psychotherapeutic theory and practice have played a major role in training. The research supervisor’s speaking position is influenced by his position as an academic psychologist, who has had a long-standing interest in feminist approaches to psychology and the infiltration of feminist thought into the previously male-dominated field of psychotherapy. Given the orientation of our speaking positions and their impact on the analysis, analysts with different speaking positions would have undoubtedly arrived at different conclusions. However as quotations from the transcripts have been provided in order to illustrate the themes
that are identified, readers can judge the persuasiveness and credibility of the analysis for themselves whilst also starting to think about possible alternative meanings and understandings (Elliott, Fischer and Rennie, 1999; Smith 1996b). It is through these criteria that the quality of the analysis should be assessed, rather than traditional criteria such as reliability and experimental controls which are based on assumptions about researcher objectivity and disengagement from the analytic process (Henwood and Pidgeon, 1992).

It should be noted that in these quotations, empty square brackets indicate where material has been omitted, information that appears within square brackets has been added for clarification, and ellipsis points (...) indicate pauses in the participants' speech. Names or other identifying information have been changed to pseudonyms in order to protect the confidentiality of the participants.

Analysis

Demographic Information

Participants' mean age was 41.3 years (range 26-51; SD 8.4). In terms of their highest educational qualifications, eight (80%) had a postgraduate degree or diploma, one (10%) had a degree, and one (10%) had qualifications equivalent to GCSEs/O-levels. Using the International Standard Classification of Occupations (International Labour Office, 1990), eight (80%) were classified as holding professional jobs, and two (20%) were senior managers or officials. At the time of the study, seven participants (70%) lived in urban centres within Great Britain, mostly in or around the London
area; one (10%) lived in Dublin, one (10%) in America, and one (10%) in New Zealand. All stated their ethnicity as ‘White’.

In terms of their experiences of therapy and counselling, all had participated in therapy as a client, whilst four (40%) had also taken the role of therapist at times. All had been in women’s group therapy, whilst nine (90%) had also been involved in individual therapy. With regard to the orientations of these therapeutic encounters, client-centred and humanistic therapy were identified on seven occasions, psychodynamic therapy four times, feminist therapy twice, cognitive-behavioural therapy twice, existential therapy once, transactional analysis once, and gestalt therapy once.

Relating to the length of time that they attended the group referred to in their interview or questionnaire, the mean duration was 84 sessions (range 18-240; SD 84.4). The mean length of time elapsed since leaving the group was 1.7 years (range 0-4; SD 1.3), with one participant still attending her group.

**Understandings of Feminism**

Before going on to explore the main themes emerging from the participants’ transcripts, it seems important to explore their conceptualisations of feminism. Through this it becomes more transparent as to how they have incorporated it into their own identity. The most common associations that arose related to ideas of difference, equality and power dynamics:
I believe that women and men are different, but the difference should not undermine any sense of equality. I think that it [feminism] accommodates difference to ensure equality of outcomes or substantive equality. (Jenny)

*I think it's [feminism] powerful behaviour... Not behaving in a subservient way.* (Kelly)

For me feminism seems to be something that allows me to look at the world and see when things aren't fair... To make sense of when I feel impotent and helpless. (Virginia)

Linked to this, references were also made to minority groups, and individual differences between women. In addition to apparently reflecting constructions of women as a minority, this could imply a belief in shared experiences between those who are different from mainstream society, in race or class for example (Krawitz and Watson, 1997):

*It [feminism] allows for an awareness of other minority groups.* (Sue)

*[When thinking about feminism] I think about women, I think about minorities.*

*I think about individuals ...I think about power dynamics in society.* (Helen)

General themes arising from the narratives of the majority of participants can be understood in terms of how one particular participant explained her conceptualisation
of feminism. Karen explained that for her feminism appeared to have two facets, the first being:

*Women together, valuing each other, validating our experiences, supporting each other [and] loving each other.*

And the second relating to:

*Challenging assumptions, sexist assumptions [ ] about women and men and their relationships in society.*

This latter remark perhaps implies a construction of feminism that highlights the roles of culture and society. Consequently this may tie in with beliefs about the existence of a patriarchal society that maintains and reinforces gender differences as a source of discrimination and inequality (Kravetz and Marecek, 1996; Morrow and Hawxhurst 1998). This appeared to be an issue highlighted by a number of the participants, who perhaps used feminism in order to make sense of inequality as defined by their beliefs about the limitations of a female gender. To illustrate:

*Women by virtue of their gender are disadvantaged in a patriarchal society.*

(Wendy)

*For me it [feminism] means using gender as one of the ways of understanding inequalities in society.* (Alice)
It's [feminism] much more about being able to have a voice and being able to, as much as one can in this society, to be free to be who one wants as a woman.

(Jo)

Feminist ideology and the group agenda: Irreconcilable?

This study was based on the belief that participating in women’s group therapy and having a feminist identity could potentially cause difficulties for women, in that the core ideologies of therapeutic practice and feminism appear to be grossly different (Cardea, 1985; Daly, 1991; Kitzinger and Perkins, 1993). However, only half of the participants reported times during the group when they had experienced conflict between their feminist identity and group orientations/expectations. One example of this reported conflict was outlined by Alice who said:

As much as we try and share our views [in the group] and you know it’s all equal and so on, somebody’s got to do the feminist analysis, and you know it’s kind of like we lead our sisters to our analysis. And you know that’s no less oppressive than Freudian rubbish thrust upon you really.

This comment echoes criticisms that have been made with regard to issues of power imbalances in therapy, with therapy charged as being rife with power conflicts and inequalities that challenge feminist philosophies of gender equivalence (Kitzinger and Perkins, 1993; Lakin, 1991; Stock et al., 1982). For participants reflecting upon this, it seems that this was not only a feature of the therapist-client relationship, but also the relationships between clients themselves. For example:
I wanted to use the group to meander [] and there were individual members of the group who wanted more structure or more focus or more work. I can think of other times when I wanted to talk about having a new baby and there were other people in the group who said ‘I’m not interested’. I don’t know that that was about me being in conflict with the whole of the group, or that what I wanted was in conflict with what some people in the group wanted. (Helen)

I was aggressive at times that conflicted with the others [values/beliefs].

(Rachel)

There was someone in the group who it transpired [] [was] quite homophobic [] I think I was shocked that this person had been sitting on that agenda for a number of years and had never spoken about it. (Sue)

Nonetheless, for some participants, rather than their feminist philosophies proving at odds with group activities, the presence of these within the context of their group appeared to be constructed as complementary to the therapeutic experience. For example, Jo, who had described the importance of “women’s space” as informed from a feminist standpoint, observed that in her group there was:

More freedom to use the space [in-session] as you wanted. There was space for anger and big cushions you could hit if you wanted...You were allowed to be emotional, encouraged to be angry.

This could perhaps be said of any group therapy. However, it does appear to echo
suggestions that there is a difference in the anger expressed in women’s groups from that occurring in mixed groups, with women’s groups more likely to encourage the display of strong emotions (Kirsh, 1987; Wolman, 1976).

With regard to these strong emotions, for Kelly, it was a case of the group apparently encouraging powerful behaviour in the women participants in terms of beliefs about taking action and regaining control over their own lives. Appearing to reflect a sense of self-efficacy as opposed to collective efficacy, her interpretations of her group interactions revolved around:

You’ve got the power, you can do it, you can take control, you can think about what you want to do. [...] Because the group was feminist so was the therapy. Areas of incompatibility were not really an issue. [...] Thinking about it now, I think that because the group was feminist although that was never stated, that was therapeutic, the process of empowerment.

Indeed, the conceptualisation of group therapy as contributing to and running parallel to feminist ideology appeared to be a common experience for many of the participants. For Jenny it seemed that possible incompatibilities were overridden by the fact that the “participants were all women”, echoing the ethos of “sisters doing it for themselves” (Karen). This was perhaps indicative of beliefs about women sharing attitudes and having similar views of the world, because they were of a shared gender.

Perhaps reflecting the previous implication of feminism as a construct that supports differences between women as well as differences from men (Proby, 1993; Reay,
1999), other participants remarked that they felt that their group encouraged dialogue around differing values and beliefs:

I feel the group I attended was very open and responsive to diversity, core issues were about how we related on a personal level. While group members held beliefs that conflicted, the therapy process per se did not create conflict about different views. (Wendy)

Any instances of conflict had to do with political perspectives not feminist consciousness, such as my different views on adoption, motherhood, family and blood ties. [ ] This dialogue across difference was one of the most important unexpected outcomes. (Karen)

Things like different people's beliefs about monogamy and faithfulness were talked about and clearly different views were held within the group and that was the way it was. (Helen)

In this light, it seems that if there is space in group therapy for differences to be addressed and explored, incompatibilities may not be considered problematic. Therefore, when considering how this relates to the participants' various constructions of feminism, it seems that one common issue was a belief that feminist values could be supported in the group if they allowed for some understanding of differences between women, which the group then gave space to explore.
Identity and the 'gendered' self as defined in-group

In light of the positive aspects of the relationship between the focus of the group and individuals’ feminist values, an associated theme that emerged related to the group’s apparent therapeutic contribution to feminist identity development. For example, Alice said:

It’s allowed me to take on parts of my [feminist] identity that most of us hide, and to wear them not as a kind of ‘in your face badge’, but as ‘this is just part of who I am’, and ‘I’m not going to apologise for it’, and ‘it just is’.

It could be that this would be a part of the process in any group. Yet as Alice explained, she appeared to believe it to be the feminist focus of her group that facilitated acceptance in her, encouraging her to take action:

‘Feminist theory is about empowerment. That made me feel like I can set up this piece of group-work that I want to do.’

This theme was also echoed by Virginia, who observed that she felt she had previously avoided thinking of herself as a woman, as to her it implied that she was weak and helpless, having little power to change her life. It seems that for her, therapeutic change needed to incorporate the development of a strong independent identity as a woman as supported through adopting a feminist framework:
I think that it [feminism] allowed me to recognise that I did not have to be a victim, just because of my sex. But when I was struggling to accept this the group challenged me and made a space for it to become a topic of exploration.

As Jo also noted, in the group she was:

Allowed to take back [my sense of self]... allowed to empower [myself] again, [and] encouraged to look at a wide range of issues... to get in tune with the feelings that were buried as a child. And to look at issues around that... about how we viewed our bodies, our relationships... how we take up space [as women].

Other participants openly acknowledged that the group allowed for them to present particular versions of themselves. This perhaps reflects elements of theories relating to socially constructed systems of thought and action that organise our perceptions of gender identity (Hess, 1990; Lorber, 2000). It appears that for some of the participants this was acknowledged within the group, with the questions that it raised voiced and explored. Thus Helen noted:

Hearing from each person, about who they want to describe themselves as. [ ] Did they see me as a mother and did I see myself as a mother? [ ] They [other group members] didn't know of any other women who were lesbian and had a child. What do you call them? [ ] Is it the biological fact of creating a child that makes you the mother or is it the mothering that makes you the mother?

(Helen)
Thus it may be that for some participants, the groups challenged and re-worked their perceptions of socially constructed identities, consequently providing the space to present themselves as they wished.

**The Therapeutic Value of Women ‘Together’**

The experiences and challenges reported by the participants seem to have been influenced by the relationships that participants developed with other group members. For the majority of participants, it appears that their experience of the group was as a forum where they felt understood and supported. In relating to others in the group it seems that they were helped to understand and work through their own experiences of inequalities and gender biases. For example:

*It was noted when I was adopting a subservient role and [I] was encouraged to see that.* (Kelly)

*Through this listening [to other women] connecting with my own experiences, my own feelings and gaining more understanding of them. [] Being made aware of my own state of mind, psyche, through presenting my experiences to others as well as listening to others’ experiences of being treated differently [from men].* (Karen)

It seemed that these relationships allowed the participants to connect with other women, and in some respects gain some form of emotional validation in terms of their ‘true’ selves (McLeod, 1994), and a sense that they were being listened to and ‘heard’
rather than being pathologised or dismissed. As Alice recounted:

[The group is] more open, more honest, less protected, less defended, but I think that’s the nature of this group, because nobody’s been pathologised, that nobody’s come out feeling like they were the ‘healthy one’.

This appears in contrast to criticism directed towards the traditional view of psychotherapy as focusing on remediating pathological behaviours rather than addressing those created through social stereotyping and women’s oppression (Kitzinger and Perkins, 1993; Parker, Georgaca, Harper, McLaughlin and Stowell-Smith, 1995; Worell and Remer, 1992). It may be that the elements of feminist practice integrated into these women’s experiences of group therapy minimised the risk of this, by making space for exploring behaviour resulting from existing in a patriarchal society rather than blaming individual mental disturbances.

Nevertheless, it did seem that for some women the relationships and affiliations created in the group became problematic rather than positive, with participants describing conflict and feelings of exclusion that arose due to a sense of their difference from other group members. For example:

There was an issue of generations within the group. There was a group of people who had been in the group for a long time and who were older [] and there was another group of us that joined this group. [] At times there was a conflict of power between those sub-groups within the group. (Helen)
Helen went on to note that:

I was the only lesbian in the group, everyone else was heterosexual. They weren't always supportive. Often what came up were homophobic stereotypical responses, but I don't know that within the group the fact that I was a minority was explicitly addressed.

Indeed, this development of sub-groups within the group appeared to have quite an isolating effect on some of the participants. In exploring her experience of this, Sue noted that:

I think I did feel jealous of the cliquiness of some of the other group members. I didn't feel that I was a part of that group.

The Role of the Feminist Therapist

Although highlighted as a specific issue for discussion in the interview, it seems that this was a theme that most of the participants had considered prior to the interview. For most participants, their group therapist or facilitator appeared to be constructed as someone primarily responsible for issues surrounding management of the therapeutic frame. As Alice and Jo explained, they believed that the role of the therapist was to:

Create a space, for people to use in certain frameworks and contexts so that people could take a turn, including the group facilitator, and say what they want from that turn. Setting boundaries, uhm... and providing space,
physical space, uhm, comfort you know all that kind of preparatory work of setting it up. Agreeing ground rules, contracting those sorts of processes. And then offering time-keeping and space management, not content management. So fifteen minutes from the end checking out that we did what we set out to do [management of the process]. (Alice)

[To manage] the boundaries of space and time so that each woman gets a chance to have their space and attention to use as they want. (Jo)

From this it appears that the therapist was viewed as almost peripheral to the group process, or as Wendy explained “the minder for the group process”. Conversely, it seems that for other participants their therapists played a more integral part in the therapy. Moreover, it appears that this was not always welcomed, resulting in what could be interpreted as mixed feelings. For example:

She talked quite openly about her experiences, history of relationships and things [] Some of the time I didn’t think that was appropriate that [she] was taking up time I was paying for talking about [her] life. (Sue)

Our convenor also has some motherly habits to attempt to ‘tidy up’, ‘wrap up’ women’s experiences neatly and to say something that will make someone ‘feel better’. I have also at times felt patronised myself. (Karen)

In this light it appears that the therapist had the potential to become quite involved in the therapeutic process. This appears in stark contrast to psychotherapy’s traditional
view of her as the neutral ‘blank screen’ (Leider, 1983). As inferred, Sue’s therapist in particular appeared to embrace the transparent approach encouraged in feminist literature by incorporating her own material into the group where relevant, and openly sharing her values with the group (Feminist Therapy Institute, 1995; Watson and Williams, 1992; Worell and Remer, 1992). Yet it appears that this was not something that she welcomed at the time.

A consensus appeared to emerge as regards the gender of the therapist, whereby with few exceptions, participants seemed to be expressing a belief that only a female therapist was useful to their therapeutic needs. Explanations for this ranged from wanting to work through transference relationships with other female figures as suggested by Wendy, to directly using the therapist as a role model as apparent in the accounts given by Jo, Karen and Virginia. However Alice noted:

> Well all other things being equal... Actually I think that the skills and values of the facilitator are more important than their gender. I think that a facilitator can make themselves vulnerable that they can be sensitive, that they have humility, that they have kind of emotional sensitivity. So I think that those are features that are more important than those to do with biological sex differences.

Nonetheless, she did qualify this by referring to the fact that the qualities that she was pointing to as important were “traditionally attached to gender”.

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Feedback on the Analysis: The participants speak

As noted, in an attempt to incorporate the spirit of co-operative inquiry into the study, it was decided to offer the preliminary analysis of the interviews to the participants to allow for discussion as to how accurately they felt it reflected their thoughts and experiences. It seems that this exercise revealed that generally the participants believed that their comments and observations had been appropriately interpreted in the analysis, and that it had “not misrepresented anything” (Kelly). It appears that the themes that were selected did reflect those most pertinent to the majority of the participants, especially those relating to the development of identity and the feminist challenge to gender-based inequalities:

I guess that space for working through these issues in the group was the most important thing really. (Wendy)

However, for some participants it seems that this may not have been addressed in as much detail as they would have liked. For example, Kelly reflected that she believed it important that readers understand the “dis-empowerment” that she had felt through “society’s social conditioning”, and that “one of the main benefits of the group was in challenging that”.

Other comments related to issues raised by other women that individual participants had not considered before. Rachel observed that although her membership of a women’s therapy group had been as a result of a training requirement, she felt that “other women [participants] talked about things that were perhaps more relevant [to
me] than [I] felt before reading this". This was echoed by Jenny who noted that although the analysis had incorporated elements she did not feel were as central to her experiences, thinking about it had allowed her to question some of the assumptions that she had made in the past about sameness between women and differences from men.

Unfortunately it was not possible to obtain feedback from three of the participants. One had left the country leaving no contact details, and two reported that although they wanted to be as involved in the study as possible other commitments were more pressing. It seems that this is one of the challenges faced by this approach, in that although one may be able to access participants on one occasion, it may not be possible to ensure that they will be available to contribute throughout the study. However, in making this an option for participants it seems that they were able to feel that their individual contributions were important and valuable to the research process.

One participant especially appeared to make good use of this, reporting on the resonance that each of the themes had to her own experiences. For Alice it seems that the therapeutic value of feminism being incorporated into the group was an experience personal to her, with a feminist framework being:

\[
\text{The most therapeutic thing actually is Making a space for women to pay attention to the things that are important to them in their lives... to actually think about 'this is my life, what's it all about?'}
\]
However, she voiced some concerns with regard to the analysis’s apparent reflection of the positive contribution that feminism could make to women’s group therapy, commenting that:

One of the problems with feminist approaches is the belief that you can use an ‘approach’ or ‘method’ as if feminist work could be so packaged. E.g. consciousness-raising becomes such an ‘approach’ when used uncritically.

Overview

This study points to some of the issues that may confront women who have feminist beliefs in terms of their relationship to the ideals of their psychotherapy groups. In exploring this, the participants reflected on their attempts to interpret events in their lives through a feminist framework, and the impact of this upon the group experience. While there was some overlap between the difficulties described by the women in this study and those alluded to by critics of therapy for women, what distinguishes this study is the extent to which participants felt that their experiences in the group were not challenged or compromised by their feminism to a great degree. The study also indicates the implications of these difficulties, where they do arise, for therapists who offer these services for women and identifies some ways in which they might be managed.

Yet, any conclusions drawn from this data set must be tentative due to the question of how representative these experiences are of the experiences of other feminists who are in group therapy. However, at this point it should be remembered that IPA is designed
to focus on describing the views/experiences of a small sample group in depth, rather than generalising to a larger population (Smith et al., 1999). Consequently, as with all findings from small-scale qualitative research, it would be possible to build a more general picture of the interaction between feminist ideology and therapeutic practice by conducting further complementary investigations with other segments of the population in order to develop a more generalised pattern of the relationship.

