Fall 1995

Views of Feminist Family Therapy: A Q-Methodological Inquiry

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A Dissertation Submitted to the Faculties of

The College of William and Mary,
Eastern Virginia Medical School,
Norfolk State University,
and Old Dominion University

in Partial Fulfillment of the Requirement
for the Degree of

Doctor of Psychology
Clinical Psychology

Virginia Consortium for Professional Psychology
October, 1995

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Abstract

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The feminist critique of family therapy has had a growing impact on theory and practice for almost two decades (Hare-Mustin, 1978; Bograd, 1990). Writings on feminist family therapy (FFT) reveal both common and diverse opinions about what FFT is. The present study examined how views of FFT are segmented using Q-methodology (Stephenson, 1953; Brown, 1980; McKeown & Thomas, 1988), a small-sample empirical technique for identifying emergent viewpoints and studying their similarities and differences. A Q-sort instrument of 60 statements was constructed to sample diverse discourse on FFT. Magraw's (1992) interviews with leading experts in FFT served as a primary source for loosely structuring the Q-sort instrument into hypothesized areas of consensus and divergence in FFT; a smaller set of items sampled critiques of both FFT and feminism in the broader culture. A convenience sample of 29 experienced and novice family therapists, 12 of whom were experts in FFT, ranked the statements by sorting them into 10 categories along a continuum from "least agree" (category 1) to "most agree" (category 10). Factor analysis of correlations among the Q-sorts produced six emergent factors or viewpoints accounting for 69% of the variance. Two factors represented distinctly feminist viewpoints; all

the FFT experts loaded on one of these two factors. The remaining participants were scattered across four other factors, representing various views of FFT. The two feminist views were interpreted in the context of schools of feminism. Three issues in particular distinguished the two views of FFT: whether feminist energy should be directed toward both sexes or more toward women; whether racial inequities override gender inequities; and the place of hierarchy between therapist and clients. Respondents on the two feminist viewpoints shared some common ground: they rejected therapeutic neutrality; viewed therapy as a political act; and endorsed challenging power arrangements in the family. The results suggest that views of FFT can be understood in a broader intellectual context: diverse views of FFT appear to parallel divisions of opinion in feminist theories and in cultural perceptions of the women's movement.

Acknowledgments

I am touched by the number of people whom I want to thank for being the best part of a long process.

Michael Rohrbaugh promised to "see me through" this dissertation when he could have justifiably resigned upon his move to the University of Arizona. Bless your heart, Michael. This study would have been impossible without you.

Ellen Rosen deserves special thanks for agreeing to be co-chair and for taking on all the administrative tasks. Joy Kannarkat was always an encouraging and supportive committee member; he contributed good ideas for future research. Mike Nichols did more than serve as a reader; he helped to put me in contact with some of the feminist family therapists who participated in the study. Laura Roberto was both kind and helpful; she contributed useful critiques from a feminist point of view.

I extend my gratitude to the women and men who, taking time out of their busy lives, completed the Q-sort. Suki Magraw, whose own dissertation provided a springboard for this one, was considerably helpful and encouraging. Donna Christensen, Suki Magraw, Jane Pillemer, and Laura Roberto all generously gave their time to read and to comment thoughtfully on the Q-sort statements before the study began.

My mother, Alison Cheek, was especially helpful to me. She spent hours discussing feminist theory with me and provided a constant source of support and encouragement. My brother, Jonathan Cheek, dispensed sound advice about getting through a dissertation. Without my old high school pal, Janie Guill, all might have been lost. When, in the middle of writing the dissertation proposal, my 1086 computer finally gave up any remote semblance of functioning, Janie generously provided me with a zippy 486. My friend, Andi N. Klein, was immensely helpful to me in countless ways, including spending a tedious evening helping me cut up the Q-sort slips. His jokes about my tendency to procrastinate nudged me back into working again and again. Andi and Kathrin Hartmann kindly listened to a practice talk in preparation for the defense meeting; they both offered invaluable suggestions for improving the presentation.

A dissertation is but one requirement for a doctoral degree. My graduate education would have been inordinantly more difficult if not for the support of good friends. Jennifer and Sean Priest took pity on a "starving graduate student" and kindly shared their dinner table with me consistently for the two years that we were next-door neighbors. Janet Fay-Dumaine, Kathy Dring, Beverly Koloian, and Pam Knox are more than fellow VCPP students, they are valued friends who helped sustain me through the longest four years of my life!

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I myself have never been able to find out precisely what feminism is: I only know that people call me a feminist whenever I express sentiments that differentiate me from a doormat.

Rebecca West, 1913

Introduction

What is feminist family therapy? Simply, "feminist family therapy is the application of feminist theory and values to family therapy" (Goodrich, Rampage, Ellman, & Halstead, 1988, p. 12). It seems a straightforward definition, yet a sampling of the feminist family therapy literature reveals different understandings of feminist theory and how it should be applied to family therapy:

> Therapy is political action.....Family therapy is not social change.....From a feminist standpoint, any theory of family or therapy has be measured against the case of power.....If you define everything in the family in terms of power issues, you are defining the family according to the world view of men.....Our feminist family therapy has nothing to do with getting the woman to realize that she is "oppressed".....It is the responsibility of the therapist to address gender issues and make them explicit to the family.[1]

What feminist family therapy *is* depends very much on whom you ask. The present study attempts to chart this territory by identifying the main viewpoints in feminist family therapy and by comparing and contrasting the similarities and differences of opinions.