**Theoretical Implications**

For this sample, it seems that each participant constructed a narrative that held meaning for her in terms of her views of feminism and how it impacted upon her group experiences. As previously noted, it appears that there were some areas of difference between the participants' feminist ideologies and the focus of the group. Examples of this included Alice and her attempts to create her own ways of working with other women in groups, and Karen and her perception of having to "fight for a voice". However, as argued by advocates of feminist therapy, for Kelly and Jo it seemed that rather than detracting from their experiences, their beliefs about feminism actively contributed to the therapeutic values of their groups (see McLeod, 1994; Worell and Remer, 1992). One explanation for this may relate to the orientation and agenda of the group, whereby in groups where these are made explicitly feminist, a focus develops on encouraging and fostering new feminist ideas as part of the group-work. Potentially diminishing the potential for incompatibility between feminism and psychotherapy, it seems that this may allow for group members to further develop and operate within their own individual feminist framework.
One theme that appeared consistently in the participants’ accounts relates to the role of the therapist. Their input into the group appeared to either facilitate a beneficial experience or highlight difficulties. Additionally, it seemed that the group experience was made more positive due to the therapist being female. It may be that the participants felt better understood and supported through a perception of ‘sameness’, which minimised the risk of re-creating the gender-based power imbalances that exist in society (Lazerson, 1992). Ultimately, rather than dictating therapeutic goals and procedures (Lakin, 1991), the therapist appeared to be constructed as encouraging and supportive.

However, especially with regard to this last point, questions remain as to the extent to which this data and the themes that emerged from it explicitly addressed issues specific to women’s groups, as opposed to those resulting from any group therapy experience. I would argue that, although similarities can be identified, the issues explored within the emerging themes do reflect something that appears specific to the single sex nature of these groups. For example where reflected upon, it appears that relationships between the women in the groups were more dependent and supportive than those that could be expected of a mixed group, with issues relating to intimacy and safety being pushed to the fore (Horne, 1999). Additionally, it also appeared that although concerns were raised about emotionally charged situations between group members, by and large the participants’ groups encouraged these to be addressed. Consequently, group members seemed to be learning to work with conflict while maintaining respect for one another. Again this is something that has been identified as particularly characteristic of women’s groups (Wolman, 1976). Finally, returning to this issue of the therapist and the role that they adopted in the group, it can be
suggested that the use of the therapist as a role model could potentially benefit any group. However, again there appeared to be something particular to these women's groups, allowing for this role modelling behaviour to manifest and encourage identity development within the context of challenging stereotypical gender role assumptions. As suggested by Walker (1987), it is this that allows for women to move beyond a traditional emotional dependency on male approval, and can be viewed as specific to women's groups.

One point that I believe it is important to reflect upon is the participants' responses to taking part in the study. As previously mentioned, feminist research aims to be transformative in terms of challenging traditional psychology and its epistemological assumptions, whilst changing the lives of women who are affected by it, both as researchers and participants (Grossman et al., 1997; Russo, 1999). As apparent in the feedback from Rachel and Jenny, it is possible that these participants felt that by making sense of their experiences within the context of the interviews, they became better informed about their lives and the impact of their group upon them.

**Limitations of the study and directions for future research**

Given that the data set consisted of retrospective accounts, the likelihood that they constituted an accurate representation of the events and experiences described was possibly diminished (Greenwald, 1980). It seems that recollections change as people revise their past in order to satisfy their present concerns and reflect their current knowledge (Greenwald 1980; Loftus and Loftus, 1980; Ross, 1989). Therefore, it may be that the experiences and events recalled and reflected upon by these participants
were structured in a way that made sense within their current framework of understanding the world. This may have changed from the times they referred to in the interviews, particularly with regard to those participants who left their groups some time ago.

More pertinently, the sample was notably atypical of the general population with the group consisting of women of a similar ethnicity, either still affiliated with the academic community or involved in psychology as therapists themselves. In addition, the majority of the sample was recruited via the Internet. This meant that women who did not have access to a computer and/or were not members of the Mailbase lists would not have been aware of the study, and therefore not have had the opportunity to participate. As noted, although it is not the intention of IPA to create a generalised picture of a population (Smith et al., 1999), there is obviously a need for further research in order to address this. In addressing this issue of ‘missing voices’, this could facilitate a more in-depth exploration of the experiences of a range of women who consider themselves to be feminist, whilst also allowing a focus on the impact of cross-cultural and multicultural factors on women working together in groups.

One final limitation that needs to be addressed relates to the creation of a power differential between the participants and the researcher. This creates a challenge for feminist research as an inadvertent source of dis-empowerment (Griffin, 1995; Hill Collins, 1990). Although it was hoped that this could be minimised by encouraging participation throughout the study, especially with regard to feedback during the analysis phase, perhaps some of the ultimate authority did remain with the researcher. As noted by Daniels and Coyle (1993), explanations for this could have included the
demands of the research process and the expectations of the participants/co-
researchers. This was perhaps amplified by a possible supposition of sameness
between the researcher and the participants in terms of their gender, social class, and
ideologies, which in turn may have influenced the analysis. In future research, it may
be that greater attention would need to be paid to the danger of aligning oneself with
the participants' life experiences without critically examining them (Hurd and
McIntyre, 1996).

Implications for the practice of counselling psychology

If this study has managed to access common experiences and conceptualisations to
any extent, then counselling psychologists may have a vital role to play in terms of the
services that they are able to offer women when working in group settings. For
example, the initial stages of therapeutic interventions for women could represent
opportunities for providing information about the influence of the socio-political
domain on women's lived experiences. However, it is clear that this would have to be
approached with caution in terms of a potential risk of creating an environment of
directive education as opposed to therapeutic growth. Indeed, this could be seen as
counter to both feminist and psychotherapeutic philosophies that endeavour to
encourage clients to embrace their own realities, and echoes an air of propaganda
similar to that of which society has already been accused in terms of patriarchy and
power imbalance (Daly, 1991; Greer, 1999).

Nonetheless, in opening this as an avenue for exploration and discussion within the
therapeutic setting, voicing this concern could also allow for the psychologist to
directly address issues such as power, neutrality and the role that they adopt in the therapy. Consequently, in challenging how they work with female clients it may be that they would be able to highlight possible inconsistencies between their ways of working and the ideologies of the client. In accounting for this in line with the client’s needs, it may be that this could also demystify and increase the transparency of the therapeutic process.

Despite this, it needs to be acknowledged that for counselling psychologists who normally adopt certain theoretical frameworks - particularly those of a more psychoanalytic persuasion - this may represent a considerable challenge. This is attributable to the requirement it makes of them to address the theoretical underpinnings of the therapeutic interventions that they would normally offer their female clients.

In addition, it could be suggested that attempts to integrate feminism and psychotherapy into a coherent model of working with women, could ultimately lead to a dilution of both ideologies to the extent that the therapeutic values of the groups are lost. However, it does seem that in order to work effectively with our female clients we, as counselling psychologists, must be aware of the social and political impact on their lived experiences. What we then do with this understanding, and whether or not it becomes an integral component of the therapy still remains open to debate. I would argue that it is an understanding that can prove vital to the therapeutic encounter in terms of providing a framework within which to conceptualise women’s presenting concerns. Consequently, it creates a source of knowledge that has the potential to inform the therapy that follows, providing direction, shaping interventions, and
ultimately perhaps influencing outcome.
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Appendices

Appendix A: Background Information Questionnaire

Appendix B: Copy of Interview Schedule

Appendix C: Sample Transcript

Appendix D: Copy of Questionnaire

Appendix E: Consent Form

Appendix F: Information Sheet for Participants

Appendix G: Notes for Contributors

Appendix H: Ethical Approval
APPENDIX A

Background Information Questionnaire

To begin, I’d like to get some background information about you (such as your age, education and occupation). The reason that I’d like this information is so that I can show those who read the research report that I have managed to obtain the views of a cross-section of people. The information that you give will never be used to identify you in any way because this research is entirely confidential. However, if you don’t want to answer some of these questions, please don’t feel that you have to.

1. How old are you? [ ] years

2. Which of the following ethnic groups would you say you belong to? (Please tick the appropriate answer)
   - Black-African
   - Black-Caribbean
   - Black-Other
   - Chinese
   - Bangladeshi
   - Indian
   - Pakistani
   - White
   - Other (please specify: ______________________)

3. What is your highest educational qualification? (Please tick the appropriate answer)
   - None
   - GCSE(s)/O-level(s)/CSE(s)
   - A-level(s)
   - Diploma (HND, SRN, etc.)
   - Degree
   - Postgraduate degree/diploma

4. What is your current occupation (or if you are no longer working, what was your last occupation)?
   ____________________________________________
5. What are your experiences of therapy and counselling?  
(Please tick as many answers that apply to you)

As a client  
As a therapist  
Individual therapy  
Group therapy  
Support groups/self help  
Long-term therapy  
Short term therapy

6. What orientations of therapy have you experienced/offered?  
(Please tick as many answers that apply to you)

Psychodynamic Therapy  
Cognitive Behavioural Therapy  
Client Centred Therapy  
Feminist Therapy  
Existentialist Therapy  
Other (please specify:__________________________)

7. How long ago did you attended your last group?

______________________________________

8. For how long did you attend?

______________________________________
APPENDIX B

Psychotherapy and Women’s Group Psychotherapy: Complementary or Contradictory?

Topic Areas for Interview

I. Introduction

Introduction of the researcher, explanation of the research – what it will involve and why do it. Explanation and signing of the consent form. Explanation and completion of the background information form.

RESEARCH AIMS:
The aim of the proposed study is to explore the relationship between feminism and psychotherapy in the context of women’s group psychotherapy, with the research being informed by (but not restricted to) existing explanations of the interaction between the two ideologies. This will involve investigating the view of women on feminism and its relationship to the practice of group psychotherapy. Thus it will allow for an examination of the extent to which feminist ideology and group therapy are seen as compatible, whilst also identifying areas of incompatibility. The purpose of this is to consider the implications that this has for the practice of women’s group psychotherapy and the practitioners who offer it.

II. Specific Questions

THOUGHTS ABOUT FEMINISM AND THE GROUP

1. In this research, I’m looking at women’s experiences of group psychotherapy and whether or not that has been influenced by their views on feminism, so before we start could you perhaps outline what words and images come to mind when I mention the term ‘feminism’.

Prompts: Could you say a little more about that?  
Do you think that that applies to you? In what way?

(a) Do you think that this has always been your understanding of feminism? 
   If ‘Yes’- where did your ideas come from?  
   If ‘No’- what where your original ideas/where did they come from?  
     - when did your views changed/what caused them to change?

(b) Were any of elements what you describe as feminism identifiable in the group that you attended?  
   If ‘Yes’ – what were they?
If 'No' – did that matter to you? Why/why not?

(c) And thinking about your experiences of therapy, in a group how do you think that you would describe group therapy to someone who knew nothing about it? What were the important features of the group for you?

EXPECTATIONS OF THE GROUP AND RELATIONSHIP TO FEMINISM

2. One of the issues that has been focused on in the literature is the decision-making process that women go through when thinking about entering a group. It seems that for some it is an obvious forum to work on issues in their life, whilst for others it may be something that is suggested by someone that they know or else part of a training programme.

(a) How did you decide to join a group?

(b) What was it about a group that appealed to you and not individual therapy? Could you say more about that?

(c) What were you expecting from the group? Could you say more about that/Can you give me an example of what you mean?

(d) To what extent did it meet your expectations? If ‘Yes’- How/in what way? If ‘No’- In what way?

(e) Thinking back, do you feel that your views about therapy changed as the group progressed? If ‘Yes’- how/why do you think your views changed? If ‘No’- could you say more about that?

(f) Do you think that perhaps your views about feminism had any impact upon that? If ‘Yes’- how in what way? Why do you think that that was? If ‘No’ - could you say more about that?

(g) Thinking back, do you feel that your views about feminism changed as the group progressed? If ‘Yes’- how/why do you think your views changed? If ‘No’ - could you say more about that?

(h) Do you think that perhaps your views about therapy had any impact upon that? If ‘Yes’- how in what way? Why do you think that that was? If ‘No’ - could you say more about that?
(i) Thinking about your experiences of the group, can you think of any instances where your views about feminism and therapy were incompatible? (Perhaps you felt that your position as a feminist was compromised in/by the group, or alternatively you may have felt that that gave positive overtones to your experiences in the group).

If ‘Yes’-what were your feelings about that?
- what response did you make to that?
- what was the outcome of that?
- How do you feel that you dealt with that incompatibility?
- Did that at any time make you question whether to continue with the group?
- Could you say more about that?
If ‘No’- Why do you feel that that this was not an issue for you?

(j) What, if anything, did you feel was therapeutic about your group?
Why do you think that was helpful?
If not anything – what do you think that you would have found therapeutic?

ROLE AND GENDER OF THE GROUP THERAPIST

3. It seems that one influence on women’s experiences of groups, or indeed any type of therapy, is the presence of the therapist and the role that they adopt in the group. It can be that they remain silent and say very little about their own opinions and experiences focusing instead on what other members of the group are talking about. Alternatively some women have talked about how their therapist took an active role, seeming to be quite open in sharing their views and experiences.

(a) What role do you think that your therapist played in the group?
Could you say more about that?

(b) Would you have liked them to adopt a different role?
How would you have liked them to be?
Why/ could you say a little more about that?

4. Another issue related to this is the therapist’s gender and whether or not individual group members found it an issue. For example, some women may feel that only another woman can really understand how they were feeling. Others, however find that what is most important is that the therapist is well trained and qualified and that their gender is a secondary matter. It could also be suggested that some women might find it more useful to interact with a male therapist especially if their issues are to do with relationships and the like.

(a) What gender was your therapist?
(b) Did you think that it was important for you to have a male/female therapist? Could you say more about that?

(c) Looking back on your experiences can you think of any examples where you would have found it beneficial to have a therapist of a different gender? Why do you think that was?

(d) Were there any instances where you felt that it was/would have been important to have a therapist of the same gender as yourself? Why do you think that was?

RELATIONSHIPS IN AND OUT OF THE GROUP

5. It seems that a lot has been written in the literature about group members' relationships with other people, both in and out of the group. Some have said that these kind of groups can damage and replace women's existing friendships, whilst others have said that it can be very positive meeting people with similar problems and that it is a relief not to have to burden friends and family any more with the problem. I'd like to now turn and look at your views on this.

(a) What were your relationships like with other members of the group? Did you meet with group members outside of the group?

(b) Can you think of any ways in which the group affected your relationships with people outside of the group, friends and family for example? Could you say more about that? Why do you think that was?

(c) Do you think that your interactions with people in the group were different or the same from other relationships that you had outside of the group? What was different? Why? Why do you think that there were no differences?

THOUGHTS FOR FUTURE PRACTICE

6. Before we finish, I would just like to ask you if when thinking about your own experiences of group psychotherapy you would have any recommendations for running women's psychotherapy groups? Do you think that these would be different from your own experiences? Could you say more about that?
7. That's all the questions that I want to ask. Is there anything that I haven't covered that you would like to talk about?

- How did you feel about taking part?
  Was there anything about the discussion that you found helpful/unhelpful?
  Could you give me an example of what you mean?

III. Closure

[Switch off audiotape recorder]

1. Thank the participant for taking part.
2. Check that the interview has not left them feeling upset/distressed
3. Remind participant that their identity will remain anonymous and that what they have said will be treated with the utmost confidence.
4. Remind participant that they will be invited to take part in the interpretation stage and that they will be welcome to a copy of the write-up in its completion.

Probes which may be used to elicit further information:

Could you say more about that?

Why do you think that is?

Could you give me an example of what you mean?

How does [did] that make you feel?
APPENDIX C

Sample Interview Transcript

R: Well, thank you for agreeing to participate. The interview will take about three-quarters of an hour, and before we start I’ll give you a quick run down of the research aims and objectives. The aim of the proposed study is to explore the relationship between feminism and psychotherapy in the context of women's group psychotherapy, with the research being informed by (but not restricted to) existing explanations of the interaction between the two ideologies. This will involve investigating the views of women in feminism and its relationship to the practice to group psychotherapy. Thus it will allow for an examination of the extent to which feminist ideology and group therapy are seen as compatible, whilst also identifying areas of incompatibility. The purpose of this research is to consider the implications that this has for the practice of women’s group psychotherapy and the practitioners who offer it. So that’s basically what the research is about and what I’ll do is just ask you a few questions as to your views, there fairly open ended and its really more of a discussion. Before we start do you have any questions?

P: Yes, can I just ask you to tell me what you mean by psychotherapy, how broad is it?

R: I mean in terms of psychotherapy I would talk about it as working with women’s or working with anybody’s problems in a self-reflective way. So I, so you’re having a discussion with someone but you’re not telling them what to do, you’re giving them the chance to speak and to have their say.

P: So its not specific to a particular theoretical framework?

R: It doesn’t have to be, you can move it from the strict analytic perspective which is obviously where the greatest problems lie, in terms of feminism because of the patriarchal roots that its developed from to the more broader, counselling type, client centred approaches, which is maybe more applicable to some people, or is maybe not so dogmatic in the principles that it applies. So I mean your basically talking about the three core conditions of empathy, genuineness and unconditional positive regard, which I think can be applicable to any helping situation.

So therefore in this research I’m looking at women’s experiences of working in groups and whether or not that has been influenced by their views on feminism, so before we continue could you perhaps outline what words and images come to min when I mention the term ‘feminism’?

P: Okay ... well, for me it means using gender as one of the ways of understanding inequalities in society. Not the only way, and so my view of feminism is an inclusive rather than an exclusive it doesn’t women’s oppressions over and above say black people’s oppression, or people with disabilities oppression. It is .... I think its Fiona Williams talks about re-constituted oppression, rather that you know ‘this plus this
plus this’ and you know makes it worse. Its about each others experiences, a unique from of privilege and oppression but that within that gender is a significant factor, and as a woman I find that a useful framework to work from, and especially a privileged white woman, I find that a useful framework.

R: Yes, I know in some texts its referred to as ‘otherness’ some kind of difference be it race, gender, social class, ecetera. I mean is this an understanding that you’ve always had or have as you’ve become more involved in the subject?

P: Oh, I think other people described me as a feminist before I did. I mean I had no kind of academic consciousness of feminism until my late thirties I would think because I was very successful without it. I was lucky. So it was only really beginning to question inequality and unfairness. Having achieved a kind of certain amount of social status though effort and energy and so on suddenly to find that things weren’t actually fair that was the point at which I started questioning, but it took me about thirty odd years to do it.

R: So you managed to get so far and then started to wonder why you weren’t getting any further...

P: Yes it wasn’t about a career or anything, it was just about beginning to notice, I think, what things were not equal, what things were not fair, so. And that was broader, it wasn’t about glass ceiling stuff, because I’ve never wanted to move up into management, first line management is as far as I’ve ever wanted to go.

R: So what kind of groups have you been involve in then?

P: Do you mean as a participant?

R: Yes well if we start there.

P: Right, I’ve got a social workers understanding of groups, do you mean social groups or other groups.

R: I mean groups that have had a therapeutic focus.

P: Uhm ... well mostly the women’s groups I’ve been involved in. Well there’s one group that I would describe not as a therapeutic group at all but was a support group, a support network, which was when I had my children. And there were six of us that left work within a period of about 6 months. And we networked, we cared for each other’s children, we got each other back into work basically and did quite a lot of freelance work, and worked together and supported each other through that period. So that was a very kind of therapeutic and supportive group which wasn’t set up for that really, we were just a young mothers group. All of us had had professional careers up to that point, so I think that it was timing that put us into the group.

R: So it sounds like that was a positive experience having the chance to network with other mother’s.
P: I mean certainly in terms of confidence in child-care, when it wasn’t anything any of us had gone into first and foremost. You know we’d all been career women. Uhm... and helping us to retain that kind of sense of ourselves, identity as working women as well as mothers. So kind of helping those things to balance. So that was very helpful. Uhm others? I’ve always been very participative in groups, so uhm... I’ve done group-work training courses, and group-work development, so as a group worker, as a social worker I used to do group-work supervision, which was actually participative, and was about exploring self and attitudes and behaviour, as well as what you were trying to do with other people, because you know its what you do in the group that makes that makes the group. So I think that my working life has been full of groups of one sort or another, you know lots of them educational groups, not much in the way of what would be designated self-help groups. In fact I’ve shied away from those sorts of therapy groups, they haven’t attracted me one bit.

R: Right, so its been more a decision to work with other people, but not necessarily a standard type therapy group? And I guess maybe not a type of group that’s had a specific leader...

P: Uhm, certainly when we ran women’s groups, when I first had children, we offered women’s groups to users of social services. So they would come and bring their children who were looked after in a crèche with our children while we met and did work about self-esteem and all of that and that felt like yes it was using my knowledge to support other women, but it was also doing quite a lot for me as well. So being in a position of a worker and also building my own self-esteem through the same processes.

R: And do you think that there was a place for feminism within those groups?

P: Oh I think so, I think so, because its about women sharing knowledge and sharing skills and kind of seeing their lives as not being their own fault if you like, but kind of being able to share what experiences they’d had that were equal and unequal. So being able to talk about what wasn’t fair and what they could do about it, and not just about assertiveness training, but also about the consequences of being assertive in a world that doesn’t expect women to be assertive. So you know, kind of working with women around how to improve their lives.

R: It sounds like you are really going back to the grass-roots approach that the early feminists adopted, maybe more of the idea of consciousness raising almost.

P: Yeah, I mean certainly that was one of the things around when I then ran the group around creative autobiography, which is what I’m currently working on. Uhm... because I looked at consciousness-raising, but in a way the difficulty with consciousness-raising is that as much as we try and all share our views and you know its all equal and so on, somebody’s got the feminist analysis, and you know its kind of like we lead our sister to our analysis. And you know that’s no less oppressive than Freudian rubbish thrust upon you really. So I looked at consciousness-raising and thought ‘its got some of the bits I quite like, but it isn’t what I’m after’ you know it just didn’t feel right.
R: I mean I think that’s one of the things that’s come up for me in reading about this, in that in order to make therapy feminist it needs to have components of feminist analysis, but who does that analysis. There are still questions about power and inequality. And I think that’s going to be the ongoing problem and one of the themes that is raised by this research in terms of this inequality of power.

P: The model that comes closest to what I think is really feminist approach is ‘learning sets’, active learning sets and that’s the closest model that I’ve found, rather than having ‘an agenda’ of any sort. What you do is create a space, for people in it to use in certain frameworks and contexts so that people take a turn, including the group facilitator, and say what they want from that turn, you know and are actually in control of what that space is and what it is about, and the analysis and so on if there is any analysis that it is self-analysis.

R: And how do you think that you would describe your understanding of a therapeutic group to someone who knew nothing about it.

P: A space in which to hear yourself. That’s the thing that is most precious to me, about being in that kind of therapeutic forum. Just being listened to so well that you can actually hear yourself. I don’t know if you know ‘Momo’ it’s a children’s story, its brilliant. Its about a child who listens in a mad society. Its definitely essential reading.

R: I mean thinking about the literature that I have read, one of the focuses has been on the decision-making processes that people go through when thinking about going to or setting up a group. I mean you mentioned before it was a kind of ‘stage of life’ thing for you. I know it other cases it can be something that is suggested by someone else, and as part of group analyst training it will be part of the course. So how did you decide to get involved in groups?

P: Well the creative autobiography group was part of my MA dissertation. So I actually set up a group really to look at creative autobiography and how it would work, having had some... because I’d had mental ill health problems myself, and the work that I had done as a result of that made me think ‘well might this be useful to other people’. So that was got me actually engaged in the group and group-work.

R: And why do you think that it was a focus on groups rather than individual work for you?

P: Oh isn’t that a good question... Uhm ...I think because I like working in groups. Uhm and because power relationships are much more evened out in groups, there’s one leader and a whole group of people. Whereas in one-to-one, you’ve kind of got the upper hand if you initiated it, whereas within a group, depending on how you set it up and how you work with it you’re a minority. So hopefully you can get the group to take most of the leadership and direction. It feels like there’s more chance of equality in a group setting than in one-to-one.
R: And if you think of the last group that you mentioned there, the creative autobiography group what were you hoping to get from that, what were you hoping that it would achieve?

P: Uhm ... I wanted to find things out because it was part of my dissertation ... Uhm ... but I wanted to do more exploring that I couldn’t do by myself, for myself. So I wanted to explore the ideas that I had, find out if they were just in my head or if other people shared them. I also wanted to know if it was just me who had these sorts of experiences, and the kind of initial feedback that I’d had, because I’d produced an exhibition, the initial feedback that I had was that other women had these experiences to, and I wanted to kind of connect up with those women and hear more about it. So I wanted to feel sane, I think that was it. I wanted to feel normal.

R: I mean it sounds like the more traditional types of therapy did not really appeal to you, sort of going to an individual counsellor or going to a standard therapy group.

P: I have done that, I have worked with an individual transpersonal counsellor. Who I think was incredibly helpful, and it was she who ... Her work with me was very much when I was ill, was very much about trust yourself, and that was the message through this work, I wanted to pass onto other women. Which is we have the resources within us if only we will do our own work, and not give ourselves away to other people. Uhm, I think that she’s a most unusual counsellor in her ability to kind of not take away any responsibility at all.

R: Uhm, and I mean do you think that your views of working in groups has changed as you have been doing it?

P: Oh yeah ... Because I still do a lot of group teaching sort of work, so I’m still involved, in setting up programmes and running groups in a particular way, with an agenda and so on. But I think that actually even there I’ve become much more open, consultative, receptive, less taking on the responsibility for the whole of the group. I’m much more able to share that with the group than I used to be because of the work. And the group that I began working with, must have been ’94, and we still, most of us still meet.

R: And do you think that your thoughts on feminism had any impact on you thinking about the group-work as you were learning through experiencing it?

P: Uhm, through creative autobiography?

R: Yeah, has it sort of informed your thoughts about groups?

P: Oh yeah, oh yeah completely, because ... feminist theory about empowerment about language, about theoretical models and frameworks, all of that made me feel like I can set up this piece of group-work that I want to do. And actually I’d planned all the sessions in my head, about what where we going to talk about and that sort of thing. And then when we started, I realised that I couldn’t to that that actually I what I was doing was producing a framework that was just placed women into pigeon-holes, that, you know, asked them to do certain things, rather than saying ‘okay this is the
space, this is what you’ve said you’ve come for, how shall we do it?’ And that’s
where the learning set idea came out, that came out of negotiating with the group, I
had to chuck my agenda away and start again. Uhm ... and the whole idea of creative
autobiography comes out of fundamentally a feminist framework, which is that
language interferes with our ability to express what we feel, who we are, what we
think, because language itself is constrained by patriarchal discourse.

R: It sounds like it has allowed you to be more flexible in your ways of working
almost, like you say throwing out the agenda.

P: Yes ... the difficult thing about feminist work, I’ve found is that you have to know
how to do the work from a non-feminist point of view. You have to be very familiar
with the theories and the methods and the values and opinions, and then you have to
question them all, and you have to put yourself into it, and then you have to make
them up again. And it demands a kind of double set of knowledge based on a very
strongly held set of values. So it looks from the outside as though you are making it up
as you are going along, which of course you are, but you are making it up within a
very powerful framework and a lot of information.

R: And were you never tempted to stick with familiar models and ways of working,
did none of that appeal to you at all.

P: Oh yeah, I looked at them, yeah they’re safe aren’t they ... ‘do this, like this, get to
there’. Uhm ... but once you start dismantling that and you start working with women,
they go like ‘well why are you doing it like this’ and its no good saying ‘its because
that’s what it says in ‘Essential Group-work’ or whatever it might be you know its
‘well why are we doing it like this?’

R: So perhaps its something about who you are ultimately accountable to, the
traditional theorists or the women with whom you are working.

P: And I think that its always the women you’re working with. I mean you have no
right to do anything which is supposed to be in their or our benefit that disregards their
or our needs. It just doesn’t make sense does it?

R: Again its like returning to the script, like reading your part and not really listening
to what comes back to you. Obviously there’s lots to be said about this, but in your
experience of being in groups or working with groups do you think that there have
been any times where the therapeutic aspects of what you’ve been trying to do has not
been compatible with your understanding of feminism?

P: Hmm ... I can’t answer the question, its too hard, because its like, its as if feminism
is a being of itself ... Uhm there has been times when my feminism has been
challenged by the work that I’ve been doing. And I am still wrestling and will
probably always will wrestle with the notion of feminism making space for women,
and the way in which gender oppresses men and where they should be and what their
needs are, because my own work is based very much on working with women and
women’s issues and lots of women don’t see it that way, they don’t want it that way,
and it excludes men, who ... I’ve met quite a few who do want to do that work, so
that's a constant kind of question mark for me. But I have worked with mixed groups and with all women groups, I haven't worked with an otherwise all-male group.

R: I guess that's what I'm getting at, in terms of it being something that you wrestle with. I mean how do you think that you deal with it? Do you just put it aside and just get on what you are dealing with or do you take some time to just focus on that?

P: Uhm... I think if it comes up, I mean one of the things that comes up is that women who have seen my exhibition say that 'my experience isn't that same as yours, its different', and my response to that is 'yeah that's good, this is just one experience, this is just mine'. You know I'm not saying this applies to everybody. But still I can hear, and some of it is to do with the anger I feel about my position as a woman in society, I can hear myself doing things which are dismissive of men, or exclusive, which I dislike about my reaction. So I'm learning about those things as I go along, you know the kind of throw-away line, you know the kind of offhand remark or something, I keep kind of... it hits me because its both things that are anti-men and pro-women are also actually anti-feminist. So its actually making me re-explore what that feminism means in my day-to-day practice.

R: I think that the point that you made about it not being the same as other people’s experience, even though you are maybe speaking to another woman, but it being your own experience. That seems to be one of the real issues in that one of the things with feminism. Sometimes it seems to lump all women together, which again seems to remove the individual’s experience from them in some respects, you know **their** experience of being a woman.

P: Yeah, all of our experience of being a woman is different, and we belong to other groups maybe more that we belong to groups of women, and that kind of assumption of what women will be like and what women will do or feel or have or whatever are stupid assumptions. Because 30% of the time they’re wrong.

R: And if you thing about the group that you are involved in at the moment, the creative autobiography group, from your own experiences, what do you think is therapeutic about that group?

P: I think that the most therapeutic thing is actually, two things really, one is making a space for women to pay attention to the things that are important to them in their lives. So to be able to share the little things rather than the recurrent stories that we are encouraged to tell, you know ‘this is the story of my life’, ‘this happened to me, that happened to me’, ‘this is why I’m like I am’. But to actually think about ‘this is my life, what’s it about?’ Uhm... ‘and what are the insignificant things that make it like this?’ So that’s one, its about letting women focus on whatever aspect of their lives that they want to, and explain that as much or as little as they want for themselves, and not to have anybody telling them what it means, at all, but just to be heard and asked a bit more, asked to clarify. Because that’s mostly what we don’t get, mostly people listen with an agenda and a frame. And the other thing is to be allowed to feel what we feel, without having to apologise, without being curtailed. That’s one of the things about the group that I belong to, that we have this kind of rule about not mopping up, so if somebody cries they are left to cry, nobody goes in with the hankie, ‘oh are you
all right love?’ None of that, you wait until they have finished. Uhm... you can be angry you can be unreasonable, you can be all those things and those emotions are given space to just be, because again, mostly that’s not allowed.

R: So if you attend to that person’s emotions its almost as though you are taking away that experience from them.

P: Yeah, we had one woman in one group that I was in who was describing something dreadful, you know, she was really very very distressed, and at one point she said ‘I need to go out, I’ll come back’, and she did and we all waited and then she came back. Afterwards, when I interviewed her after the group she said ‘well if anybody had done anything that would have taken it away from me, as it was I was left with it and therefore it was manageable.’ And I was asking ‘what would happen if you hit something inside of yourself that was unmanageable?’ but as far as she was concerned the fact that she had been left with it meant that it was manageable, it’s the taking away that’s unmanageable, its really interesting.

R: Again I guess that one of the questions that comes up is if you are in group with some kind of facilitator to what extent they participate in the group? I guess that in some of the groups that you’ve been in you have been the facilitator, but there have been others, and I’m really asking about the role that they adopt. I mean what kind of role do you think that you have adopted in the groups that you have run, and what kind of role has the facilitator adopted in the groups that you have been a part of?

P; Uhm, setting boundaries, uhm... and providing space, so physical space, uhm, comfort you know all that kind of preparatory work of setting it up. Agreeing ground rules, contracting those sorts of processes. And then offering time-keeping and space management, not content management, so space management. So 15 minutes before the end checking out that we did what we set out to do. So that kind of reminder, you know management of the process, that’s how I see it.

R: So perhaps more of an administrative role?

P: Yeah, its like servicing the group that’s how I see it rather than running the group.

R: And do you think that there have been times where you would have liked to have adopted more of a directive role, or you would have liked the facilitator to have done more in the group, or has that been enough for you do you think?

P: I think that’s enough, that if I’ve got clear boundaries and expectations than I’m quite happy to let go in the group, so that even when it was my role to facilitate when it was my turn as it were, I didn’t do that, I was a participant, and somebody else did it and that felt very safe.

R: And again, I guess we’re talking about single sex groups and that your facilitator would be a woman. But what about it mixed groups or predominantly women’s groups do you think that the gender of the facilitator matters?
P: Well it’s really funny, all my stereotypes and prejudices say ‘yes, yes of course it ought to be a woman’, and one of the creative autobiography groups that’s been running recently has been a group of older women with a male facilitator, and that’s been really positive and enabling and all the rest of it. So I just think that its somebody with the right skills. I mean I would always prefer a woman, but that’s a personal choice.

R: So why do you think that the stereotypes jump in first for you? Is that from you personal experience or...

P: Uhm... I think that there is something about women’s space, that men in my experience often take more control than women, but that isn’t absolutely true, I’ve met lots of really [unclear] women facilitators. Uhm... I also think that there is something shared, I mean something biologically shared, between women, but again not all women, because not all women have been mothers, not all women are... So biology has its limits too, doesn’t it? Uhm... but its, I don’t know really, as I said I struggle with the boundaries really. Yes I say I would prefer a woman, but if I didn’t like the woman I wouldn’t. My MA dissertation was supervised by a man because I trusted him more than I trusted any of the women that I could have had, so...

R: So on one hand there’s something about training and the actual ability to do the work that’s going to be more important than gender, but on the other hand you feel that sometimes gender would be more important?

P: Well all other things being equal... Actually I think that the skill and the values of the facilitator are more important than their gender. And there would have been a time when you wouldn’t have heard me say that, but that’s what I think.

R: And that’s quite interesting because one of the things that I was expecting would be that people would say ‘oh, its got to be a woman’. But interestingly enough most people have reflected the same viewpoint as you. Having been in a group they have perhaps discovered that maybe there are other things that are more important.

P: I think that a facilitator can make themselves vulnerable, uhm... that they can be sensitive, that they have humility, that they have kind of emotional sensitivity. Now those things are kind of traditionally attached to gender aren’t they? But they’re absolutely not inextricable attached to gender. So I think that those are features that are more important than those to do with biological sex differences.

R: Yeah, that’s great... One other area that I wanted to look at was to do with relationships with other both in and out of the group. For example Celia Kitzinger and Rachel Perkins have said that these kind of groups can damage and replace women’s existing friendships creating a false relationships that can’t exist in the real world. However, others have said that it can be very positive meeting people with similar problems and that it is a relief not to have to burden friends and family with the issues. I mean what do you think that your relationships have been like with people that you have worked with in the groups?
P: I think that they’re always better, they’re closer, uhm... and they’re more open, more honest, less protected, less defended, but I think that that’s the nature of this group, because in these groups nobody’s been pathologised, that nobody’s come out feeling like they were the healthy one, that they were the ‘alright one’ who sorted other people out by their great wisdom and skill. So, I mean by actually sharing my vulnerability, my experience has always been that women, most women connect more honestly and with more intimacy than I think is normally allowed. That then feeds into other working relationships.

R: And do you think that it’s a relationship that can exist outside of the group, being able to meet with the women in other contexts for example?

P: I do I work with them, I mean some of these were my colleagues, one was an ex-student. Uhm... one of the groups that I was in was at a family centre where I’m a member of the management team. So, I have on-going relationship with virtually all of the women.

R: But it sounds like its been able to move through to a deeper level through the group-work.

P: Yeah, there is a kind of connection through the group-work, that I would describe it as it forms a foundation for the day-to-day interaction. So it isn’t kind of there in your face, kind of ‘oh, how are you today’, you know this kind of stuff, but there is, there feels like there’s a kind of trust within that relationship, of ‘I don’t have to pretend that I’m always all right with this person’, which mostly we do.

R: And you said that its fed into other relationships as well with people who aren’t maybe part of the group?

P: Yeah, I think so... yes I’m much more open about... I mean part of being in a group has made me much more open with other people, about my experiences about being... it’s a joke with some of my friends that I’m more out about being a mad woman than I am about being a lesbian. So, its like ‘here I am’, you know ‘this is what you get’, ‘this is who I am’, and I think just the ability to be heard and to be validated within a group allows me to feel much more validated day-to-day.

R: So perhaps something about the strength of character that you’ve got from being in the group?

P: Yeah, its allowed me to take on parts of my identity that most of us hide, and to wear them not as a kind of ‘in your face’ badge, but as ‘this is just part of who I am’, and I’m not going to apologise for it, and it just is.

R: So it’s intrinsically a side of yourself that is there, but it doesn’t just come out in the group context.

P: Its part of my life, and its part of my repertoire, its part of my tool kit, it isn’t something for me to trip over, so I think that’s it.
**R:** So you say that it's something that's allowed you to be more open with people, but do you think that the relationships that you have with people in the group are different from your other relationships?

**P:** Uhm ... I'm going to answer the question but it's not going to be a direct answer. The other day I was just thinking ... because I'm recently separated ... so I was just thinking 'I'll just count up the amazing women I know and am friends with' and was just kind of thinking who those women were and what my relationship with them was. Amongst those were women in the group but not only and not all the women in the group but also other women. So I think that my relationships with women and some men are significantly affected by my ability to make those relationships in that group. Uhm ... but they don't stand separately. Does that answer your question?

**R:** Yes, so there's the basis there in that it's enabled you to make better or more positive relationships outside of the group, but in terms of the people that you feel that you have the best relationships with it doesn't matter whether they're in the group or not they are just connections that you've made with different people for different reasons perhaps.

**P:** And I make good relationships with people outside the group because I'm much more who I am.

**R:** So perhaps a kind of follow-on effect in that it may have triggered other things, and I'm assuming that it has not been detrimental to your other relationships.

**P:** Oh no, what its done has its increased congruence for me, so that improves the quality of relationships where other people are capable of congruence as well.

**R:** Well we are coming to the end of the things that I wanted to talk about, but before we finish, I would just like to ask you if when thinking about your own experiences of being in groups and organising groups you would have any recommendations for running women's groups. If someone came to you and said 'right I'm thinking about setting up a women's group or a self-help group or a therapy group', what kind of suggestions do you think that you would make?