The first article on feminist family therapy appeared in 1978. In that article, Hare-Mustin (1978) argued that feminist principles could be incorporated

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[1] The sources for these quotes in order are: Pilalis & Anderton, 1986, p. 102; Goldner, 1985a, p. 44; Goodrich, 1991, p. 23; Simon, 1984, p. 38; Simon, 1984, p. 39; Goodrich, Rampage, Ellman, & Halstead, 1988, p. 21.

easily into existing family therapy frameworks. Several feminist family therapists soon challenged that notion. The first papers maintained that systems theory and feminism are incompatible (Goldner, 1985a; James & McIntyre, 1983); others urged systems theorists to become *more* systemic and incorporate feminist analyses of the larger social/political system (Lerner, 1988; Pilalis & Anderton, 1986). Critiques of existing family therapy schools followed (Ault-Riche, 1986; Penfold, 1989). The feminist family therapy field continued to grow and eventually forwarded various models for feminist practice.

Although many areas of apparent consensus remain, some issues are now debated. For example, feminists disagree about therapist position. Some believe that a feminist therapist should maintain a hierarchical position with clients (Goldner, 1991; Magraw, 1992); others advocate minimizing the power and status differentials between therapist and client (Hare-Mustin, 1978; Osborne, 1983). When working with violent and/or incestuous families, one opinion holds that conjoint therapy is contraindicated (Avis, 1988; Bograd, 1986a); another view insists that change can only occur through conjoint treatment with the marital/family system (Magraw, 1992). Another debated issue is whether there is a place for psychoanalytic concepts within feminist family therapy: must a feminist family therapy include some theory of the individual? Some say "yes," (Goldner, 1985b; Luepnitz, 1988) others say "definitely not" (Magraw, 1992). A recently emerging issue is if feminism addresses all forms of oppression (Hall & Greene, 1994).

Feminist family therapy--like feminism itself--has its share of critics. One criticism is that feminist family therapists impose values on clients (Nichols, 1985). Others regard the brand of feminism espoused within family therapy as only applicable to white, middle-class women (Coyne, 1992). Still others consider sexism a minor problem in comparison to other social ills (Kingston, 1986). Criticism of feminist family therapy is also linked to the current "sameness-difference" debate in feminism: are women and men "inherently" different? One view is that feminists should stop exaggerating the differences between the genders, both in the wider social context and in therapy (Nichols, 1991).

It is difficult to make sense of the varying applications of feminist theories and values to family therapy. What issues do feminists agree on and on what issues do they disagree? What ideas and beliefs support the differing views contained in the literature? Do feminist family therapists endorse any of the criticisms leveled by commentators? Would therapists who do not take a feminist approach to family therapy subscribe to any feminist ideas or agree with any of the feminist critique of traditional family therapy? The purpose of the present study is to begin answering these questions through Q-methodology.

Q-methodology is a quantitative, empirical method for objectively analyzing points of view among small samples of persons (McKeown & Thomas, 1988). By ranking a circumscribed set of stimuli, (which could be statements, photographs, video excerpts, etc.), the respondent provides a model of her or his

perspective on the topic under study. Each person's rankings of the stimuli are correlated, showing who has sorted the items in a similar way. Factor analysis shows the main points of view represented by the respondents; a person's factor loading indicates with which viewpoint she or he is most associated. In the present study, a sample of statements representing the areas in which there appear to be consensus and divergence on feminist family therapy was given to feminist and non-feminist family therapists to examine how points of view were segmented among them.

Feminist Family Therapy Literature

One can trace the development of feminist family therapy through a review of its literature. After the publication of the first article in 1978, notable developments occurred over the next 16 years. Perhaps what gave feminist family therapy its biggest boost was the spotlight it received in two consecutive years, 1984 and 1985, in the *Family Therapy Networker.* Eight years into its development the first book appeared, an edited volume of 10 chapters. Also around that time feminist family therapists began to appraise the current status of the family therapy field and offered an opinion that feminism could keep the family therapy field from getting entrenched in "more of the same."

Ten years into its history, two quite different books concerning the practical application of feminist family therapy were published. Feminist family therapists also began to promulgate their views in fields related to, but outside,

mainstream family therapy. By this time, as well, the field was beginning to flourish with numerous articles. In the early 1990s, feminist family therapists were confident enough to assertively outline the patriarchal notions that ensure "failure" as a family therapist. Another topic that began to receive attention in the early 1990s was working with men in feminist family therapy. Finally, in at least five studies, researchers have examined feminist family therapy empirically.

Developmental Milestones. Hare-Mustin's (1978) article, "A Feminist Approach to Family Therapy," introduced feminism to the family therapy field.[2] Her article became the point of departure for feminist writings on family therapy. Hare-Mustin critiqued family therapy from a feminist viewpoint and outlined techniques for a feminist approach. These included:

* Making a contract for therapy with the family as a way of establishing mutual accountability and to help the family discover how they negotiate their own rules;
* Giving task assignments that are free from sexist bias;
* Using rules of communication developed by women's consciousness-raising groups;
* Becoming aware that generational coalitions may have more to do with power imbalances in the family than with pathology;
* Being mindful of language and the messages word choices convey (e.g., "father absence" and "maternal deprivation" p. 189);

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[2] Although a year earlier Rice and Rice (1977) published an article on non-sexist marital therapy, feminists distinguish between feminist and non-sexist therapy (Simola, 1992).

* Acting as a model for the women in the family;

* Reinforcing all family members for steps taken to connect with people and interests outside the family;

* Being aware that alliance with clients can be either in service to the women in the family or not, and critically examining one's own self for biases.

Hare-Mustin asserted that feminist principles could be applied successfully to family therapy.

At the end of 1978, Carter, Papp, Silverstein, and Walters organized The Women's Project in Family Therapy. Their objective was to provide a vehicle for introducing feminist principles into family therapy and developing a theoretical framework for the study of women's issues. They brought their work together, individually and collectively, in the publication of *The Invisible Web* in 1988. The book represents the women's different theoretical orientations and provides many case examples.