**P:** Uhm ... be honest about what you want out of it, what you're doing it for, and if its about rescuing other people then the chances are that it will be a negative experience in the long run, maybe not in the short run but in the long run. Because we, and I include myself in this, often set out on those sorts of things by way of helping other people and making ourselves feel better through doing that. Uhm ... so be prepared to make yourself vulnerable, don't ask anyone else to do what you're not prepared to do yourself. Uhm ... be ready to learn, this is an exciting adventure. Uhm ... and understand the importance of basic group-work techniques, the things that we have learned over and over again about how you set groups up in the first place, so that the people understand why they're there, and things like confidentiality, and ground-rules and time-keeping and participation, and note-taking and that, all of those things need plenty of time because without them the group won't work properly.
R: So about being organised to a certain extent in terms of the ground-rules and so on, but then allowing for flexibility and not going with ‘this is my agenda, this is what the group will do’, but being open to other group members’ ideas about what they want from the group.

P: Yes, I think organised in terms of process and being clear about that, and that content is really about negotiating, and keeping negotiating that. So that what you are doing is working together on what happens and how it happens and when it happens.

R: Great, well that’s really all I wanted to ask about. Is there anything that I haven’t covered that you would like to talk about?

P: I think that the thing that I want to say is about ‘therapeutic’, because my question right at the beginning is ‘what do we mean by psychotherapy, what do we mean by therapeutic?’ And for a long time I actually avoided the word therapeutic, because of the connotations of treatment. Because that’s what they equal in peoples’ minds, and my guess is that when Rachel Perkins and Celia Kitzinger talk about it, that’s what they’re talking about, is they’re talking about treating people, and having frames of reference that say ‘this is how to heal people’s hurt’ or whatever it might be, how to make people better. Uhm... and actually ‘therapeutic’ means that there is a beneficial effect, so that’s why I would include a wide range of activities within ‘therapeutic’ and exclude quite a lot of things that are deemed to be ‘therapeutic’. Because what we know from feminist literature is that what’s set up to be therapeutic is downright oppressive, confusing, misleading, you know just like in the mental health services the majority of what’s provided is mostly disruptive and intrusive.

R: I guess that when you strip it down people coming to the mental health services for psychotherapy are really coming for treatment when they are hurt and damaged and the expectation is that they will go out cured...

P: And fixed

R: And I guess that is really where the main argument lies for a lot of feminist writers have with psychotherapy in that you need to be looking at what is ‘therapeutic’ rather than what is ‘treatment’ and perhaps that’s where the feminist frameworks can be brought to bear on the topic.

P: And I do think that feminism is about making it up as we go along, I really do... There’s a very good article that I found in ‘Affilia’ which is a women in social work journal, about feminist ethics, and it describes the way that masters students had gone from an MA course to practising in the field, and how they had to re-work their ethics, their feminist ethics, in terms of those practice situations, and kind of re-make them for the circumstances that they found themselves in. And I think if feminism becomes dogma its just as dead as psychoanalysis, in terms of its value.

R: So maybe that is one of the challenges facing feminism and feminist therapy as it continues to develop perhaps in more mainstream mental health services, in terms of being able to work within your own ethical boundaries while still accounting for your practice.
P: And patriarchy changes all the time so feminism needs to. I’m a gardener, you know I know the works never finished.

R: Yes there’s always pruning or weeding.

P: Exactly dandelions growing where there weren’t any last year!
FEMINISM AND WOMEN’S GROUP PSYCHOTHERAPY: COMPLEMENTARY OR CONTRADICTORY?

Information Sheet about the Study

The aim of this research is to explore the experiences of women who have participated in therapy groups, and how those experiences are shaped by their ideas about feminism and psychotherapy.

You will be asked to complete a semi-structured questionnaire in order to share your ideas with the researcher. The questionnaire should take about an forty minutes and will ask you a series of open-ended questions to help to focus you on the material. The questions will not pry into the particulars of your own issues during the course of your therapy, but will look at areas such as, your understanding of feminism, the therapeutic focus of your therapy group, and its aims and objectives, and the role that the therapist played. On receipt of your response I hope to contact you on one further occasion to discuss your experiences of participating and how you feel your comments should be interpreted and written up.

It is hoped that by thinking about these issues that you will have the chance to reflect on your own experiences of therapy in a way that allows you to maximise your role as a participant and co-researcher.

In any write-up of this research to protect confidentiality I will not quote any identifying information such as names or locations. In the case of submission for journal publication, these confidentiality precautions will be maintained. Once having agreed to the study you still have the right to withdraw from it at any time without giving any reason for your withdrawal.

If you have any queries or concerns about the study and what will be required of you, then please do not hesitate to contact either myself or my research supervisor, Dr. Adrian Coyle, at the address or telephone number above.
This research project is being carried out as part-fulfilment of the Practitioner Doctorate in Psychotherapeutic and Counselling Psychology at the University of Surrey, by Victoria Jane Sims and supervised by Dr. Adrian Coyle. The aim of this research is to explore the experiences of women who participate in therapy groups, and how those experiences are shaped by their ideas about feminism and psychotherapy.

The investigation will take the form of a semi-structured questionnaire. This will allow for you to reflect on any issues that you feel pertain to the topic. To protect confidentiality I will not quote any identifying information such as names or locations. In making the transcriptions therefore, your name will be replaced by a letter and I will not record the names of other people or places that may arise in the questionnaire. In any write-up of this research or any submission for journal publication, these confidentiality precautions will be maintained. Once having agreed to the study you still have the right to withdraw from it at any time without giving any reason for your withdrawal.

If you have any questions so far or feel that you would like further information about this research please ask the researcher.

If you are interested in participating, and do not have conditional questions, please read the following paragraph, and if you are in agreement, sign where indicated.

I agree that the purposes of this research and the nature of my participation in this research have been clearly explained to me in a manner that I understand. I therefore consent to be interviewed about my experiences as a member of a therapy group and my ideas about feminism and psychotherapy.

NAME: Date:

On behalf of all those involved with this research project, I undertake that professional confidentiality will be ensured at all times. The anonymity of the above interviewee will be protected.

NAME: Date:
Psychotherapy and Women’s Group Psychotherapy: Complementary or Contradictory?

QUESTIONNAIRE

Please try to answer the questions below as FULLY as possible, except where YES/NO answers are required.

RESEARCH AIMS:
The aim of the proposed study is to explore the relationship between feminism and psychotherapy in the context of women’s experiences of group psychotherapy, with the research being informed by (but not restricted to) existing explanations of the interaction between the two ideologies. This will involve investigating the view of women on feminism and its relationship to the practice of group psychotherapy. Thus it will allow for an examination of the extent to which feminist ideology and group therapy are seen as compatible, whilst also identifying areas of incompatibility. The purpose of this is to consider the implications that this has for the practice of women’s group psychotherapy and the practitioners who offer it.

THOUGHTS ABOUT FEMINISM AND THE GROUP

Q.1. Could you outline what words and images come to mind when I use the term ‘Feminism’?

Q.2. In what way, if any, do you feel that this understanding applies to you?

Q.3. Do you think that this has always been your understanding of feminism?

   a) If ‘Yes’- where did your ideas come from?
b) If 'No' - what were your original ideas and where did they come from?

c) If 'No' - when did your views change/what caused them to change?

Q.4. Were any of elements what you describe as feminism identifiable in the group that you attended?

a) If 'Yes' - what were they?

b) If 'No' - did that matter to you? Why/why not?

Q.5. Thinking about your experiences of therapy, in a group how do you think that you would describe group therapy to someone who knew nothing about it?

Q.6. What were the important features of the group for you?
EXPECTATIONS OF THE GROUP AND RELATIONSHIP TO FEMINISM

One of the issues that has been focused on in the literature is the decision-making process that women go through when thinking about entering a group. It seems that for some it is an obvious forum to work on issues in their life, whilst for others it may be something that is suggested by someone that they know or else part of a training programme.

Q.7. How did you decide to join a group?

Q.8. What was it about a group that appealed to you and not individual therapy?

Q.9. What were you expecting from the group?

a) Could you give an example of what you mean?

Q.10. To what extent did it meet your expectations?

a) If ‘Yes’- How/in what way?
b) If ‘No’ - In what way?

Q.11. Thinking back, do you feel that your views about therapy changed as the group progressed?

a) If ‘Yes’ - how/why do you think your views changed?

b) If ‘No’ - could you say more about that?

Q.12. Do you think that perhaps your views about feminism had any impact upon that?

a) If ‘Yes’ - in what way?

b) If ‘No’ - could you say more about that?

Q.13. Thinking back, do you feel that your views about feminism changed as the group progressed?
Q.14. Do you think that perhaps your views about therapy had any impact upon that?

a) If ‘Yes’- how in what way? Why do you think that that was?

b) If ‘No’ - could you say more about that?

Q.15. Thinking about your experiences of the group, can you think of any instances where your views about feminism and therapy were incompatible?

a) If ‘Yes’-what were your feelings about that?

-what response did you make to that?

-what was the outcome of that?
-how do you feel that you dealt with that incompatibility?

-did that at any time make you question whether to continue with the group?

b) If ‘No’- Why do you feel that this was not an issue for you?

Q.16. What, if anything, did you feel was therapeutic about your group?

a) If not anything – what do you think that you would have found therapeutic?

ROLE AND GENDER OF THE GROUP THERAPIST

It seems that one influence on women’s experiences of groups, or indeed any type of therapy, is the presence of the therapist and the role that they adopt in the group. It can be that they remain silent and say very little about their own opinions and experiences focusing instead on what other members of the group are talking about. Alternatively some women have talked about how their therapist took an active role, seeming to be quite open in sharing their views and experiences.

Q.17. What role do you think that your therapist played in the group?
Q.18. Would you have liked them to adopt a different role?

a) If ‘Yes’- How would you have liked them to be?

Another issue related to this is the therapist’s gender and whether or not individual group members found it an issue. For example, some women may feel that only another woman can really understand how they were feeling. Others, however find that what is most important is that the therapist is well trained and qualified and that their gender is a secondary matter. It could also be suggested that some women might find it more useful to interact with a male therapist especially if their issues are to do with relationships and the like.

Q.19. What gender was your therapist?

Q.20. Did you think that it was important for you to have a therapist of that gender?

Q.21. Looking back on your experiences can you think of any examples where you would have found it beneficial to have a therapist of a different gender?

a) Why/why not?

Q.22. Were there any instances where you felt that it was/would have been important to have a therapist of the same gender as yourself?

a) If ‘Yes’- Why do you think that was?
RELATIONSHIPS IN AND OUT OF THE GROUP

It seems that a lot has been written in the literature about group members' relationships with other people, both in and out of the group. Some have said that these kind of groups can damage and replace women’s existing friendships, whilst others have said that it can be very positive meeting people with similar problems and that it is a relief not to have to burden friends and family any more with the problem. I’d like to now turn and look at your views on this.

Q.23. What were your relationships like with other members of the group?

Q.24. Did you meet with group members outside of the group?

Q.25. Can you think of any ways in which the group affected your relationships with people outside of the group, friends and family for example?

   a) If ‘Yes’- Why do you think that was?

Q.26. Do you think that your interactions with people in the group were different or the same from other relationships that you had outside of the group?

   a) If ‘Different’- What was different?

   b) If ‘Same’- Why do you think that there were no differences?
THOUGHTS FOR FUTURE PRACTICE

Q.28. Thinking about your own experiences of group psychotherapy you would have any recommendations for running women’s psychotherapy groups?

Q.29. Is there anything that you would like to add, which you feel has importance for you and has not been covered by this questionnaire?

THANK YOU VERY MUCH FOR YOUR CO-OPERATION
APPENDIX E

RESEARCH CONSENT FORM

This research project is being carried out as part-fulfilment of the Practitioner Doctorate in Psychotherapeutic and Counselling Psychology at the University of Surrey, by Victoria Jane Sims and supervised by Dr. Adrian Coyle. The aim of this research is to explore the experiences of women who participate in therapy groups, either as a therapist or a member, and how those experiences are shaped by ideas about feminism and psychotherapy.

You will be asked to take part in a focus group in order to share your ideas. This will not take the form of a formal interview but rather a chance for you to discuss the issues that you feel pertain to the topic. The material generated by the group will be recorded on audio tape so that, in writing up the research people’s experiences can be directly cited. Naturally, to protect confidentiality I will not quote and identifying information such as names or locations. In making the transcriptions therefore, your name will be replaced by a letter and I will not record the names of other people or places that may arise in the interview. In any write-up of this research or any submission for journal publication, these confidentiality precautions will be maintained.

If you have any questions so far or feel that you would like further information about this research please ask the researcher.

If you are interested in participating, and do not have any conditional questions, please read the following paragraph, and if you are in agreement, sign where indicated.

I agree that the purposes of this research and the nature of my participation in this research have been clearly explained to me in a manner that I understand. I therefore consent to be interviewed about my experiences as a member of a Women’s therapy group and my ideas about feminism and psychotherapy. I also consent to an audio tape being made of this discussion and to all or parts of this recording being transcribed for the purposes of research. I understand that this recording will be destroyed on completion of the study.

Signed... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ... ......
FEMINISM AND WOMEN'S GROUP PSYCHOTHERAPY: COMPLEMENTARY OR CONTRADICTORY?

Information Sheet about the Study

The aim of this research is to explore the experiences of women who have participated in therapy groups, and how those experiences are shaped by their ideas about feminism and psychotherapy.

You will be asked to participate in a semi-structured interview in order to share your ideas with the researcher. The interview will last for about an hour during which you will be asked a series of open-ended questions to help to focus you on the material. The questions will not pry into the particulars of your own issues during the course of your therapy, but will look at areas such as, your understanding of feminism, the therapeutic focus of your therapy group, and its aims and objectives, and the role that the therapist played. After the interview I will then contact you to discuss your experiences of the interview and how you feel your comments should be interpreted and written up. This will either be via telephone or e-mail.

It is hoped that by talking about these issues that you will have the chance to reflect on your own experiences of therapy in a way that allows you to maximise your role as a participant and co-researcher.

The material discussed will be recorded on audio tape, so that in writing up the research people’s experiences can be cited directly, and on completion of the study the tape recording will be destroyed. To protect confidentiality I will not quote any identifying information such as names or locations. In any write-up of this research or any submission for journal publication, these confidentiality precautions will be maintained. Once having agreed to the study you still have the right to withdraw from it at any time without giving any reason for your withdrawal.

If you have any queries or concerns about the study and what will be required of you, then please do not hesitate to contact either myself or my research supervisor, Dr. Adrian Coyle, at the address or telephone number above.
AIMS AND SCOPE

General policy: Feminism & Psychology aims to provide an international forum for debate at the interface between feminism and psychology. The principal aim of the journal is to foster the development of feminist theory and practice in — and beyond — psychology, and to represent the concerns of women in a wide range of contexts across the academic–applied ‘divide’. It publishes high-quality, original research and debates that acknowledge gender and other social inequalities and consider their psychological effects; studies of sex differences are published only when set in this critical context. Contributions should consider the implications of ‘race’, class, sexuality and other social inequalities where relevant. The journal seeks to maintain a balance of theoretical and empirical papers, and to integrate research, practice and broader social concerns.

Feminism & Psychology encourages contributions from members of groups which are generally under-represented in psychology journals, and individuals at all stages of their ‘careers’. The journal has a policy of not publishing sexist, racist or heterosexist material. The journal encourages positive reviewing, which aims to provide supportive and constructive feedback to authors.

Feminism & Psychology publishes:

* Theoretical and empirical articles
* Research reviews
* Reports and reviews of issues relevant to practice
* Book reviews
* Observations and Commentaries
* Special Features
* A ‘Spoken Word’ section

Special features are designed to highlight the views of women who are the clients, students, survivors or general users of psychology, and to present debate on a wide range of contemporary issues surrounding feminism and psychology. The Spoken Word features topical contributions (discussions, interviews, profiles) which rely primarily on the spoken rather than the written word.

Copyright: Before publication authors are requested to assign copyright to SAGE Publications, subject to retaining their right to reuse the material in other publications written or edited by themselves and due to be published at least one year after initial publication in the journal.

NOTES FOR CONTRIBUTORS

1. All submissions will be peer reviewed. Papers written in English are invited for consideration, provided they have not been published, nor are currently under consideration, elsewhere. The journal also aims to include translated pieces which have been published previously elsewhere, in languages other than English.

2. Manuscripts should be typewritten, double-spaced throughout, on A4, or 8.5" x 11", paper with generous margins, and not right-justified. References should be Harvard system, and in the following style: e.g.


   All figures should be of a reproducible standard. Footnotes should be kept to a minimum, and presented as End Notes. Papers should normally be between 5000 and 8000 words, but exceptionally up to 10,000 words for theoretical and empirical articles, research reviews and reports of practice; and between 500 and 2000 words for observations and commentaries. Please provide a word count. A variety of formats will be welcomed.

3. An abstract of approximately 150 words should be included with each submission; but need not be supplied for observations or commentaries.

4. Authors’ names, titles and affiliations, with complete mailing addresses and telephone numbers, should appear on a separate cover page. Authors are invited to provide any biographical information they would wish reviewers to take into account on a separate sheet. The aim of this information is to avoid discrimination against those without standard academic backgrounds or institutional support. All submitted articles will be reviewed anonymously.

5. Submissions are welcomed for Special Features and The Spoken Word. These will normally be developed in conjunction with a member of the Editorial Group. In the first instance, suggestions should be sent to the Special Features Coordinator of the Editorial Group.

6. Authors should avoid the use of sexist, racist and heterosexist language. Manuscripts that do not conform to these specifications will not be considered. Authors are encouraged to use clear language which avoids unnecessary jargon.

7. Twenty-five offprints of the article, plus a copy of the journal, will be supplied to article authors on publication.

8. Book reviews will normally be commissioned by the Book Review Editor although unsolicited reviews will be considered, and the journal will also review other media and relevant fiction.

9. Six copies of all manuscript submissions, including the original, should be sent to the Editor, at the Department of Social Sciences, Loughborough University, Loughborough, Leicestershire LE11 3TU, UK. A copy on disk will be required before publication, but should not be included with the initial submission. Further information may be sought from any member of the Editorial Group.
Dear Miss Sims

Feminism and women’s group psychotherapy: Complementary or Contradictory (ACE/99/62/Psych)

I am writing to inform you that the Chairman, on behalf of the Advisory Committee on Ethics has considered the above protocol has approved it on the understanding that the Ethics Guidelines are observed.

The letter of approval relates only to the study specified in your research protocol (ACE/99/62/Psych). The Committee should be notified of any changes to the proposal, any adverse reactions and if the study is terminated earlier than expected (with reasons). I enclose a copy of the Ethics Guidelines for your information.

Date of approval by the Advisory Committee on Ethics: 10 March 2000
Date of expiry of Advisory Committee on Ethics approval: 09 March 2005

Please inform me when the research has been completed.

Yours sincerely

Helen Schuyleman (Mrs)
Secretary, University Advisory Committee on Ethics
Registry

cc: Professor L J King, Chairman, ACE
    Dr A Coyle, Principal Investigator, Dept of Psychology

Enc
Feminist identity development and theoretical orientation: An investigation into their impact on the therapeutic practice of therapists who offer psychological support to women

Using the example of a feminist ideological framework, this research explored the influence of practitioners' personal belief/value systems upon their therapeutic practice. The impact of this on the practice of 73 psychoanalysts, clinical and counselling psychologists, and counsellors was assessed, whilst also attending to the role played by the practitioners' theoretical orientations. As well as using pre-existing questionnaires, in quantifying the level of feminist practice evidenced by the participants, a third instrument was constructed. The construction of this third measure and its psychometric properties are evaluated and discussed. Statistical analysis revealed a series of relationships between the variables, particularly with regard to feminist identity and feminist practice. Indeed, following multiple regression analyses, feminist identity was found to predict feminist practice. Theoretical orientation, however, was not found to relate to feminist identity or to predict feminist practice. In light of these findings the implications for counselling psychology are discussed, with suggestions made for future research.
Feminist identity development and theoretical orientation: An investigation into their impact on the therapeutic practice of therapists who offer psychological support to women

Introduction

A theoretical orientation can be regarded as the interpretative framework within which a therapeutic practitioner may operate, serving to organise knowledge, generate hypotheses and shape conceptions around “pathology, health, reality and the therapeutic process” (Norcross, 1985, p. 16). Informed by a particular epistemological position, it seems that having a theoretical orientation can prove vital to therapeutic practitioners. In part this has been attributed to the contribution that it makes towards reducing the complexity of the therapeutic situation in terms of guiding the therapist as to which therapeutic skills and techniques to employ in order to work with clients’ presenting problems most effectively (Ambühl and Orlinsky, 1997). However, it seems that little investigation has been undertaken into how practitioners arrive at their particular theoretical approach.