In 1984 and 1985, the *Family Therapy Networker* brought feminist family therapy to a wider audience through a series of articles. Layton's (1984) article, the first in the 1984 issue, delineated how psychoanalytic ideas could be incorporated into feminist family therapy. She focused on the ways in which family therapy ignores gender issues and denies the importance of parent-child relationships, male-female relationships, attachment and intimacy, and the marital relationship. Layton believes that family therapy's disregard of gender issues is a direct result of its rejection of psychoanalytic theory -- a theory that

"has never been shy about the subject of gender" (p. 21). She maintains that "in family systems theory, the old rubric of the female as a sickly version of the healthy male has not been discarded, it is just hidden in the notion of the differentiated self" (p. 22). Layton argued for a refocusing on the marital dyad, rather than on the family triangle. In her view, it is essential that family therapy adopt an understanding and theory of gender relationships.

Following Layton's article is an interview with the organizers of The Women's Project in Family Therapy (Carter, Silverstein, Papp, and Walters) (Simon, 1984). The women's comments outline some of the feminist criticisms of family therapy (e.g., the family exploits women) and demonstrate their awareness of the criticisms leveled at feminist therapy (e.g., imposing values on clients). In the final article, Riche (1984) criticizes the feminist principles of non-directive and egalitarian therapy. She believes that such axioms create an irresponsible therapist: Therapists must direct therapy. For her, this means using strategic techniques and employing a hierarchical relationship with clients. A case study follows that outlines when she "think(s) as a feminist, when as a family therapist" (p. 43).

In the following year, 1985, the *Networker* again focused on feminism. The feature article presented five case studies of feminist family therapy. For each case the various authors describe applications of feminist theory to different models of family therapy. Lerner (1985) draws parallels between feminism and Bowen family therapy. As she notes, "Bowen and his followers at

The Georgetown Family Center openly disagree with feminist ideology" (p. 36). Indeed, Bowen's notion of differentiation has been the subject of repeated criticism from feminist family therapists. Lerner uses Bowen techniques to help a daughter work through her relationship with her mother so that the daughter can move forward in her own marriage and life. Layton (1985) approaches her case from a psychoanalytic perspective, employing re-parenting and role reversal as the therapeutic correctives for the couple in therapy. Her guiding paradigm is to discover the unmet needs of each person in the dyad in the belief that "spouses not only search for what they never had; they also homeostatically repeat what they have always had" (p. 41).

Bepko's (1985) approach in her therapy is to "make the power issues explicit and encourage both women and men to be more aware of the price of power" (p. 49). In the marital case described, Bepko attempts to help a couple negotiate a proposed relocation for the husband's employment in another state. She encourages the wife to take a firm stance on the proposed relocation and urges the husband to examine the emotional issues surrounding the couple's discord. In the fourth case, Goodrich, Rampage, Ellman, and Halstead (1985) adopt a team approach. The primary therapist consults with the team after the first session to analyze the case from a feminist perspective and to plan the treatment. Therapy in this case study centers on helping the client to become aware of her cultural training and to expand her vision of possibilities; the choice of what to do is left to the client. The final case, written by Silverstein (1985),

tackles a mother-daughter relationship. Silverstein uses strategic therapy and a paradoxical directive to reconnect the two women.

The first book on feminist family therapy appeared in 1986, *Women and Family Therapy*. Edited by Ault-Riche (1986), the volume contains ten chapters including a thorough critique of five schools of family therapy; training therapists to take a feminist perspective; interactions with established social systems; chapters on working with violence, alcoholism, depression, eating disorders, minority women, lesbian relationships; and a final chapter on nuclear war. Each chapter contains a feminist analysis of these problems and/or ways of living for women in the United States culture.

In 1986 and 1987, feminist family therapists reflected on the current state of the family therapy field and feminism's place within it. Imber-Black (1986) viewed family therapy as faced with important choices in its development in the mid-1980s. She believed that family therapy could "pull in and consolidate" or expand its horizons by examining families in the larger sociopolitical context. "Drawing a boundary around the family as 'client' is.....a political act, one which unwittingly allies the family therapist with broad social forces affecting" families (p. 30). According to Imber-Black, excluding content in the search for pattern is a serious oversight. When family systems theory asserts that content has no meaning, Imber-Black pointed out, a content is in fact created that supports the status quo. She argued that the concepts of circularity and triads do not provide systems therapists with tools to help those persons who have less power, and

less access to resources, than others in the system. In her view, family therapy needs to teach trainees how to be astute analyzers of the social and political forces affecting the family.

While Imber-Black saw family therapy as at a crossroads, Hare-Mustin (1987) viewed family therapy as "driving on cruise control." In Hare-Mustin's view, family therapy theorists refuse to acknowledge and address a fundamental issue: "Gender is the basic category on which the world is organized" (p. 15). Hare-Mustin labeled this ignoring of gender differences "beta prejudice." She illustrated beta prejudice in systems theory as working from the assumption that a husband and wife share the same hierarchical level. Therefore, they have equal access to power and resources. However, as she noted, this condition does not exist in today's society.

In contrast, psychodynamic theory exaggerates gender differences, an error Hare-Mustin labeled "alpha prejudice." According to Hare-Mustin, family therapists who use a psychodynamic approach base their thinking and interventions on a model of human functioning that creates a dichotomy between masculine and feminine and "leads to a hierarchy, one considered superior to the other" (p. 24). Hare-Mustin concluded that beta and alpha prejudices inherent in family therapy theories means that there will be only "more of the same" for families unless the field makes some fundamental changes.

Goldner (1987) elaborated on Hare-Mustin's concerns by asking the question, "what works for *whom* in family therapy?" Family therapy, in Goldner's

view, has become a technology. Problems are identified and a technique is applied to provide a solution. "The issues that divide men and women, parents and children, cannot be reduced to technical organizational problems (he's too close, she's too distant). They are, ultimately, moral, political, historical, and existential dilemmas" (p. 110). Circularity remains a double description in Goldner's opinion: descriptively it implies an equal balance in the dance of reciprocity. In reality, men are at the top of the hierarchy, retaining the power. Pointedly, Goldner observed that family therapy treats love and the maintenance of relationships--the woman's job--as though it were not work and did not require skill. She maintained that therapists rush in to "fix" the family structure, rely on the woman to hold the family together and simultaneously blame her for the problems in the first place. Goldner emphasized that without examining the sociopolitical and historical context of the family, family therapy never considers if the basic structure of the family as it is serves everyone well.

Among feminists in academia there was a growing debate about the similarity versus difference approach to studying and understanding women's lives. An article by Hare-Mustin (1988) reflected this debate in feminist family therapy. She was critical of the work of Gilligan, and others like her, because she saw the stress on difference as again recreating Parsons' division of the instrumental man and the expressive woman. The culture eagerly adopts such theories because, in Hare-Mustin's view, they keep things the same -- men are not encouraged to be more expressive, women are not encouraged to be more

instrumental. In her opinion, family therapy has not generated new models of working with the family that account for women's changed status in the larger culture. It is frequently forgotten, she noted, that women with children who work outside the home are doubly burdened, and that women, as well as men, undervalue the work that women do to maintain family relationships and household functioning. According to Hare-Mustin, family therapy continues to operate with an image of the family in which women function in one sphere and men in another.

By 1988 there was enough published literature on feminist family therapy for Avis (1988) to write an overview of feminist thinking in family therapy and to provide a bibliography. Indeed, Avis notes that only in the last five years of the preceding ten had the number of articles published made her article possible. Avis includes a summary of the feminist critiques of family therapy and explains the different "schools" of feminism. She reviews research on sex differences and women's mental health, and then-current theories of women's psychological development. An annotated bibliography of fifty-one readings follows the review.

Two substantive blueprints for conducting feminist-informed family therapy were published in 1988. One was Goodrich, Rampage, Ellman, and Halstead's *Feminist Family Therapy. A Casebook.* As the title implies, most of the book consists of case examples. The title leads the reader to expect descriptions of families in therapy, but most of the cases involve childless couples. The authors write that they intentionally focused on couples to avoid

"generational distraction" and to keep the spotlight on gender issues. The cases describe a "corporate" (upper-middle-class) couple, a single-parent family, a "standard" ("hysterical-obsessional relationship") couple, a lesbian couple, and a physically violent father.

Their approach to therapy is to use a team for consultative purposes. After the intake session (and subsequently as the primary therapist desires) the team consults together on cases:

> Regardless of the particulars of the case, there are certain questions which we regard as crucial to a feminist consultation and always keep before us: How are our clients understanding gender, and how is that understanding limiting their ability to solve their problems? How are we understanding gender, and how is that understanding affecting our conception of the client's problem? What gender bias is contained in the theory we are using and how is it hindering the therapeutic process? (pp. 36-37).

Goodrich et al. stress that their feminist family therapy is not a "grab bag" of therapeutic techniques, but a political and philosophical orientation which informs their therapy. They believe that any standard family therapy technique may be used as long as it is not applied in a sexist manner and does not reinforce the patriarchal status quo. In their view, the therapist should be competent and expert, respectful and nurturing, toward clients. An essential part of their model is analyzing and making explicit to the family the gender issues involved in the family's problem. For these therapists, the goal of therapy is not just to change the family, but to change the way the family relates to society and to each other as individuals.

Markedly different from *A Casebook*, Luepnitz incorporates a psychoanalytic orientation in her book, *The Family Interpreted. Feminist Theory in Clinical Practice* (1988). Although she offers three case examples at the end of her book, Luepnitz does not claim to have developed a complete model for her feminist family therapy. At the time of publication, 1988, she believed a fully formed feminist family therapy to be at least 10 years down the road. Luepnitz devotes significant attention to the history of the family because "family therapists are interested in change. To change something responsibly, one must know it in context" (p. 9). Where she departs from most other feminist family therapy writers, however, is in her staunch belief that there will never be a feminist cybernetics. For Luepnitz, object relations (as revised by feminists) is the best choice for incorporating an understanding of the individual and gender roles into family therapy.

In Luepnitz's model the therapist provides a "holding environment" for the family and teaches family members to be holding environments for each other. Luepnitz uses transference and countertransference to understand the family and to discern what may be happening in the family. The family's projection onto the therapist and onto each other provides material for hypothesis formation and interpretation. Transgenerational repetition provides the key to help couples understand how they came to choose one another. Luepnitz moves beyond interpretation and applies feminist principles to help families plan change. "The feminist therapist is definitely concerned with helping the family achieve

symptom-relief, not in just any possible way, but in ways that allow the family to be less patriarchal, less father-absent, and more connected to the community than before" (p. 193).

Hare-Mustin attempted to introduce the feminist critique of family therapy to a wider audience in 1979 and 1980. However, it was another eight years before that critique showed up again in fields outside and tangential to mainstream family therapy. Hare-Mustin's 1979 paper, "Family Therapy and Sex Role Stereotypes," was published in the *Counseling Psychologist.* She outlined the traditional view in family therapy (i.e., "dominant mother-ineffectual father as the cause of practically every serious psychological difficulty" p. 31) and then critiqued that from a feminist point of view. As in her 1978 paper, she offered similar guidelines for working with families that would diminish sex role stereotypes.