One suggestion, is that when presented with a variety of ways of working, practitioners will adopt orientations that are most related to their own personal ideology/belief system, using these to shape their therapeutic interventions (Enns, 1992; Vasco, Garcia-Marques and Dryden, 1993). Consequently, it has been acknowledged that there may be a relationship between therapist variables (in terms of their differing values and belief systems), their chosen theoretical orientation, and the
approach adopted by the therapist in practice (Crits-Cristoph, Baranackie, Kurcias, Beck, Carroll, Perry, Luborsky, McLellan, Woody, Thompson, Gallagher and Zitrin, 1991; Lambert, 1989). However, theoretical and practical questions remain as to the nature of this relationship (Lyddon, 1989).

This study was designed to address some of these issues, using the example of feminist ideologies and the possible impact of these on therapeutic work undertaken with women. Based upon the assumption that feminist beliefs - within the context of an ideological stance - are constructs that can be accommodated within a therapist’s theoretical orientation, this research attempted to answer a specific research question: does the existence of a feminist-based belief system relate to, or indeed predict a feminist framework of therapeutic work, and if so, what is the relationship of the therapist’s theoretical orientation to this? In order to understand the context within which this research operated, it is necessary to take a brief look at the development of feminist approaches to therapy, and the contributions that these have made to practice.

It appears that, as with lesbian and gay affirmative therapy, feminist therapy can perhaps be regarded as product of our time (Milton and Coyle, 1999; Simon and Whitfield, 1995), having developed out of a complex of historical conditions; the marginal status of women and the specific impact of the Women’s Movement for example (Forisha, 1981). Accordingly, it appears that the therapeutic focus of feminist practice “turns inward to promote personal integration, but also turns outward to act as a force against the societal, sex-differentiated expectations that discourage personal integration in individuals within the society” (p. 315, Forisha, 1981).
Given this, in the past two and a half decades of feminist practice and research, various therapeutic approaches to working with women have been developed (Brown, 1992; Hill, 1990; Morrow and Hawxhurst, 1998; Watson and Williams, 1992). Early feminist therapy was founded on three basic principles (Butler, 1985; Cammaert and Larsen, 1988; Gilbert, 1980; Sturdivant, 1980). Firstly, it made a commitment to equality within therapy, reiterating the importance of minimising the power differential in the relationship between the therapist and the client. Secondly, it highlighted a commitment to bringing the nature and effects of sexual inequality into therapy. Issues of dual causality (i.e. highlighting the role of personal and societal factors) were used to inform women’s presenting problems, as influenced by models of ‘consciousness raising’. Indeed, the third principle advocated the view that personal change and social change went hand in hand. Thus, it was hypothesised that personal issues relating to gender and power dynamics could also be constructed as political issues, thereby creating a necessity for socio-political issues to be incorporated into the therapeutic arena (Eichenbaum and Orbach, 1982; Kravetz and Marecek, 1996; Morrow and Hawxhurst, 1998; Reed and Garvin, 1996).

Consequently, it appears that feminist practice did not develop from one particular theory of therapy, but from a whole new set of values and a system for how they could be integrated into existing therapies (Watson and Williams, 1992). As such, feminist practice has seemed more of a philosophical standpoint than a prescriptive technique (Sturdivant, 1980). However, other theorists suggested that it could be conceptualised so as to inform specific ways of working with women. For example, Tong (1989) argues that “each feminist theory or perspective attempts to describe women’s oppression, to explain its causes and consequences, and to prescribe strategies for
women's liberation" (p.1). Hence, feminist therapy defined as a therapeutic intervention has been constructed as involving the 'breaking away from traditional stereotypes, opening options and viewing sex-roles as fluid' (Rothberg and Ubell, 1987, p. 134).

Questions stemming from this relate to the role that the therapist is expected to take. Indeed, what criteria should a therapist fulfil in order to describe herself as a feminist therapist? In this instance I refer to the therapist as a 'her', and shall continue to do so throughout this paper. This is based upon my acceptance of the definition of feminism as fundamentally grounded in and informed by women's relationships with other women, not their relationships with men (Ermarth, 2000). As Ermarth goes onto explain, this definition means that:

"Men cannot be feminists, not even those men who really do sympathise with women's struggle to assume full cultural and economic partnership; men who really do their share of domestic work; men who really do rejoice in seeing a woman succeed." (p. 113)

However, it does appear that feminism is about more than being female, whereby it is not enough to be a woman working therapeutically with clients on issues surrounding their gender. One suggestion is that a feminist therapist can be recognised through the explicit integration of feminist analysis into her practice, thus tying women's individual distress in therapy to collective political struggles toward societal change (Brown, 1992; Watson and Williams, 1992). In view of this, whilst focusing on the dynamics between the therapist and the client as developed through the therapeutic
relationship (Clarkson, 1994, 1995; Ryder and Shillito-Clarke, 1998), therapy conducted within a feminist framework also encourages movement towards a broader sphere within which the influence of culture and society upon the client can also be explored. If this is true, then it can be suggested that rather than the therapist’s own beliefs and values being something that may interfere with the therapeutic process - a concern of traditional psychotherapies - it is these beliefs that may actually facilitate this movement in therapy (Hill and Ballou, 1998).

**Research Aims and Hypotheses**

The main aim of this study was to explore the possible influence of feminist identity - as a therapist variable - on the therapeutic practice offered by therapists who work with women, whilst also assessing the possible impact of other variables on the interventions that these therapists utilise. It was hypothesised that there would be a significant positive correlation between therapists’ level of feminist identity development and elements of feminist ideology as incorporated into their therapeutic practice. Additionally, it was hypothesised that there would be a relationship between feminist identity and theoretical orientation, which in combination would act as predictors of therapeutic practice.

As noted, it was also intended that the research would involve some exploratory analysis into the impact of other variables on practice, and relationships between them. These include the professional body with which participants were affiliated, and their stated theoretical orientation.
In addition, the research aimed to highlight areas for counselling psychologists to address in terms of the potential for their philosophical standpoints to be utilised as sources of knowledge that can inform and contribute to the therapeutic encounter. From this, it could be suggested that personal ideologies could be conceptualised as integrative tools, something to be synthesised with, rather than suppressed by the theoretical framework within which therapists operate, thus strengthening the concept of integrative therapeutic work (Palmer and Woolfe, 2000).

Method

Participants and Procedure

Questionnaire packs were mailed to Two hundred members of The United Kingdom Council for Psychotherapy (UKCP), The British Confederation of Psychotherapists (BCP), The British Association of Counselling and Psychotherapy (BACP), and The British Psychological Society (BPS) (chartered clinical or counselling psychologists only) (see Appendices A-C). This also included a short background information questionnaire designed to elicit demographic data and information regarding length of career, method of training and stated theoretical orientation (Appendix D). Using a simple random sampling strategy, names were selected from the registers that these organisations published (for example see Fife-Shaw, 2000). It was hoped that by following this sampling procedure and recruiting from a variety of organisations, a cross-section of participants would be accessed, which would include practitioners offering a variety of therapeutic interventions.
An information letter accompanied the questionnaire packs sent to the selected participants. This invited their participation and detailed the aims of the research, confidentiality of all the data, the researcher’s academic status, and a contact address and telephone number for any further queries (Appendix E). The return of the questionnaires was facilitated by the inclusion of a stamped self-addressed envelope in each of the packs, in order to curtail any financial imposition on the participants that may have resulted in their non-participation.

A total of 87 questionnaires were returned; of these 14 were returned incomplete with 9 outlining reasons for why the potential participant had felt unable to participate fully. Of these, three explained that although they would have liked to participate they could not currently afford the time, and two felt that they were not eligible to participate as they were no longer working. Of the four remaining, all referred to specific problems with the questionnaires, particularly that which assessed feminist identity. Particular comments questioned the measure’s apparent blurring of the concepts ‘female’ and ‘feminist’. In addition, scale items were accused of measuring somewhat outdated and stereotyped constructions of feminism. Thus 73 completed questionnaires were received, a response rate of 36.5%.

**Instruments**

*Construction of the Measurement of Practice Questionnaire (MPQ)*

In reflecting on feminist practice, Hill and Ballou (1998) suggest that no instruments exist that are specifically designed to measure the procedures and methods of feminist
therapy. To respond to this deficit the researcher constructed a 42-item questionnaire. The information necessary to do so was taken from ‘The Feminist Therapy Code of Ethics’ (Feminist Therapy Institute, 1995). This outlines methods and principles for working therapeutically with women within a feminist framework (see Appendix F for copy). Additional items were sourced from qualitative research into feminist practice (Watson and Williams, 1992; Worell and Remer, 1992).

All participants completed items making up this instrument. Responses to items were made on a 7-point scale, where 1 = strongly disagree and 7 = strongly agree. Some items were reversed scored. Responses to the items were totalled and scores for the questionnaire could range from 42 to 294. High scores indicated stronger evidence for the adoption of feminist methods of practice in therapy.

In the design phase of the questionnaire, three self-designated feminist therapists were approached and asked to complete and comment on the measurement of practice questionnaire. In view of their suggestions, the wording of the instructions to participants was amended and an explanation of the importance of applying the statements to their own practice incorporated. Several questions were also rephrased to improve their clarity. General feedback implied that the questionnaire was able to represent accurately the issues that these therapists felt they attended to in their practice, specifically those relating to the importance of therapists’ personal values being transparent in therapy.

In order to ascertain the internal consistency of this measure, a Cronbach Alpha coefficient was generated from the participants’ responses to each scale item. This test
ascertains whether all of the questionnaire items measure the same thing by dividing the test into two halves in every possible fashion, correlating the scores of the halves and then finding the mean of the correlations. Acceptable scores for internal reliability are quoted as ranging from between $\alpha = 0.7$ to $\alpha = 0.8$ and above (Cramer, 1998; Foster, 1998). Additionally, following the initial administration of the questionnaire to participants in the main study, a random sample was contacted after a month and asked to complete it a second time in order to allow for some calculation to be made about test-retest reliability.

**Measurement of Theoretical Orientation: Counsellor Theoretical Position Scale (CTPS)**

All participants completed items making up this instrument. This was a pre-existing scale, designed to measure practitioners’ theoretical and epistemological frameworks (Poznanski and McLennan, 1999). Consisting of a number of items taken from other measures (Coan, 1979; Mahoney and Lyddon, 1988; O’Hanlon, 1994; Sundland and Barker, 1962; Wallach and Strupp, 1964), it consisted of two 20-item sub-scales: Rational-Intuitive (R-I) and Objective-Subjective (O-S). Responses to items were made on a 7-point scale, where 1 = completely disagree and 7 = completely agree. Some items were reverse scored. Responses to the items were totalled, and scores for both sub-scales could range from 20 to 140. High sub-scale scores indicated stronger preferences for rational and for objective beliefs, respectively.

As a measure of practitioners’ specific theoretical orientations, high scores on both the rational and objective belief sub-scales are attributed to a cognitive-behavioural
perspective. Practitioners working within a psychodynamic framework are identified by a lower score on the rational sub-scale, which indicates a more intuitive approach (Beck, 1976; Malan, 1970). Additionally, Poznanski and McLennan (1999) argue that experiential or phenomenological therapists are likely to respond more positively to scale items proposing subjective beliefs, and therefore score lower on the objective-subjective sub-scale. Finally, they predict that those adopting a family or systemic perspective can be expected to respond more positively to items prescribing a subjective and rational approach (Frey and Raming, 1977; Goldenberg and Goldenberg, 1991). Although a feminist orientation is not specifically measured by this scale, suggestions have been made in terms of conceptualising feminist therapy within the framework of family and systemic practice due to similarities in their philosophies (Leupnitz, 1988). Consequently, as with systemic or family therapists, it was expected that participants adhering to a feminist orientation would also score highly on the rational-intuitive sub-scale, but lower on the objective-subjective sub-scale.

Previous factor analysis of this scale showed that item-intercorrelations supported a two-factor solution that corresponded to the two sub-scales (Poznanski and McLennan, 1999). Poznanski and McLennan (1999) argue that the pattern of item loadings was consistent with the theoretically derived content of the items, constituting evidence of the construct validity of the scale. With regard to internal reliability, the internal consistency coefficients of the items making up the Objective-Subjective and Rational-Intuitive sub-scales were quoted as \( \alpha = 0.87 \) and \( \alpha = 8.1 \) respectively. Therefore, it was decided that this was a good measure of theoretical orientation to use.
Measurement of Feminist Identity: Feminist Identity Composite (FIDQ)

This was a pre-existing scale designed to measure the level of feminist identity development in women (Fischer, Tokar, Mergl, Good, Hill and Blum, 2000). Consequently, it had been worded accordingly, e.g. ‘I am proud to be a competent woman’. It was decided not to alter these items or exclude them totally - to allow applicability to male participants - as this could have diminished the reliability and validity of the measure (Fife-Shaw, 2000). Unfortunately, it seemed that there was no other measure of feminist identity development in existence that was not subject to the same gender biases. Therefore, it was not possible to include male participants in this stage of the research and only the female participants were required to complete items making up this instrument.

The questionnaire is a composite of the ‘Feminist Identity Development Scale’ (FIDS) (Bargad and Hyde, 1991) and the ‘Feminist Identity Scale’ (FIS) (Rickard, 1989, 1990). Both of these scales were developed from the Downing and Roush ‘Five Level Feminist Identity Development Model’ (1985). Thisconceptualises a developmental process of how women may acquire and maintain a positive feminist identity (Fischer et al., 2000), as a result of movement through five levels as outlined in Table 1.
Table 1: Stages of Feminist Identity Development in Women as Hypothesised by Downing and Roush (1985)

<table>
<thead>
<tr>
<th>Passive Acceptance</th>
<th>Revelation</th>
<th>Embeddedness-Emanation</th>
<th>Synthesis</th>
<th>Active Commitment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Characterised by the acceptance of traditional sex-roles. Men are considered superior.</td>
<td>Catalysed by a series of crises, resulting in questioning of self and roles, and feelings of anger. Men are perceived as negative.</td>
<td>Characterised by connectedness with other select women. Affirmation and strengthening of new identity.</td>
<td>Development of an authentic and positive feminist identity. Evaluate men on an individual basis.</td>
<td>Consolidation of feminist identity. Commitment to meaningful action, to a non-sexist world. Men are considered equal but not the same as women</td>
</tr>
</tbody>
</table>

It was believed that by using a composite that incorporated these levels, rather than the two original scales, the time taken to complete the questionnaire pack would be minimised, whereby hopefully more participants would feel encouraged to complete the questionnaires as it demanded less of them.

Responses to items were made on a 5-point scale, where 1 = strongly agree and 5 = strongly disagree. Following Downing and Roush’s model, each scale item corresponded to a particular level of feminist identity development; therefore it became possible to identify at what level each participant was situated. Additionally, after this was ascertained, items related to passive acceptance were reverse scored, allowing for the questionnaire scores to be totalled to give an overall measure of feminist identity for each participant. Consequently, whilst relating to specific scale
items, a higher total score was also believed to be indicative of a greater degree of feminist identity development.

Previous psychometric evaluation of the composite measure indicated that all five stages of the Downing and Roush model were reflected by the five factors generated through factor analysis, whilst the mean coefficient alpha for these factors was quoted as $\alpha = 0.77$ (Fischer et al., 2000). Fischer et al. (2000) also argue that their results provide strong support for the convergent, discriminant and structural validity of the measure. Given this, it was decided that this composite measure of feminist identity development would be an appropriate tool to assess feminist identity in the female participants.

**Ethical Issues**

Ethical issues surrounding the confidentiality of all data was attended to in the information letter accompanying all questionnaires. This confirmed that all data would be kept confidential for the duration of the research, and destroyed on its completion. Each set of questionnaires was assigned an identifying code, which was tallied to the potential participant’s name and contact details. These were kept separate from the completed questionnaires. It was intended that this would address the risk of the respondent being identified by anyone other than the researcher, thus maintaining confidentiality procedures. This explanation was also outlined in the information letter accompanying the questionnaires. In addition, the letter impressed upon participants that they were free to withdraw from the study at any time, for any reason.

Throughout the investigation, the researcher drew on her experience and knowledge of
the research area in order to provide the appropriate level of support and information about the study and what was being requested.

**Data Analysis**

On retrieval of completed questionnaires, all data were entered into SPSS (windows - version 10). With regard to the first research question - relating to the relationship between feminist identity and feminist practice - given that the conditions for the use of a parametric test were met, a Pearson’s product moment correlation was calculated. In exploring the second hypothesis - suggesting that there would be a relationship between feminist identity and theoretical orientation, which in combination would act as predictors of feminist therapeutic practice - the data were submitted to further correlational analysis. Subsequently the relevant data were entered into a regression model, with the intention of exploring the predictive power of feminist identity and theoretical orientation on therapeutic practice, and the variance that can be accounted for by each of these factors. Due to the presence of more than one independent variable this was on a multiple scale.

Additionally, as noted, it was decided to undertake some exploratory analysis into the impact of other variables on feminist practice as measured by the MPQ and also the relationship between these other variables themselves. This included the relationship between participants’ affiliation with a specific professional body and their level of feminist practice; the relationship between participants stated theoretical orientation and their level of feminist practice; and the relationship between participants stated...
theoretical orientation and that measured by the CTPS. These were explored using statistical measures of association.

As already outlined, additional analysis included an investigation into the reliability and validity of the Measurement of Practice Questionnaire. Readers will find the findings from this analysis in the results section of this write-up before the main hypotheses are addressed. This was felt appropriate due to the implications that the statistical strength of this new measure would have for the viability of the subsequent statistical analyses.

Results

Sample Details

73 completed questionnaires were received, a response rate of 36.5%. The participants were 47 women and 26 men. Their mean age was 48.1 years (Range = 25-82 years, SD = 12.6). Their mean amount of counselling and psychotherapeutic experience was 14.2 years (Range = 2-53 years, SD = 10.2). With regard to participants’ stated theoretical orientations, many pointed to more than one therapeutic approach. Consequently, a psychodynamic approach was identified 49 times, cognitive-behavioural 38 times, client-centred, 35 times, feminist 11 times, existential 7 times. 33 participants referred to other approaches not encompassed by the aforementioned categories. Similarly, with regard to the participants’ membership of professional bodies, it appeared that many participants had more than one affiliation, with the BPS being identified on 45 occasions, the UKCP 30 times, the BACP 19 times, the BCP 8 times. Other organisations were noted in 16 instances.
Evidence of Internal and Test-retest reliability of the MPQ scale

Results from the Cronbach alpha coefficient test conducted on the Measurement of Practice Questionnaire scores yielded a figure of $\alpha = 0.7877$. This was felt to reflect an acceptable level of internal consistency. With regard to test-retest reliability, a highly significant positive correlation was found between the total scores on the measurement of practice questionnaire administered at time one and time two ($r = 0.967, p < 0.01$). The distribution of this can be seen in Figure 1.

Figure 1: Scatterplot showing the correlation of total scores on the measurement of practice questionnaire (MPQ) between its first and second administration to the selected participant sample.
Feminist Identity as related to Feminist Practice

Given that feminist identity development was only assessed in the female participants, it was only possible to calculate the statistical significance of the relationship of this to feminist practice for these participants. An analysis of the scores generated on the measures of feminist identity development (FIDQ) and feminist practice (MPQ) revealed a significant positive correlation ($r = 0.591, p < 0.01$). In attempting to explore this relationship further, total scores for each of the levels of feminist identity development were examined for statistical association. Results from this showed, highly significant positive correlations between the level of Revelation and measure of practice ($r = .299, p< 0.05$), Embeddedness-Emanation and measure of practice ($r = .383, p< 0.01$), Synthesis and measure of practice ($r = .401, p< 0.01$), and Active Commitment and measure of practice ($r = .608, p< 0.01$). It is also interesting to note that the strength of these correlations increased as feminist identity moved up through the levels leading to Active Commitment. This gives rise to the suggestion that the more feminist a participant, the more feminist their practice.

The data were further screened to assess normality, linearity, homoscedasticity and interdependence of residuals (Appendix G), which revealed that the assumptions for regression were met. Therefore, in seeking to discover whether this was indeed a predictive relationship, the levels of feminist identity were entered into a regression analysis. Using the standard method (due to the inter-correlation of the independent variables) a significant model emerged as shown in Table 2. This displays the correlations between the variables, the unstandardised regression coefficients ($B$) and intercept, the standardised regression coefficients ($\beta$), $R^2$, and adjusted $R^2$. 
Table 2: Standard multiple regression for levels of feminist identity on feminist therapeutic practice

<table>
<thead>
<tr>
<th>Variables</th>
<th>MPQ_TOT</th>
<th>PA</th>
<th>Rev</th>
<th>EE</th>
<th>Syn</th>
<th>AC</th>
</tr>
</thead>
<tbody>
<tr>
<td>PA</td>
<td>-.217</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rev</td>
<td>.299</td>
<td>.063</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>EE</td>
<td>.383</td>
<td>-.067</td>
<td>.733</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Syn</td>
<td>.401</td>
<td>-.068</td>
<td>-.052</td>
<td>-.014</td>
<td></td>
<td></td>
</tr>
<tr>
<td>AC</td>
<td>.608</td>
<td>-.249</td>
<td>.435</td>
<td>.400</td>
<td>.445</td>
<td></td>
</tr>
<tr>
<td>Means</td>
<td>201.911</td>
<td>15.78</td>
<td>20.31</td>
<td>19.76</td>
<td>36.29</td>
<td>25.47</td>
</tr>
<tr>
<td>B</td>
<td>(Intercept = 130.981)</td>
<td>-.282</td>
<td>-.112</td>
<td>.717</td>
<td>.762</td>
<td>1.407*</td>
</tr>
<tr>
<td>β</td>
<td>-.080</td>
<td>-.050</td>
<td>.252</td>
<td>.212</td>
<td>.415</td>
<td></td>
</tr>
</tbody>
</table>

R² = .436  
Adjusted R² = .364  
R = .660**

** p<.01  
* p<.05

PA = Passive Acceptance  
REV = Revelation  
EE = Embeddedness-Emanation  
SYN = Synthesis  
AC = Active Commitment

The regression output (R) was significantly different from zero (F₅, 39 = 6.033, p< .001). For the regression coefficient that differed significantly from zero, 95% confidence limits were calculated. The confidence limits for the active commitment level of feminist identity development were .270 to 2.544. Only one of the independent variables contributed significantly to the prediction of measurement of practice. Altogether, 44% (36% adjusted) of the variability in scores on the measurement of practice questionnaire was predicted by knowing the level of feminist identity development.
Theoretical Orientation as related to Feminist Identity

Statistical analysis revealed that there were no significant relationships between theoretical orientation and feminist identity for female participants, either with regard to the total scores ($r = -.109, p > .05$), or the breakdown of scores into the two sub-scale measures on the CPTS ($r = -.153, p > .05; r = -.026, p > .05$).

Theoretical Orientation as related to Feminist Practice

The data were subjected to further correlational analysis in order to explore the relationship between theoretical orientation and feminist practice. The results of this are summarised in Table 3.

Table 3: A correlation matrix for total score on CTPS, CTPS sub-scale totals and measure of practice as measured by MPQ

<table>
<thead>
<tr>
<th>Variables</th>
<th>RI</th>
<th>OS</th>
<th>CTPS</th>
<th>MPQ</th>
</tr>
</thead>
<tbody>
<tr>
<td>RI</td>
<td>Pearson Correlation</td>
<td>1.000</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Sig. (2-tailed)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>OS</td>
<td>Pearson Correlation</td>
<td>.315**</td>
<td>1.000</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Sig. (2-tailed)</td>
<td>.007</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CTPS</td>
<td>Pearson Correlation</td>
<td>.822**</td>
<td>.800**</td>
<td>1.000</td>
</tr>
<tr>
<td></td>
<td>Sig. (2-tailed)</td>
<td>.000</td>
<td>.000</td>
<td></td>
</tr>
<tr>
<td>MPQ</td>
<td>Pearson Correlation</td>
<td>-.176</td>
<td>-.009</td>
<td>-.117</td>
</tr>
<tr>
<td></td>
<td>Sig. (2-tailed)</td>
<td>.135</td>
<td>.939</td>
<td>.324</td>
</tr>
</tbody>
</table>

** $p<.01$
* $p<.05$

RI = Total score on Rational-Intuitive Sub-Scale
OS = Total score on Objective-Subjective Sub-Scale
CTPS = Total of both sub-scales
MPQ = Total score on MPQ
This indicates that participants who scored highly on the Rational-Intuitive sub-scale were also likely to score more highly on the Objective-Subjective sub-scale \( (r = 0.315, p < 0.01) \). Previous research has implied that these are participants more likely to represent a therapeutic approach informed from a cognitive-behavioural perspective (Beck 1976; Poznanski and McLennan, 1999). Although not significant, negative relationships were apparent between high scores on the sub-scales and total score and the total of the measurement of practice questionnaire \( (r = -.176, p > .01; r = -.009, p > .01; r = -.117, p > .01) \). However, even had they proved significant relationships, the small scores indicate that this would have only been a weak association.

**Theoretical Orientation and Feminist Identity as Predictors of Feminist Practice**

Following data screening, the total scores from each of the instruments were entered into a multiple regression analysis in order to address the hypotheses that feminist identity and theoretical orientation would predict feminist practice. Table 4 displays the correlations between the variables, the unstandardised regression coefficients \( (B) \) and intercept, the standardised regression coefficients \( (\beta) \), \( R^2 \), and adjusted \( R^2 \). The regression output \( (R) \) was not significantly different from zero \( (F_{2, 70} = 1.745, p > 0.01) \).
Table 4: Standard multiple regression of theoretical orientation and feminist identity variables on therapeutic practice

<table>
<thead>
<tr>
<th>Variables</th>
<th>MPQ_TOT</th>
<th>CTPS_TOT</th>
<th>FIDQ</th>
<th>B</th>
<th>( \beta )</th>
</tr>
</thead>
<tbody>
<tr>
<td>CTPS_TOT</td>
<td>-.117</td>
<td>-8.41E-02</td>
<td>-.096</td>
<td></td>
<td></td>
</tr>
<tr>
<td>FIDQ</td>
<td>.196</td>
<td>5.217E-02</td>
<td>.185</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intercept</td>
<td></td>
<td></td>
<td></td>
<td>205.474</td>
<td></td>
</tr>
<tr>
<td>Means</td>
<td>200.151</td>
<td>116.616</td>
<td>85.931</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Standard</td>
<td>18.568</td>
<td>21.223</td>
<td>65.834</td>
<td></td>
<td></td>
</tr>
<tr>
<td>deviations</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* * **p<.01
* * **p<.05

MPQ = Total Score on MPQ
CTPS = Total Score on CTPS
FIDQ = Total Score on FIDQ

It was decided that this result could have reflected some difference between the scores of male and female participants. In addition, given that male participants did not complete one of the measures (the composite FIDQ), the statistical output generated could have been affected. Consequently, the data file was split into two groups according to gender. On submitting this data for regression analysis, once again a significant model emerged for the female participants, the results of which are summarised in Table 5. The regression output (R) was significantly different from zero (\( F_{2, 44} = 12.426, p < .001, \) Adjusted R square = .332). For the regression coefficient that differed significantly from zero, 95% confidence limits were calculated. The confidence limits for feminist identity development were .317 to .781. Altogether, 36% (33% adjusted) of the variability in scores on the measurement of practice questionnaire was predicted by knowing feminist identity and theoretical orientation, although the contribution of theoretical orientation was not statistically proven.
Table 5: Standard multiple regression of theoretical orientation and feminist identity variables on therapeutic practice for female participants

<table>
<thead>
<tr>
<th>Variables</th>
<th>MPQ_TOT</th>
<th>CTPS_TOT</th>
<th>FIDQ</th>
<th>$B$</th>
<th>$R^2$</th>
</tr>
</thead>
<tbody>
<tr>
<td>CTPS_TOT</td>
<td>-.175</td>
<td>-7.77E-02</td>
<td>-.111</td>
<td>.549**</td>
<td>.361</td>
</tr>
<tr>
<td>FIDQ</td>
<td>.591</td>
<td>-.109</td>
<td>.549**</td>
<td>.578</td>
<td>.332</td>
</tr>
</tbody>
</table>

Intercept = 137.313

Means

<table>
<thead>
<tr>
<th></th>
<th>Mean</th>
<th>Standard Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>CTPS_TOT</td>
<td>201.660</td>
<td>16.484</td>
</tr>
<tr>
<td>FIDQ</td>
<td>115.128</td>
<td>23.622</td>
</tr>
<tr>
<td></td>
<td>133.468</td>
<td>17.359</td>
</tr>
</tbody>
</table>

Relationship between gender of participants and level of feminist practice as measured by MPQ

In further investigating these apparent differences between male and female participants’ responses, it was decided to undertake some exploratory analysis into whether female participants exhibited a greater degree of feminist practice than male participants. It was hoped that this would allow for some preliminary evaluation to be made as to the potential impact of gender on feminist oriented therapeutic practice.

Basic descriptive analysis of the scores on the measurement of practice questionnaire indicated that the female participants’ mean total scores were slightly higher as compared with the male participants’, and that the range was also narrower. This is summarised in Table 6.
Table 6: Descriptive statistics for male and female participants’ scores on the measurement of practice questionnaire.

<table>
<thead>
<tr>
<th>GENDER</th>
<th>N</th>
<th>Minimum</th>
<th>Maximum</th>
<th>Mean</th>
<th>Std. Deviation</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>26</td>
<td>82.00</td>
<td>148.00</td>
<td>157.425</td>
<td>21.93112</td>
<td>480.974</td>
</tr>
<tr>
<td>Valid N (listwise)</td>
<td>26</td>
<td>82.00</td>
<td>148.00</td>
<td>157.425</td>
<td>21.93112</td>
<td>480.974</td>
</tr>
<tr>
<td>Female</td>
<td>47</td>
<td>69.00</td>
<td>169.00</td>
<td>201.6596</td>
<td>16.48356</td>
<td>271.708</td>
</tr>
<tr>
<td>Valid N (listwise)</td>
<td>47</td>
<td>69.00</td>
<td>169.00</td>
<td>201.6596</td>
<td>16.48356</td>
<td>271.708</td>
</tr>
</tbody>
</table>

In exploring whether this difference was by chance or a reflection of a true gender discrepancy, the scores were analysed using an independent t-test. This revealed that there was no significant difference between the groups as divided by gender (t = -.933, df = 71, p > .01).

Influence of other factors on Feminist Practice

As outlined in the research aims of this study, it was decided that a useful avenue of exploration could include some assessment of the impact of other variables on feminist practice as measured by the MPQ, whilst also exploring other potential relationships between these variables. This was split into three lines of inquiry, although the researcher acknowledges that other combinations may have been possible.

**Relationship between participants’ affiliation with a specific professional body and their level of feminist practice**

Participant responses to professional body membership were coded in order to render the data fit for quantitative analysis (member = 1, non-member = 0). In looking at the relationship of professional affiliation to feminist practice, correlation analysis indicated that the only positive significant relationship existed for those participants...
who belonged to the British Association of Counselling and Psychotherapy (r = .268, p< .05). The rest of the scores are summarised in Table 7.

Table 7: Correlation matrix for participants’ professional body affiliations and total MPQ scores.

<table>
<thead>
<tr>
<th>Variables</th>
<th>UKCP</th>
<th>BPS</th>
<th>BCP</th>
<th>BACP</th>
<th>OTH</th>
<th>MPQ</th>
</tr>
</thead>
<tbody>
<tr>
<td>UKCP Pearson Correlation</td>
<td>1.000</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sig. (2-tailed)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BPS Pearson Correlation</td>
<td>-.658**</td>
<td>1.000</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sig. (2-tailed)</td>
<td>.000</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BCP Pearson Correlation</td>
<td>.242*</td>
<td>-.264*</td>
<td>1.000</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sig. (2-tailed)</td>
<td>.039</td>
<td>.024</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BACP Pearson Correlation</td>
<td>.266*</td>
<td>-.238*</td>
<td>-.008</td>
<td>1.000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sig. (2-tailed)</td>
<td>.023</td>
<td>.042</td>
<td>.945</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>OTH Pearson Correlation</td>
<td>.230*</td>
<td>-.059</td>
<td>-.238*</td>
<td>-.088</td>
<td>1.000</td>
<td></td>
</tr>
<tr>
<td>Sig. (2-tailed)</td>
<td>.050</td>
<td>.621</td>
<td>.042</td>
<td>.460</td>
<td>.</td>
<td></td>
</tr>
<tr>
<td>MPQ Pearson Correlation</td>
<td>.131</td>
<td>-.036</td>
<td>-.184</td>
<td>.268*</td>
<td>-.010</td>
<td>1.000</td>
</tr>
<tr>
<td>Sig. (2-tailed)</td>
<td>.271</td>
<td>.760</td>
<td>.120</td>
<td>.022</td>
<td>.935</td>
<td>.</td>
</tr>
</tbody>
</table>

** p<.01
* p<.05

UKCP = United Kingdom Council for Psychotherapy
BPS = British Psychological Society
BCP = British Confederation of Psychotherapists
BACP = British Association of Counselling and Psychotherapy
OTH = Other Affiliations
MPQ = Total score on MPQ

Relationship between participant’s stated theoretical orientation and that measured by the Counsellor Theoretical Position Scale

In order to assess this, positive association with a particular theoretical orientation (as identified in the background information questionnaire) was given a score of 1, whilst where participants did not report a particular affiliation a score of 0 was ascribed. Correlational analysis indicated a negative relationship between psychodynamic
therapy as a stated theoretical orientation and the total score on the CTPS \( (r = -.363, p < .01) \), and a positive relationship for cognitive-behavioural therapy as a stated theoretical orientation and the total score on the CTPS \( (r = .385, p < .01) \). In splitting the total CTPS score into its two sub-scales, significant relationships were demonstrated to exist between a number of factors, but only on the Rational-Intuitive sub-scale. The correlations and their associated p values are shown in Table 8.

**Table 8: Significant correlation statistics and p values for therapeutic orientation and R-I sub-scale totals**

<table>
<thead>
<tr>
<th>Variables</th>
<th>RI</th>
<th>PSY</th>
<th>CBT</th>
<th>CC</th>
<th>FEM</th>
<th>EXT</th>
<th>OTH</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>RI</strong></td>
<td>Pearson Correlation</td>
<td>1.000</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Sig. (2-tailed)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>PSY</strong></td>
<td>Pearson Correlation</td>
<td>-.470**</td>
<td>1.000</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Sig. (2-tailed)</td>
<td>.000</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>CBT</strong></td>
<td>Pearson Correlation</td>
<td>.410**</td>
<td>-0.088</td>
<td>1.000</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Sig. (2-tailed)</td>
<td>.000</td>
<td>.459</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>CC</strong></td>
<td>Pearson Correlation</td>
<td>.242*</td>
<td>.030</td>
<td>.372**</td>
<td>1.000</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Sig. (2-tailed)</td>
<td>.039</td>
<td>.804</td>
<td>.001</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>FEM</strong></td>
<td>Pearson Correlation</td>
<td>-.040</td>
<td>-.031</td>
<td>.021</td>
<td>.132</td>
<td>1.000</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Sig. (2-tailed)</td>
<td>.734</td>
<td>.793</td>
<td>.860</td>
<td>.265</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>EXT</strong></td>
<td>Pearson Correlation</td>
<td>.271*</td>
<td>.030</td>
<td>.219</td>
<td>.246*</td>
<td>-.007</td>
<td>1.000</td>
</tr>
<tr>
<td></td>
<td>Sig. (2-tailed)</td>
<td>.021</td>
<td>.082</td>
<td>.062</td>
<td>.036</td>
<td>.952</td>
<td></td>
</tr>
<tr>
<td><strong>OTH</strong></td>
<td>Pearson Correlation</td>
<td>-.011</td>
<td>-.185</td>
<td>-.010</td>
<td>-.100</td>
<td>-.383**</td>
<td>-.015</td>
</tr>
<tr>
<td></td>
<td>Sig. (2-tailed)</td>
<td>.927</td>
<td>.118</td>
<td>.934</td>
<td>.983</td>
<td>.001</td>
<td>.897</td>
</tr>
</tbody>
</table>

** p<.01
* p<.05

RI = Total score on Rational-Intuitive Sub-Scale
PSY = Psychodynamic Psychotherapy
CBT = Cognitive-Behavioural Therapy
CC = Client-Centred Therapy
FEM = Feminist Therapy
EXT = Existential Therapy
OTH = Other types of therapy
Relationship between participants’ stated theoretical orientation and their level of feminist practice

In exploring this dynamic further, it was the intention of the researcher to make some preliminary judgements about whether professionals’ stated theoretical orientation bore any relationship to their practice. For example, based on suggestions that the framework of psychoanalytical psychotherapy appears irreconcilable with the ideologies of feminist therapy (Cardea, 1985; Daly, 1991; Kitzinger and Perkins, 1993; Laidlaw and Malmo, 1990), it was expected that participants who identified themselves as working from a psychoanalytic perspective would score lower on the MPQ. Similarly, lower MPQ scores were also expected of those participants who presented themselves as working from a cognitive-behavioural perspective, the rationale for this being their focus on presenting symptoms and faulty thinking patterns as opposed to cultural and social inequalities (Beck, 1995; Rector, Zuroff, and Segal, 1999).

However, statistical analysis only indicated a significant relationship between stated theoretical orientation and feminist practice for those participants who defined themselves as working within a client-centred and/or feminist theoretical framework (r = .196, p< .05; r = .202, p< .05). In addition, post hoc regression analysis indicated that this association did not have the statistical significance to act as a model of prediction (F2, 70 = 2.633, p>.01, Adjusted R square. 043).
Discussion

General Comments and Summary of Results

It was intended that this study would allow for an exploration of the possible influence of feminist identity upon the therapeutic practice undertaken by therapists who work with women, whilst also assessing for other variables that could possibly predict the interventions that these therapists utilise. With this in mind, it was hypothesised that a relationship would be proven to exist between therapists' level of feminist identity and the feminist elements of their methods of therapeutic practice. In acknowledging that there was also the potential for practitioners' theoretical orientation to play a role in this dynamic, it was also envisaged that there would be a relationship between feminist identity and theoretical orientation. Ultimately, the combination of, and inter-relationships between these factors were expected to create an interaction whereby feminist identity and theoretical orientation would be indicative and indeed predictive of feminist therapeutic practice.