The second paper, "Family Therapy May Be Dangerous for Your Health," was published in 1980 in *Professional Psychology.* In this article, Hare-Mustin elaborated two main points. First, traditional family therapy focuses on what is good for the family and ignores the needs of the individual in the family. Second, the 1950s traditional family is held up as a model of ideal family mental health. Hare-Mustin maintained that both problems may "disadvantage individuals and limit their well-being and mental health" (p. 938) in family therapy.

Eight years after Hare-Mustin's articles, Bograd (1988b) contributed a chapter critiquing family systems theory in a book on feminist psychotherapies. In a counseling journal, Enns (1988) reviewed the feminist critique of family therapy and provided suggestions to family counselors for adopting a feminist approach with families. (Her article prompted a critical response from Lopez (1989) in the same journal. He faulted Enns for being "epistemologically incorrect" by confusing and trying to combine linear and circular views of behavior.) Candib's (1989) presentation at the Ninth Annual Workshop of the Society of Teachers of Family Medicine later appeared in print in *Family Systems Medicine.* Candib critiqued family-life-cycle theory for its sex-role stereotyped assumptions, its discrimination against poor and minority peoples, and its homophobia. She called for a family-life-cycle theory in medical practice that would incorporate the entire range of human relationships and diversity. According to the editor's note preceding her article, Candib's talk "stimulated much heated response and follow-up discussion" (p. 473).

Avis' (1989) updated bibliography reflects the multitude of articles published in 1988 and 1989 on feminist family therapy, and related topics. Whereas her 1988 annotated bibliography included fifty-one journal articles, book chapters, and books, her 1989 list includes 118 references. Despite the increasing number of publications on feminist concerns, by the end of the 1980's some feminists had abandoned family therapy altogether (Penfold, 1989). Penfold (1989) appealed to feminists to stay with family therapy rather than

abandoning it because of its "inherent contradictions." She warned that without continuing feminist contributions, family therapy would not develop new theories and models that incorporate women's different experience and socialization.

Twelve years after Hare-Mustin's ground-breaking article, the feminist critique of family therapy had solidified enough for Kaschak (1990) to write a humorous article entitled, "How To Be a Failure as a Family Therapist." She gives 10 guidelines for failing with families:

(1) Ignore as irrelevant both the structure and function of the family as an institution (p. 71).

(2) Assiduously ignore the ill effects of marriage and the family upon women (p. 72).

(3) Never ask whether the traditional model of the family can be altered sufficiently or alternatives developed that are not oppressive to women (p. 73).

(4) Believe that the systems model is an evaluatively neutral cybernetic model; do not admit to having values at all; look back with great nostalgia and longing on the decade of the 50s (p. 73-74).

(5) View female domination in any sphere as a problem (p. 75).

(6) Insist that neither conceptualization about nor intervention in families requires consideration of the larger systems within which the family system is embedded (p. 75).

(7) Never consider gender as relevant to your work (p. 76).

(8) Ignore or consider irrelevant your own gender and its stimulus value (p. 77).

(9) Never concern yourself with who has the power in society, as this has nothing to do with power distribution in the family (p. 78).

(10) Know that everyone participates in maintaining any given behavior in a family. It serves a function for all members. Moral assessment is not your concern (p. 79).

In the early 1990's, several feminist family therapists began to examine men's place in families and feminist family therapy. In *Gender and Power in Families* O'Brien (1990) contributed a chapter exploring "how adult males respond to emotional problems" (p. 196). O'Brien believes that it is essential to study both the dominant and the subordinate players in patriarchal systems. Otherwise, she asserts, we will never fully understand how power differentials are maintained in the family. In this same book, Mason and Mason (1990) describe a workshop limited to male participants that they conducted at a conference on feminism and family therapy. Their view is that men need to be convinced that they, too, stand to gain from re-ordered gender relationships.

Feminist Approaches for Men in Family Therapy, edited by Bograd (1990), originally appeared in the *Journal of Feminist Family Therapy* and was later published as a book. The premise of this work is that if feminist family therapy makes claims for being *more* systemic, then this analysis must also include the negative impact of gender role stereotyping on men and how they function in their families. Chapters address issues such as how traditional family therapy frameworks may prevent men from making changes; integrating feminist perspectives with recent men's studies; the interactions between women therapists and men in families; male perspectives on depression in men and

men's relationships with their mothers; and sections on treating violent men and training male therapists in a feminist therapy orientation.

The vast majority of feminist writings on family therapy have been theoretical pieces and case examples. There have been, however, some empirical studies. These include the development of two rating scales; a comparison of feminist family therapy with the structural and strategic schools; and an investigation of mother blaming by family therapists.

Empirical Research. Chaney and Piercy (1988) attempted to operationalize feminist family therapy through the development of a "Feminist Family Therapist Behavior Checklist." The 39-item checklist identifies therapists' feminist family therapy skills in five major areas. The five areas are: Sex-Role Analysis, Shifts Balance of Power Between Male and Female Clients, Therapist Empowers Female Clients, Skill Training, and Therapist Minimizes Hierarchy Between Therapist and Clients. There are four to twelve techniques under each of the five areas; these are checked off for their presence or absence in a family therapy session. The items were selected from an unpublished dissertation on feminist family therapy, feminist family therapy techniques in the published literature, and the techniques used by Chaney in her family therapy practice.

Sixty therapists used the final version of the checklist to rate videotapes of full therapy sessions. The researchers found that the checklist "discriminate(d) between self-reported feminists and non-feminists, between men and women, and between expert categorizations of feminist and nonfeminist

therapy sessions" (p. 305). Chaney and Piercy developed the scale in the hope that it might be used to test empirically the effectiveness of feminist family therapy.