In practice, the results indicated that the degree of feminist identity development was proven to be related to, and indeed predictive of feminist practice with regard to female practitioners. In exploring this further, it did appear that there was some relationship between the specific level of participants' feminist identity development and the degree to which their practice integrated feminist-oriented elements. Therefore, it could be suggested that a practitioner who operated at the level of Active Commitment with regard to their feminist identity would be more likely to adopt a feminist framework for their practice than one who was at the level of Passive Acceptance. However, in developing a predictive model for this, regression analysis
showed that only practitioners at the level of Active Commitment could be anticipated to adopt what was conceptualised as feminist practice.

Contrary to the hypotheses noted above, the results did not substantiate a relationship between theoretical orientation and feminist practice for male or female participants. Consequently, in developing a regression model, the results from this study indicate that theoretical orientation would not be a predictor of feminist practice. There appear to be a number of reasons why this could be the case which will be explored later. Moreover, this would not necessarily imply that that other types of practice could not be predicted by theoretical orientation.

On dividing the participants into groups using gender as the grouping variable, linking to the findings above, statistical analysis once again demonstrated the predictive potential of feminist identity on feminist practice for female practitioners.

Exploratory analysis into the impact of other variables and relationships between them - which included the professional body with which participants were affiliated and participants’ stated theoretical orientation – indicated several points.

1. There was a relationship between professional body affiliation and feminist practice, but only for those practitioners who were members of the British Association of Counselling and Psychotherapy.

2. A relationship was proven between stated theoretical orientation and feminist practice, for those participants who defined themselves as working within a
client-centred and/or feminist theoretical framework. However, these frameworks were not found to predict feminist practice.

3. In line with the findings of Poznanski and McLennan (1999), with regard to the relationship between participants' stated theoretical orientation and that measured by the CTPS, relationships were evident between a stated psychodynamic approach and a low total score on the CTPS and also the sub-scale measuring a rational-intuitive orientation. Additionally, a high score on the CTPS total and the R-I sub-scale was found to relate to participants who regarded themselves as working from a cognitive-behavioural perspective. Smaller relationships were found to exist between high R-I scores and both client-centred and existential orientations.

This last point supports suggestions that have been made with regard to psychodynamic practitioners being more likely to hold beliefs that emphasise intuitive models of knowledge as opposed to a rational ones, whilst cognitive-behavioural practitioners can be expected to reflect models of knowledge that are informed by rationality as opposed to intuition (Poznanski and McLennan, 1999).

Specific Comments and Limitations of the Study

These findings indicate several routes of inquiry that deserve further attention. Firstly, it appeared that the potential of the study - and consequently the results generated - was restricted by the decision not to administer the Feminist Identity Development Questionnaire to the male participants. Although the researcher felt that this was the right choice to make - given the limitations of this questionnaire and the lack of an
appropriate alternative - it does highlight the need for a parallel questionnaire to measure feminist identity in men. Indeed, perhaps it would be more fruitful to generate a new measure of feminist identity development that would not be gender specific. The development of such an implement could be useful in contributing to the debate surrounding the potential for men to be feminists, with a view to challenging the notion that to be a feminist one has to be a woman (Ermarth, 2000).

Secondly, given that part of the study revolved around the development of a new questionnaire, it seems that further attention needs to be paid to the validation of this as a measure of feminist practice. Although internal and test-retest reliability were proven, the strength of these may have been compromised by the limited sample size and the lack of a substantial number of self-ascribed feminist therapists in the study. One solution would be to administer the test to a greater number of participants in order to allow for a factor analysis of the measure. This would enable an evaluation of whether items on the scale represented subsets and underlying psychological dimensions of practice (Gray, 2000; Tabachnick and Fidell, 1996).

Furthermore, in reflecting on this questionnaire, it may be that other variables impacted upon the participants’ style of practice in addition to their level of feminist identity development. For example, it may be that participants’ experiences of personal therapy influenced the approach that they adopted when working with their own clients, in terms of what they had found useful or, perhaps more importantly, problematic in their own therapy. More pertinently, it may be that some of the participants were more aware of issues around stereotyping and cultural oppression than others, given their own life experiences, membership of ‘minority groups’, and/or
experiences of difference in terms of their sexuality, ethnic group, or class.
Consequently, it may be that these therapists would practise in a fashion that could be regarded as reflective of feminism, in terms of making space for exploring these societal influences on psychological functioning, but that this was as a consequence of these other important influences on their lives and not of their feminist identity. In order to respond to this, future studies would need to attempt to incorporate an exploration of the potential impact of these additional variables on practice.

Thirdly, questions need to be asked about the appropriateness of the CTPS as the measure of theoretical orientation for this study. It may be that, although a feminist stance can be likened to systemic or family work as measured by the scale, the measure was not sensitive enough to reflect some of the more specific elements that would constitute a feminist orientation. In view of this, it is possible that no relationships were found to exist between a theoretical orientation, and feminist identity and/or practice, as the scale did not measure a feminist orientation to the degree that had been hoped. However, it also remains of interest that no other orientations were found to be related or more specifically unrelated to a feminist approach. For example, as already outlined, it could have been envisaged that a psychodynamic orientation would be negatively related to feminist practice, given their potentially irreconcilable differing ideological foundations (Cardea, 1985; Daly, 1991; Kitzinger and Perkins, 1993; Laidlaw and Malmo, 1990).

Explanations for the lack of statistical relationship between those theoretical orientations measured and feminist identity in this study, could relate to sampling errors, whereby those participants selected did not represent a true reflection of the
general population. Consequently, it may be that relationships would be found if this study were replicated on a larger scale with the intention of accessing the views of a more diversified sample base. However, it is also possible that methodological issues could have accounted for this outcome. For example, although all of the questionnaires were fully completed by participants included in the relevant parts of the study, it is interesting to note that many were returned with comments written on them about a lack of clarity of scale items, convoluted language, and some items seeming to ask more than one thing. These comments could have reflected a trend for participants to complete the questionnaire without fully understanding it, which may have generated an inaccurate representation of their theoretical orientation. This again gives rise to a need for further investigations; in this case with the view to developing further measures of theoretical orientation that challenge these apparent limitations.

**Implications for the practice of Counselling Psychology**

The research also aimed to highlight areas for counselling psychologists to address in terms of the potential for their personal belief system to inform the therapeutic process as a beneficial tool for support and change.

In investigating this, it does appear that the study was reflective of this, with those participants demonstrating more highly developed feminist identities also utilising what were conceptualised as feminist methods of practice. In view of this, further empirical investigations could be devised in order to ascertain whether this apparent integration of ideology into practice complemented and/or enhanced therapeutic outcome. This is an important issue for counselling psychologists to address in terms of issues such as the therapeutic relationship, its integration into practice (Clarkson,
1994, 1995), and the impact that therapists’ personal values can have on its development (Hill and Ballou, 1998). Indeed, it appears that the manner in which this relationship is constructed allows for the client to be engaged in therapy in a way that maximises their lived experiences, rather than trying to fit them into pre-existing models of therapy or pathologising their concerns. This appears in contrast to criticism directed towards traditional views of psychotherapy as focusing on remediating pathological behaviours (Kitzinger and Perkins, 1993; Parker, Georgaca, Harper, McLaughlin and Stowell-Smith, 1995; Worell and Remer, 1992).

Therefore, it may be that the therapist’s conceptualisations of the importance of social, cultural and political factors in both their and their clients’ lives - and the creation of space within the therapeutic encounter to explore these - is something that can facilitate a therapeutic relationship. Indeed, explicitly focusing on the therapist-client relationship, and perhaps exploring the extent to which it perhaps replicates those formed in wider society, could challenge and eschew the construction of psychology as a discipline that recreates and maintains the power inequalities between men and women in society (Kitzinger and Perkins, 1993, Lakin, 1991).

Conclusion

In concluding this paper, it can be suggested that this research appears to have accomplished a number of things, whilst also opening up a number of avenues that demand further attention in order to address its shortcomings and explore further the new questions that it has generated. It was hoped that this study would encourage investigation, beyond the basics of practice in feminist therapy, towards a more elaborate evaluation of how feminist theory was reflected in the practice of a number
of therapists, not all of whom would necessarily refer to themselves as feminist therapists. In addressing this, it does appear that movement has been made towards creating a measure that can more accurately assess the workings of feminist therapy empirically than qualitative evaluations have so far managed (Hill and Ballou, 1998). It has also contributed to the debate as to the role that therapists’ personal values play in the therapeutic encounter, consequently appearing to support the growing body of literature which calls for psychology to break away from its logical positivist roots (Ayer, 1959) and question ‘the traditional, value-free conceptualisation of science’ (Krasner and Houts, 1984, p. 840).

However, although it is tempting to view these findings with optimism, with regard to building a consensual understanding of the interaction between values and practice, they should be embraced with caution. It is clear that much further research is needed before any concrete conclusions can be made, especially given that therapists will have a variety of values and personal beliefs that potentially inform their practice, not only those of a feminist nature as explored in this study. Moreover, the question remains unanswered as to the impact that theoretical orientation has on this dynamic, which is then further complicated by the possibility for diversity within orientations as well as between them. It is difficult to accept that it plays no role at all, as this study appears to imply. Indeed, it may well be that this role is mediated by other factors of which this study took little account.

Nonetheless, it is encouraging to believe that therapists can enter the therapeutic encounter as ‘real people’ who, although adopting the mantle of ‘psychological expert’, are able to acknowledge socio-political influences on their own lives and
accept and embrace those affecting the lives of their clients. It is acknowledged that it will necessary for therapists to exert caution in allowing their ideologies to influence their practice, given that at times these will differ vastly from those of their clients. However, the potential for therapists to integrate their own ideological commitments into therapy, as opposed them having to remain ‘skeletons in the closet’, is something that creates great possibilities for developing a creative approach to therapy.
References


Approaches to Counselling and Psychotherapy’, *The Counseling Psychologist* 16: 190-234.


Appendices

Appendix A: Measurement of Feminist Practice Questionnaire (MPQ)

Appendix B: Counsellor Theoretical Position Questionnaire (CTPS)

Appendix C: Composite Measure of Feminist Identity Development Questionnaire (FIDQ)

Appendix D: Background Information Questionnaire

Appendix E: Information Letter for Participants

Appendix F: Copy of Feminist Therapy Code of Ethics

Appendix G: Calculations of normality and linearity

Appendix H: Participants’ Demographic Information Statistics

Appendix I: Notes for Contributors

Appendix J: Ethical Approval
APPENDIX A

Measurement of Practice Questionnaire

Below is a list of statements referring to issues of therapeutic practice. By using the scale below each statement, please tell me how much you agree or disagree with its content by circling the appropriate number. It is intended that you respond to the statements with the view that when they refer to 'the therapist' and therapeutic practice you put yourself in this position and answer according to your own practice. Therefore precede each statement with the phrase “In my practice...”

1. The therapist demonstrates competent behaviour and flexibility.

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>Strongly Agree</th>
</tr>
</thead>
</table>

2. Therapy allows for equal participation in goal-setting and choice of strategy.

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>Strongly Agree</th>
</tr>
</thead>
</table>

3. The therapist encourages the client to initiate change in self.

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>Strongly Agree</th>
</tr>
</thead>
</table>

4. The therapist encourages the client to initiate change in situation.

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>Strongly Agree</th>
</tr>
</thead>
</table>

5. The therapist assists clients in identifying their thoughts and feelings in relation to various situations.

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>Strongly Agree</th>
</tr>
</thead>
</table>

6. The therapist is a neutral observer of human behaviour.

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>Strongly Agree</th>
</tr>
</thead>
</table>
7. Therapeutic work enables the client to nurture and empower the self.

Strongly 1 2 3 4 5 6 7 Strongly
Disagree
Agree

8. Work in the sessions strengthens the client’s abilities to identify and appreciate their strengths.

Strongly 1 2 3 4 5 6 7 Strongly
Disagree
Agree

9. Therapeutic work focuses primarily on changing the client’s thoughts and feelings.

Strongly 1 2 3 4 5 6 7 Strongly
Disagree
Agree

10. The therapist assists the client in achieving personal goals.

Strongly 1 2 3 4 5 6 7 Strongly
Disagree
Agree

11. The aim of therapeutic work is empowerment.

Strongly 1 2 3 4 5 6 7 Strongly
Disagree
Agree

12. Sessions provide a space for analysing gender inequalities.

Strongly 1 2 3 4 5 6 7 Strongly
Disagree
Agree

13. Therapeutic work enables deficits to be reframed as strengths.

Strongly 1 2 3 4 5 6 7 Strongly
Disagree
Agree

14. Therapy is an inherently value-laden process.

Strongly 1 2 3 4 5 6 7 Strongly
Disagree
Agree
15. Therapy allows women to identify the impact of common social problems upon them.

<table>
<thead>
<tr>
<th>Strongly</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disagree</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

16. Therapist’s personal material is not discussed with clients.

<table>
<thead>
<tr>
<th>Strongly</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disagree</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

17. The therapist acts to facilitate fuller expression of clients’ feelings, thoughts and behaviours.

<table>
<thead>
<tr>
<th>Strongly</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disagree</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

18. Selecting the goals of therapy is primarily the therapist’s responsibility.

<table>
<thead>
<tr>
<th>Strongly</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
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19. Therapy allows clients to gain appreciation of gender specific characteristics.

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20. Sessions give the client permission to practise new actions and skills.

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21. The therapist helps the client to learn that roles can be modified, refined, elaborated or relinquished.

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22. It is the aim of therapy to help free clients from traditional sex-roles.

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</table>
23. Clients’ problems can be understood apart from the specific society in which they live.

Strongly 1 2 3 4 5 6 7 Strongly Agree
Disagree

24. The therapist having emotional distance from clients is preferable to therapists having emotional connection to clients.

Strongly 1 2 3 4 5 6 7 Strongly Agree
Disagree

25. It is appropriate for the therapist to assist clients in accessing other services where necessary.

Strongly 1 2 3 4 5 6 7 Strongly Agree
Disagree

26. The therapist’s goal is to uncover and respect cultural and experiential differences.

Strongly 1 2 3 4 5 6 7 Strongly Agree
Disagree

27. It is the responsibility of the therapist to acknowledge power differentials between themselves and the client.

Strongly 1 2 3 4 5 6 7 Strongly Agree
Disagree

28. Therapist self-disclosure can be an essential and facilitative therapeutic tool.

Strongly 1 2 3 4 5 6 7 Strongly Agree
Disagree

29. Part of the therapist’s role is to be actively involved in their community.

Strongly 1 2 3 4 5 6 7 Strongly Agree
Disagree
30. Therapy emphasises the importance of sharing of common experiences among women.

Strongly Disagree

31. A major goal of therapy is to help clients adjust successfully to their social environments.

Strongly Disagree

32. Therapy allows for an exploration of the ways in which people are oppressed in society, for example: ageism, sexism, heterosexism, racism and classism.

Strongly Disagree

33. Therapeutic work acknowledges the role of culture in the client’s psychological distress.

Strongly Disagree

34. Therapeutic work focuses primarily on changing the client’s behaviour.

Strongly Disagree

35. Therapeutic work focuses primarily on changing the client’s values.

Strongly Disagree

36. The therapist keeps their values out of the therapeutic process.

Strongly Disagree
37. A major goal of therapy is to help clients adjust their social environments to fit them.

Strongly 1 2 3 4 5 6 7 Strongly Disagree Agree

38. The therapist and client are equal partners in the therapeutic process.

Strongly 1 2 3 4 5 6 7 Strongly Disagree Agree

39. Clients are fully informed about the process of therapy.

Strongly 1 2 3 4 5 6 7 Strongly Disagree Agree

40. The therapist’s values are clearly stated to clients.

Strongly 1 2 3 4 5 6 7 Strongly Disagree Agree

41. Due to their extensive training, the therapist knows clients better than clients know themselves.

Strongly 1 2 3 4 5 6 7 Strongly Disagree Agree

42. I understand that problematic behaviours by individuals most often represent adaptive responses to a “sexist” society.

Strongly 1 2 3 4 5 6 7 Strongly Disagree Agree
APPENDIX B

Measure of Theoretical Orientation: Counsellor Theoretical Position Scale

Below is a list of statements referring to issues related to theoretical orientation. By using the scale below each statement, please tell me how much you agree or disagree with its content by circling the appropriate number.

Sub-scale One:

1. Unconscious motives and intuitive processes should be considered as essential aspects of psychological theory.

Completely 1 2 3 4 5 6 7 Completely Agree
Disagree

2. Unconscious motivation is a very important aspect of human behaviour.

Completely 1 2 3 4 5 6 7 Completely Agree
Disagree

3. The emotional process in counselling or psychotherapy is a vital agent of change.

Completely 1 2 3 4 5 6 7 Completely Agree
Disagree

4. Interpretation of symbolic meaning enables illumination of the depth of human experience.

Completely 1 2 3 4 5 6 7 Completely Agree
Disagree

5. The concept of unconscious process is of limited therapeutic value.

Completely 1 2 3 4 5 6 7 Completely Agree
Disagree

6. I generally prefer to practice a goal-directed approach to counselling or psychotherapy.

Completely 1 2 3 4 5 6 7 Completely Agree
Disagree
7. Understanding a client’s childhood is crucial to therapeutic change.

Completely 1 2 3 4 5 6 7 Completely
Disagree

8. Counselling or psychotherapy should focus on ‘here-and-now’ experiences:
   There is no need to focus on the client’s past.

Completely 1 2 3 4 5 6 7 Completely
Disagree

9. Human beings need to know meanings rather than simply factual information.

Completely 1 2 3 4 5 6 7 Completely
Disagree

10. It is essential to focus on feeling and meaning as communicated by a client.

Completely 1 2 3 4 5 6 7 Completely
Disagree

11. People can learn effective coping skills without necessarily having to go into the depth of their private experience.

Completely 1 2 3 4 5 6 7 Completely
Disagree

12. Introspective and intuitive methods in counselling or psychotherapy are more useful than explanations which do not go beyond observable behaviour.

Completely 1 2 3 4 5 6 7 Completely
Disagree

13. Self-knowledge deepens our understanding of life.

Completely 1 2 3 4 5 6 7 Completely
Disagree
14. An effective counsellor or psychotherapist demonstrates sensitivity and personal involvement towards the client.

Completely 1 2 3 4 5 6 7 Completely Disagree

15. Careful re-examination by a client of his/her personal history can alter the client’s present emotional life.

Completely 1 2 3 4 5 6 7 Completely Disagree

16. It is important for a counsellor or psychotherapist to feel strong personal and emotional involvement with a client.

Completely 1 2 3 4 5 6 7 Completely Disagree

17. Search for meaning and wholeness in life is the essence of human existence.

Completely 1 2 3 4 5 6 7 Completely Disagree

18. Establishing a client’s awareness of his/her own emotions and desires is a beneficial therapeutic outcome in itself.

Completely 1 2 3 4 5 6 7 Completely Disagree

19. I believe counselling or psychotherapy is much more an art than a science.

Completely 1 2 3 4 5 6 7 Completely Disagree

20. As a counsellor/psychotherapist I usually take on an active role in structuring the interview.

Completely 1 2 3 4 5 6 7 Completely Disagree
Sub-scale Two:

1. Emotional stability is a product of one’s logical and consistent thinking behaviour.

Completely 1 2 3 4 5 6 7 Completely Agree
Disagree

2. Cognition is the most powerful factor in determining experience.

Completely 1 2 3 4 5 6 7 Completely Agree
Disagree

3. An understanding of the reasons for one’s behaviour is crucial to behavioural change.

Completely 1 2 3 4 5 6 7 Completely Agree
Disagree

4. Knowledge is valid only if it is based on logic and/or reason.

Completely 1 2 3 4 5 6 7 Completely Agree
Disagree

5. Irrationality is the fundamental cause of psychological dysfunction.

Completely 1 2 3 4 5 6 7 Completely Agree
Disagree

6. Clients need to be guided and given information in order to achieve their therapeutic goals.

Completely 1 2 3 4 5 6 7 Completely Agree
Disagree

7. Improving the client’s level of social adjustment ought to be the main therapeutic aim.

Completely 1 2 3 4 5 6 7 Completely Agree
Disagree
8. As a counsellor/psychotherapist I maintain a detached and objective approach during counselling or psychotherapy interviews.