Black and Piercy (1991) produced "The Feminist Family Therapy Scale." They designed this scale to measure the degree to which a therapist conceptualizes family therapy from a feminist perspective. On a Likert scale, respondents indicate their degree of agreement with 17 items. Two examples of items on the scale are, "Traditional approaches to family therapy validate the uniqueness of women's experience" and "If therapists do not challenge traditional relationships, clients will perceive this as approval of these relationships" (p. 120). Scale scores represent a respondent's conceptualization of family therapy on a continuum from traditional to feminist. Black and Piercy suggested that the scale could be used to measure trainees' conceptualization of family therapy from a feminist perspective, as an outcome measure for feminist training, and as a measure of the efficacy of feminist family therapy (when used with other instruments).

On a different investigative track, Fish (1989) compared the similarities and differences between structural, strategic, and feminist-informed family therapies. She used two previous Delphi studies to make the comparisons, finding that the structural family and feminist family therapies both view faulty family structure as the root of problems. However, each type of therapist pinpointed the source of faulty structure in a different location. Fish found that

structuralists believe that the primary culprit resided in a lack of adherence to generational structure. Strategic therapists did not focus on family structure per se, but on "how the individual defines the structure in which s/he lives" (p. 312). In contrast, feminists believed that rigid adherence to a "gender-based" structure caused difficulties in families. Fish's investigation revealed that only feminist family therapists examined family structure as it is embedded in the larger social system.

Fish elaborated on the similarities and differences between structural and feminist therapists. Both structural and feminist therapists worked to reorganize the family structure. Structuralists rearranged family hierarchy to resolve the presenting problem; feminists helped the family recognize the constraints imposed on them by the socially sanctioned (patriarchal) form of the family. While Fish found that the structural and feminist-informed family therapies shared some commonalities, strategic therapy tended to stand out on its own. Fish concluded that the three therapies have much in common and enough difference to make each a distinct form of therapy.

Two consistent feminist critiques of family therapy are that therapists blame mothers for family problems and ask mothers to make the most changes in therapy. McCollum and Russell (1992) tested these two notions by asking a random selection of AAMFT therapists to rate a brief vignette. The vignette consisted of a mother, father, 15-year-old "problem" child, and a younger sibling. Four versions of the vignette represented every possible combination of a

mother, father, and symptomatic child in various triads of who was most concerned, who minimized, and the sex of the child. They asked participants to rate each parent on a 7-point scale ranging from very functional to very dysfunctional. Each participant also provided a brief treatment plan describing who and what they would like to see changed.

Results of this study revealed that mothers did not get labeled as more dysfunctional than fathers. When the teenage problem child was female, fathers tended to be rated as more dysfunctional than mothers. "Concern about the child" was rated as more dysfunctional by participants no matter which parent was identified as engaging in this behavior. However, the authors point out that concern about a child is most often expressed by the mother. Therefore, participants in this study might be labeling a stereotypical female behavior as dysfunctional. In the treatment plans provided by participants, most therapists asked both mother and father to make changes; there was even a slight bias toward asking the father to change more.

Another study of therapists' gender bias was conducted by Ivey and Conoley (1994). They asked 70 lay people and 70 therapists to complete the Family Communication Rating Form (FCRF), the Family Conflict Negotiation Rating Form (FCNR), the Family Support and Nurturance Rating Form (FSNRF), and the Individual Rating Form (IRF) after viewing a 10-minute videotape of a family. Two videotapes were made for this study. In both, the therapist asked a family of four (a mother, father, daughter, and son) to plan a one-day vacation

together. In one condition, the mother was "moderately directive" while the father was "moderately passive." In the second condition, the roles were reversed; in both conditions the daughter was "withdrawn and nonresponsive" and the son was "oppositional."

The authors report that therapists rated the father-led family interaction as significantly healthier than the mother-led family style of interaction. There was not a significant difference in ratings between professional and lay observers. In terms of parental functioning, both types of observers rated the mother similarly. The lay participants, however, tended to rate the father more favorably in both conditions than did the therapists. When observers rated the father individually, both rated him less favorably in the mother-led family. When rating the mother's healthiness individually, lay observers rated her more favorably in the mother-led family. Therapists, however, rated the mother's healthiness about the same in both father- and mother-led family conditions. Ivey and Conoley suggested that a passive father was more harshly evaluated than a passive mother by therapists.

The authors note limitations to this study, including the fact that the therapists were not necessarily family therapists. Therefore their results may represent the general mental health population rather than family therapists in particular. They surmised that gender bias against female-led families appeared to affect therapists' evaluation of families. The researchers believed their study raised questions about the best way to train therapists about these biases.

The research on feminist family therapy is still in its early stages and it is not the primary focus of published work. Greater attention has been given to several particular issues. Predominant topics in the literature have been: the compatibility of feminism and systems theory; the pragmatics of feminist family therapy; treating incest and violence in the family; and feminists' distress about how the family therapy field has responded to feminism. In addition, there may be an emerging issue about whether feminism addresses the interests of all oppressed groups of people.

Substantive Issues in the Literature

Compatibility of Feminism and Systems Theory. A debate about the compatibility of feminism and systems theory began in the early 1980s. Some feminist writers addressed this issue from a theoretical perspective while others attempted to provide practical solutions for such a collaboration.

Libow, Raskin, and Caust (1982) believe that feminist therapy and family therapy share many similarities. Among these similarities are rejecting the medical model; using relabeling or reframing; employing therapist modeling; and using concrete, observable, behaviorally defined goals to measure client change. In areas of divergence, Libow et al. note a number of differences. They begin by noting that the view of causality is "one of the most striking theoretical differences" (p. 8) between feminist therapy and systems theory. Feminists use a linear definition of causality while family therapists typically adopt a circular view of causality. They note that feminists take historical and cultural forces into

account when examining clients' difficulties; systems theorists focus on the present and tend not to delve into the specifics of the past. According to these authors, systems therapists work toward facilitating change in the family only; feminists have an additional goal of working toward change in the culture.