Completely 1 2 3 4 5 6 7 Completely
Disagree
Agree

9. It is unwise for a counsellor or psychotherapist to respond to a client in a spontaneous, not thought-through manner.

Completely 1 2 3 4 5 6 7 Completely
Disagree
Agree

10. Any claimed mental process can be translated into a statement describing observable behaviour.

Completely 1 2 3 4 5 6 7 Completely
Disagree
Agree

11. Valid information comes only from empirical research.

Completely 1 2 3 4 5 6 7 Completely
Disagree
Agree

12. Nothing is true if it is illogical.

Completely 1 2 3 4 5 6 7 Completely
Disagree
Agree

13. The brain is the prime mover in human social development.

Completely 1 2 3 4 5 6 7 Completely
Disagree
Agree

14. Logical analysis and synthesis of information is crucial to one’s survival.

Completely 1 2 3 4 5 6 7 Completely
Disagree
Agree

15. Emotional involvement by a therapist defeats the purpose of therapy.

Completely 1 2 3 4 5 6 7 Completely
Disagree
Agree
16. Intense negative emotions are manifestations of unrealistic and non-logical cognitions.

Completely Agree
Disagree

17. It is preferable that a counsellor or psychotherapist remains personally uninvolved in the therapeutic relationship.

Completely Agree
Disagree

18. Specific training in counselling or psychotherapy techniques is vital to therapeutic outcome.

Completely Agree
Disagree


Completely Agree
Disagree

20. Higher intellectual processes over-ride more primitive functions of feeling and behaviour.

Completely Agree
Disagree
Feminist Identity Development Questionnaire

Below is a list of statements referring to issues related to feminist identity development. By using the scale below each statement, please tell me how much you agree or disagree with its content by circling the appropriate number.

1. I am very committed to a cause that I believe contributes to a more fair and just world for all people.

   Strongly Disagree  1  2  3  4  5  Strongly Agree

2. I want to work to improve women's status.

   Strongly Disagree  1  2  3  4  5  Strongly Agree

3. I am willing to make certain sacrifices to effect change in this society in order to create a nonsexist, peaceful place where all people have equal opportunities.

   Strongly Disagree  1  2  3  4  5  Strongly Agree

4. It is very satisfying to be able to use my talents and skills in my work in the women's movement.

   Strongly Disagree  1  2  3  4  5  Strongly Agree

5. I care very deeply about men and women having equal opportunities in all respects.

   Strongly Disagree  1  2  3  4  5  Strongly Agree

6. I choose my "causes" carefully to work for greater equality of all people.

   Strongly Disagree  1  2  3  4  5  Strongly Agree

7. I feel that I am a very powerful and effective spokesperson for the women's issues I am concerned with right now.

   Strongly Disagree  1  2  3  4  5  Strongly Agree
8. On some level, my motivation for almost every activity I engage in is my desire for an egalitarian world.

Strongly Disagree  1  2  3  4  5  Strongly Agree

9. I owe it not only to women but to all people to work for greater opportunity and equality for all.

Strongly Disagree  1  2  3  4  5  Strongly Agree

10. I feel like I have blended my female attributes with my unique personal qualities.

Strongly Disagree  1  2  3  4  5  Strongly Agree

11. I am proud to be a competent woman.

Strongly Disagree  1  2  3  4  5  Strongly Agree

12. I have incorporated what is female and feminine with my unique personality.

Strongly Disagree  1  2  3  4  5  Strongly Agree

13. I enjoy the pride and self-assurance that comes from being a strong female.

Strongly Disagree  1  2  3  4  5  Strongly Agree

14. As I have grown in my beliefs I have realised that it is more important to value women as individuals than as members of a larger group of women.

Strongly Disagree  1  2  3  4  5  Strongly Agree

15. If I were to paint a picture or write a poem, it would probably be about women or women's issues.

Strongly Disagree  1  2  3  4  5  Strongly Agree

16. Gradually, I am beginning to see how sexist society really is.

Strongly Disagree  1  2  3  4  5  Strongly Agree
17. I feel angry when I think about the way I am treated by men and boys.

Strongly Disagree  1  2  3  4  5  Strongly Agree

18. Men receive many advantages in society and because of this are against equality for women.

Strongly Disagree  1  2  3  4  5  Strongly Agree

19. I never realised until recently that I have experienced oppression and discrimination as a woman in society.

Strongly Disagree  1  2  3  4  5  Strongly Agree

20. I feel like I’ve been duped into believing society’s perceptions of me as a woman.

Strongly Disagree  1  2  3  4  5  Strongly Agree

21. My female friends are like me in that we are all angry at men and the way we have been treated as women.

Strongly Disagree  1  2  3  4  5  Strongly Agree

22. In my interaction with men, I am always looking for ways I may be discriminated against because I am female.

Strongly Disagree  1  2  3  4  5  Strongly Agree

23. Regretfully, I can see ways in which I have perpetuated sexist attitudes in the past.

Strongly Disagree  1  2  3  4  5  Strongly Agree

24. I am very interested in women writers.

Strongly Disagree  1  2  3  4  5  Strongly Agree

25. I am very interested in women musicians.

Strongly Disagree  1  2  3  4  5  Strongly Agree
26. I am very interested in women artists.

Strongly Disagree  1  2  3  4  5  Strongly Agree

27. I am very interested in women's studies.

Strongly Disagree  1  2  3  4  5  Strongly Agree

28. I don't see much point in questioning the general expectation that men should be masculine and women should be feminine.

Strongly Disagree  1  2  3  4  5  Strongly Agree

29. One thing I especially like about being a woman is that men will offer me a seat on a crowded bus or open doors for me because I am a woman.

Strongly Disagree  1  2  3  4  5  Strongly Agree

30. I like being a traditional female.

Strongly Disagree  1  2  3  4  5  Strongly Agree

31. I think that men and women had it better in the 1950s when married women were housewives and their husbands supported them.

Strongly Disagree  1  2  3  4  5  Strongly Agree

32. If I were married to a man and my husband was offered a job in another county, it would be my obligation to move in support of his career.

Strongly Disagree  1  2  3  4  5  Strongly Agree

33. I think that most women will feel fulfilled by being a wife and mother.

Strongly Disagree  1  2  3  4  5  Strongly Agree

34. I think it's lucky that women aren't expected to do some of the more dangerous jobs that men are expected to do.

Strongly Disagree  1  2  3  4  5  Strongly Agree
35. I do not want to have equal status with men.
Strongly Disagree 1 2 3 4 5 Strongly Agree

36. I evaluate men as individuals, not as members of a group of oppressors.
Strongly Disagree 1 2 3 4 5 Strongly Agree

37. I just feel like I need to be around women who share my point of view right now.
Strongly Disagree 1 2 3 4 5 Strongly Agree

38. I feel that some men are sensitive to women’s issues.
Strongly Disagree 1 2 3 4 5 Strongly Agree

39. I share most of my time with a few close women friends who share my feminist values.
Strongly Disagree 1 2 3 4 5 Strongly Agree
APPENDIX D

Background Information Questionnaire

To begin, I'd like to get some background information about you (such as your age, education and occupation). The reason that I’d like this information is so that I can show those who read the research report that I have managed to obtain the views of a cross-section of people. The information that you give will never be used to identify you in any way because this research is entirely confidential. However, if you don’t want to answer some of these questions, please don’t feel that you have to.

1. Are you: male_ female_

2. How old are you? [ ] years

3. Which of the following ethnic group would you say you belong to?
(Please tick the appropriate answer)

- Bangladeshi
- Black-African
- Black-Caribbean
- Black-Other
- Chinese
- Indian
- Pakistani
- White
- Other (please specify: ________________________)

4. What is your highest educational qualification?
(Please tick the appropriate answer)

- None
- GCSE(s)/O-level(s)/CSE(s)
- A-level(s)
- Diploma (HND, SRN, etc.)
- Degree
- Postgraduate degree/diploma
5. What is your current job title (or if you are no longer working, what was your last occupation)?

6. What are your experiences of therapy and counselling?

(Please tick as many answers that apply to you)

- As a client
- As a therapist
- Individual therapy
- Group therapy
- Support groups/self help
- Long-term therapy
- Short term therapy

7. As a therapist what theoretical orientation do you work according to?

(Please tick as many answers that apply to you)

- Psychodynamic Therapy
- Cognitive Behavioural Therapy
- Client Centred Therapy
- Feminist Therapy
- Existentialist Therapy
- Other (please specify: _____________________)

8. For how long have you been in professional practice?

9. To which professional bodies do you belong?

(Please tick as many answers that apply to you)

- United Kingdom Council for Psychotherapy
- British Psychological Society
- British Confederation of Psychotherapists
- British Association of Counsellors
- Other (please specify: _____________________)
Feminist identity development and theoretical orientation: An investigation into their impact on the therapeutic practice of therapists who offer psychological support to women

Dear

I am writing to invite you to participate in the above study, as your involvement and input would be greatly valued and appreciated.

This research project is being carried out as part-fulfilment of the Practitioner Doctorate in Psychotherapeutic and Counselling Psychology at the University of Surrey, by Victoria Jane Sims and supervised by Dr. Adrian Coyle. It has been approved by the University Advisory Committee on Ethics. The aim of this research is to explore your experiences of working therapeutically with women and how the therapeutic approach that you adopt with this client group may or may not be related to your personal ideology, in this case any feminist beliefs that you might have.

It is hoped that by exploring these issues that you will have the chance to reflect on your own experiences of therapeutic work in a way that allows you to maximise your role as both a participant and co-researcher in the study.

In the study you will be asked to complete three questionnaires exploring your personal ideology/values, practice and your theoretical approach to therapy, along with some short background information questions. This should take you approximately 30 minutes. Once you have done this it would be appreciated if you could return the completed material to the researcher in the addressed envelope enclosed for which postage has already been paid. On having agreed to participate in
the study you will still have the right to withdraw from it at any time without giving any reason for your withdrawal. To protect confidentiality, your questionnaires have been assigned a code which means that your identity is known only to the researcher. This will also ensure that duplicate questionnaires are not sent to you. **Additionally, I will not quote any identifying information such as names or locations.** In any write-up of this research or any submission for journal publication, these confidentiality precautions will be maintained. The questionnaires and associated data will be destroyed on completion of the study.

If you have any questions or concerns about the study and what will be required of you, then please do not hesitate to contact either myself or my research supervisor, at the University’s Department of Psychology, by telephone on 01483 879176 or alternatively, if you have access to a computer I can be contacted via e-mail at **psm2vs@surrey.ac.uk**.

Thank you for your attention in this matter, I look forward to hearing from you.

Yours sincerely

Victoria Jane Sims
Counselling Psychologist in Training
FEMINIST THERAPISTS

I. Cultural Diversities and Oppressions

A. A feminist therapist increases her accessibility to and for a wide range of clients from her own and other identified groups through flexible delivery of services. When appropriate, the feminist therapist assists clients in accessing other services.

B. A feminist therapist is aware of the meaning and impact of her own ethnic and cultural background, gender, class, and sexual orientation and actively attempts to become more knowledgeable about alternatives from sources other than her clients. The therapist's goal is to uncover and respect cultural and experiential differences.

C. A feminist therapist evaluates her ongoing interactions with her clientele for any evidence of the therapist's biases or discriminatory attitudes and practice. The feminist therapist accepts responsibility for taking action to confront and change any interfering or oppressing biases she has.

II. Power Differentials

A. A feminist therapist acknowledges the inherent power differentials between client and therapist and models effective use of personal power. In using the power differential to the benefit of the client, she does not take control or power which rightfully belongs to her client.

B. A feminist therapist discloses information to the client which facilitates the therapeutic process. The therapist is responsible for using self-disclosure with purpose and discretion in the interests of the client.

C. A feminist therapist negotiates and renegotiates formal and/or informal contracts with clients in an ongoing mutual process.

D. A feminist therapist educates her clients regarding their rights as consumers of therapy, including procedures for resolving differences and filing grievances.

III. Overlapping Relationships

A. A feminist therapist recognizes the complexity and conflicting priorities inherent in multiple or overlapping relationships. The therapist accepts responsibility for maintaining an awareness of potential abuse of or harm to the client.

B. A feminist therapist is actively involved in her community. As a result, she is especially sensitive about confidentiality. Recognizing that her clients' concerns and general well-being are primary, she monitors both public and private statements and comments.

C. A feminist therapist does not engage in sexual intimacies nor overtly or covertly sexualized behaviors with a client or former client.

IV. Therapist Accountability

A. A feminist therapist works only with those issues and clients within the realm of her competencies.

B. A feminist therapist recognizes her personal and professional needs, and utilizes ongoing self-evaluation, peer support, consultation, supervision, continuing education, and/or personal therapy to evaluate, maintain, and improve her work with clients, her competencies, and her emotional well-being.

C. A feminist therapist continually reevaluates her training, theoretical background, and research to include developments in feminist knowledge. She integrates feminism into psychological theory, receives ongoing therapy training, and acknowledges the limits of her competencies.

D. A feminist therapist engages in self-care activities in an ongoing manner. She acknowledges her own vulnerabilities and seeks to care for herself outside the therapy setting. She models the ability and willingness to self-nurture in appropriate and self-empowering ways.

V. Social Change

A. A feminist therapist actively questions other therapeutic practices in her community that appear abusive to clients or therapists and, when possible, intervenes as early as appropriate or feasible or assists clients in intervening when it is facilitative to their growth.

B. A feminist therapist seeks multiple avenues for impacting change, including public education and advocacy within professional organizations, lobbying for legislative actions, and other appropriate activities.
APPENDIX G

Statistics for normality, linearity, homoscedasticity and interdependence of residuals on FIDQ and MPQ scores

Descriptives for unstandardised scores

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*a: This is a lower bound of the true significance.

Lilliefors Significance Correction
Regression Residuals

Scatterplot

Dependent Variable: MPQ TOTAL

Q-Q plots to show distribution of data

Normal Q-Q Plot of PA
Normal Q-Q Plot of AC

Expected Normal Value

Observed Value

Normal Q-Q Plot of MPQ TOTAL

Expected Normal Value

Observed Value

Descriptives for z-scores

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* This is a lower bound of the true significance.

a. Lilliefors Significance Correction
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Regression Residuals

Scatterplot

Dependent Variable: Zscore(MPQ TOTAL)

Regression Standardized Predicted Value

Q-Q plots to show distribution of z-score data

Normal Q-Q Plot of Zscore (PA)
Normal Q-Q Plot of Zscore (AC)

Expected Normal Value

Observed Value

Normal Q-Q Plot of Zscore (MPQ TOTAL)

Expected Normal Value

Observed Value
## APPENDIX H

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AIMS AND SCOPE

General policy: Feminism & Psychology aims to provide an international forum for debate at the interface between feminism and psychology. The principal aim of the journal is to foster the development of feminist theory and practice - and beyond - psychology, and to represent the concerns of women in a wide range of contexts across the academic-applied ‘divide’. It publishes high-quality, original research and debates that acknowledge gender and other social inequalities and consider their psychological effects; studies of sex differences are published only when set in this critical context. Contributions should consider the implications of ‘race’, class, sexuality and other social inequalities where relevant. The journal seeks to maintain a balance of theoretical and empirical papers, and to integrate research, practice and broader social concerns.

Feminism & Psychology encourages contributions from members of groups which are generally underrepresented in psychology journals, and individuals at all stages of their ‘careers’. The journal has a policy of not publishing sexist, racist or heterosexist material. The journal encourages positive reviewing, which aims to provide supportive and constructive feedback to authors.

Feminism & Psychology publishes:

* Theoretical and empirical articles
* Research reviews
* Reports and reviews of issues relevant to practice
* Book reviews
* Observations and Commentaries
* Special Features
* A ‘Spoken Word’ section

Special features are designed to highlight the views of women who are the clients, students, survivors or general users of psychology, and to present debate on a wide range of contemporary issues surrounding feminism and psychology. The Spoken Word features topical contributions (discussions, interviews, profiles) which rely primarily on the spoken rather than the written word.

NOTES FOR CONTRIBUTORS

1. All submissions will be peer reviewed. Papers written in English are invited for consideration, provided they have not been published, nor are currently under consideration, elsewhere. The journal also aims to include translated pieces which have been published previously elsewhere, in languages other than English.

2. Manuscripts should be typewritten, double-spaced throughout, on A4, or 8.5” x 11”, paper with generous margins, and not right-justified. References should be Harvard system, and in the following style: e.g.


   All figures should be of a reproducible standard. Footnotes should be kept to a minimum, and presented as End Notes. Papers should normally be between 5000 and 8000 words, but exceptionally up to 10,000 words for theoretical and empirical articles, research reviews and reports of practice; and between 500 and 2000 words for observations and commentaries. Please provide a word count. A variety of formats will be welcomed.

3. An abstract of approximately 150 words should be included with each submission; but need not be supplied for observations or commentaries.

4. Authors’ names, titles and affiliations, with complete mailing addresses and telephone numbers, should appear on a separate cover page. Authors are invited to provide any biographical information they would wish reviewers to take into account on a separate sheet. The aim of this information is to avoid discrimination against those without standard academic backgrounds or institutional support. All submitted articles will be reviewed anonymously.

5. Submissions are welcomed for Special Features and The Spoken Word. These will normally be developed in conjunction with a member of the Editorial Group. In the first instance, suggestions should be sent to the Special Features Coordinator of the Editorial Group.

6. Authors should avoid the use of sexist, racist and heterosexist language. Manuscripts that do not conform to these specifications will not be considered. Authors are encouraged to use clear language which avoids unnecessary jargon.

7. Twenty-five offprints of the article, plus a copy of the journal, will be supplied to article authors on publication.

8. Book reviews will normally be commissioned by the Book Review Editor although unsolicited reviews will be considered, and the journal will also review other media and relevant fiction.

9. Six copies of all manuscript submissions, including the original, should be sent to the Editor, at the Department of Social Sciences, Loughborough University, Loughborough, Leicestershire LE11 3TU, UK. A copy on disk will be required before publication, but should not be included with the initial submission. Further information may be sought from any member of the Editorial Group.

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19 March 2001

Miss Victoria Sims  
Trainee Counselling Psychologist  
Department of Psychology  
University of Surrey

Dear Miss Sims

Feminist identity development and theoretical orientation: An investigation into their impact in the therapeutic practice of therapists who offer psychological support to women (ACE/2001/08/Psych)

I am writing to inform you that the Advisory Committee on Ethics has considered the above protocol and the subsequent information supplied, and has approved it on the understanding that the Ethics Guidelines are observed and the following condition is met:

- That the wording of the Information Sheet/Introductory Letter to Volunteers is amended as marked on the enclosed, and the new version is submitted to the Committee for their records.

The letter of approval relates only to the study specified in your research protocol (ACE/2001/08/Psych). The Committee should be notified of any changes to the proposal, any adverse reactions and if the study is terminated earlier than expected (with reasons). I enclose a copy of the Ethics Guidelines for your information.

I should be grateful if you would confirm in writing your acceptance of the condition above, enclosing the amended document.

Date of approval by the Advisory Committee on Ethics: 19 March 2001  
Date of expiry of the Advisory Committee on Ethics approval: 18 March 2006

Please inform me when the research has been completed.

Yours sincerely

Catherine Ashbee (Mrs)  
Secretary, University Advisory Committee on Ethics

cc: Professor L J King, Chairman, ACE  
Dr A Coyle, Principal Investigator, Dept of Psychology