The use of therapist power is another area of contention noted by the authors. Feminist therapists make use of referent power, while family therapists typically adopt the stance of one who has expert power. The role played by each type of therapist is connected to the use of power. Feminist therapists view themselves as facilitators of change; work toward minimizing hierarchical differences between themselves and clients; and eschew "manipulative" techniques (e.g., indirect suggestion). Systems therapists see themselves as in charge of the therapy and "orchestrator" of change, using whatever techniques they believe will induce change. Finally, Libow et al. note that feminist therapies characteristically advocate confronting cultural and sex-role stereotypes with clients; systems theory does not do this.

Libow et al. see advantages in combining feminism and family systems therapy. Because the family is an important social institution, feminist family therapy can change not only a particular family, but begin to influence a cornerstone of social organization. Family systems work requires therapists to be active and directive. The authors believe that when this is combined with the traditional "feminine" traits of relating empathy and eliciting feelings, a feminist family therapist has a powerful array of tools at her disposal. Through this

combination of techniques and approaches, a feminist family therapist models both instrumental and expressive behaviors.

Australian family therapists James and McIntyre (1983) have a different view of the viability of blending feminism and systems theory. They maintain that systems theory is inherently sexist because it does not concern itself with forces outside the family. "Inasmuch as family therapists see family dysfunction purely as an internal event, radically separated from its social origins, they take on an explicit social role, that of apologist for the contemporary family form, and facilitator of its reproduction" (p. 126). They argue that systems theory by its very nature is incapable of commenting on a system itself and it "must accept existing social structures" (p. 127). On its own, systems theory will never be able to account for family functioning. In their view, a comprehensive understanding of family structure and intervention requires the addition of psychodynamic and sociopolitical analyses.

Like James and McIntyre, Goldner (1985a) is pessimistic about the compatibility of feminism and family therapy. She gives three reasons why family therapy has neglected gender issues. First, it had taken until the mid-1980's for family therapy to come to grips with the fact that its theories and therapies were developed on 1950's white middle-class families. Second, feminists had not critiqued family therapy earlier because "family therapy has had virtually no impact on the culture at large" (p. 32) in the way that psychoanalytic thinking has. And, third, only now have feminists reached the life

stage where family is a priority and concern; therefore their new focus on family therapy.

Goldner believes that "the feminist assertion that power in family life is socially structured by gender simply offends the systemic aesthetic" (p. 33). She describes the historical development of the family into modern times that has resulted in two different and rigidly separate "spheres of influence" for women and men. In her analysis, "the overinvolved mother and peripheral father of the archetypal 'family case' emerge as products of a historical process two hundred years in the making" (p. 35). Family therapy's reluctance to acknowledge this historical "fact" prevents it from making changes. Viewing the family as an ahistorical and closed system means a continued reliance on using the mother to gain entry into the family, blaming her for family problems, and counting on the father's increased involvement to solve problems. Goldner concludes that perhaps the best that family therapy can do at this point is to make clear for women and men the conflicts that are inherent in their social roles.

In Lerner's (1988) view, feminism and several schools of family therapy have areas where there is agreement. She is puzzled by the resistance of family therapy to integrate feminism into its theoretical concepts. She believes that labeling feminist theory linear and systems theory circular is a "false dichotomy." According to Lerner, there is a great deal of circularity contained in feminist theory. She agrees with other feminists that systems theory is not systemic enough:

> At the heart of systemic theory is the notion that a dysfunctional individual can best be helped by disrupting and changing the rigid rules, expectations, and structures that inhibit growth in the family system. Yet, systems theory has not seriously addressed the parallel notion that dysfunctional families can best be helped by disrupting and changing the rigid rules, expectations, and structures of patriarchal culture (p. 51-52).

MacKinnon and Miller (1987) critiqued a particular combination of feminism and systems theory, the Milan approach. They stress the importance of examining the sociopolitical context in which any theory arises. The new epistemology -- the inclusion of Bateson's cybernetic approach into family therapy theories -- gained prominence in the wake of Reaganomics and substantial political losses for the women's movement. Central problems in the Milan approach, for these authors, are sweeping away the concept of power and therapist neutrality. This is especially a difficulty in cases of incest, battering, and child abuse.

The Milan school, according to MacKinnon and Miller, has many other problems that make it difficult to reconcile with feminism. It regards affective expression as one more piece of information, which in their view, reflects a male approach to therapy. Milan therapy considers the family as a unit without considering recent sociological and psychological studies critiquing the current composition of the family. It ignores the impact of a therapist's personal and political views of the family and how this influences therapy. It assumes that therapist and family are equal contributors to the therapeutic process.

MacKinnon and Miller point out that families entering therapy frequently regard therapists as professional sources of authority -- a fact that this perspective ignores.

The constructivist view within Milan therapy is an obstacle for these authors because "Many Milan therapists operate as if the family's distress is created solely by the family's individually constructed view of reality. They do not acknowledge the social processes whereby families or therapists arrive at the content of their constructions...." (p. 152). The authors acknowledge potential in second order cybernetics and the constructivist view if the questions asked to families included, "Who has been most influential in determining current beliefs? Who is most served by the current beliefs and social definitions of problems and relationships? What has been the socio-historical evolution of these beliefs" (p. 153). However, the way therapists apply the Milan approach now, they conclude, is in collusion with currently conservative Western political thought.

Approaching the debate from a pragmatic viewpoint, Pilalis and Anderton (1986) offered their model of a feminist family therapy. They combine systems theory and socialist feminism. In their view, the two paradigms merge where "feminism provides the supplementary analysis required in family systems theory, and family systems theory provides feminism with a more developed understanding of the processes of problem formation and resolution in the family system" (p. 105). Interestingly, Pilalis and Anderton regard power as a "view of

causality" that family therapy and feminism have in common. Many feminists critiquing family therapy would disagree strongly with this assumption.

Their model assumes that problems are maintained by all who are involved in it, including the "outside" force of societal norms. The goal of therapy is to "empower family members in relation to each other and to empower the family in relation to society" (pp. 106-107). Their techniques include:

* Reframing the presenting problem to include a description of the current power issues in the family;
* Using circular questioning to elicit information regarding power relationships and the connections between these and the presenting problem;
* Describing for the family the link between power relationships and the presenting problem;
* Assuming the role of facilitator-educator for the family;
* Asking the family to negotiate therapy goals with each other so that a common perception of the problem emerges and with it a solution;
* Acting as a model for the family in how to negotiate, interpret, and self-monitor;
* Using both expert and referent power (pp. 110-111).

Grunebaum (1987) proposed contextual therapy as the method most suited to solving feminist objections to status-quo family therapy. The advantages are that it is systemic *and* includes "the important human dimensions of intention, choice, and responsibility" (p. 650). Uniquely, Grunebaum maintains, contextual theory and therapy purposefully address "imbalances of reciprocity" (p. 653). The therapist takes each person's side and

simultaneously holds her or him responsible. Thus, therapist neutrality is not an issue. The therapist addresses power differentials directly as s/he works to resolve factual injustices with various family members. Further, these power imbalances can be talked about in the family therapy as by-products of dominant social structures, both past and present.

According to Terry (1992), systems theory does not consider gender training and feminism adopts the view that women in therapy can solve their socialization handicaps without their partner present. Terry attempts to "blend" these two views, bringing together the "interaction between the familial interactional and the sociocultural contexts" (p. 201). She believes that therapists must be careful not to impose upon families their own understanding of gender-role inculturation. The therapist should find out how each person in the family understands "sociocultural beliefs" and how each person incorporates their beliefs into family life. Different family members may "hear" different beliefs due to their position in the family, experience, and gender.

Although Terry does not give specific techniques for assessing couples, she notes that therapists should examine gendered beliefs in the following contexts: "congruency versus incongruency of meaning" between familial and sociocultural levels; "overtness versus covertness of meaning" (i.e., can the family handle conflict directly or not?); and "rigidity versus flexibility."

Pragmatics of Feminist Family Therapy. In addition to the books cited earlier that describe techniques of feminist family therapy, there are some

articles addressing the pragmatics of feminist family therapy, both in technique and in the training of family therapists. Because violence in the family has been extensively addressed, both theoretically and pragmatically, it is being treated separately in the next section.

An essential goal of feminist therapy is empowering women. But how does a therapist empower a woman? Avis (1991) outlined her methods for empowering women in therapy, beginning with the premise that the patriarchal context in which women live cannot be changed through therapy. What can be altered is how a woman responds to her social context. Avis begins by providing a supportive environment in the therapy room. For example, when working with a distressed couple, she spends a number of sessions working with the woman alone. In this way, the woman client is free to express herself without being concerned about placating her male partner. Before beginning conjoint sessions, Avis spends several individual sessions with the male partner to explore his beliefs and difficulties with the partnership.

One of Avis' first goals is to tell her women clients that she believes they are their own best expert on themselves. She nurtures this capacity through metaphor and by encouraging the woman to listen to herself. Avis accomplishes this through several techniques, including inner guide exercises, reframing symptoms as messages from the inner self, and Eriksonian hypnotherapy. Avis avoids "over-helping" her clients, takes their fears seriously and joins "with the part of her that is reluctant, affirm the importance of going slowly, of listening to

all of herself, and of waiting until she is ready to make any change" (p. 146). To change a client's belief system, Avis employs cognitive restructuring and provides new information. With her clients, she explores gender-role socialization, addresses how household responsibilities are delegated (and who has the power to delegate), and provides factual information that challenges ingrained beliefs.

The next step, for Avis, is to encourage women to be pro-active on their own behalf. She invites women to accept the notion that they are responsible for taking action for themselves. Anger is reframed as a useful tool for self-understanding and an impetus to take action. Coaching women on how to say "no," is another path to empowerment. Educating her clients on how to interpret and handle "change-back messages" helps women to integrate their therapeutic gains. Avis also regards group work as an extremely useful method for helping women to empower themselves through the support and challenge they receive from other group members.

Sheinberg and Penn (1991) integrated recent developmental research on gender differences/similarities and therapeutic techniques to develop a series of questions for use in therapy. Their vision is that both women and men are sometimes connected and sometimes differentiated. To help family members develop both capacities, these therapists ask "gender questions." Gender questions are brought into the therapeutic conversation when it appears that rigid gender beliefs are constricting clients' possible range of behaviors and

responses to life circumstances. Questions focus on the gender "norms" clients are aspiring to, the norms their parents aspired to, and how they might "re-norm" themselves for the future.

The authors use a second technique they call a "gender mantra." The gender mantra is constructed for an individual; it contains elements of the client's current relationship and family-of-origin relationship. The first part of the mantra targets the client's usual response, and the second part ties that into the unacknowledged desire for attachment. Clients invoke their individualized mantra when they find themselves on the brink of a problematic and repetitive behavior or thought. For example, a woman whose mother did not want her to compete with her brother, experiences agoraphobia when she is at risk of surpassing her husband's achievements. Sheinberg and Penn developed this mantra for her to say when she felt anxious: "I hold back from putting myself first in the hope that I will win my mother's love and approval" (p. 40).

There are few detailed feminist re-workings of standard family therapy techniques. An exception is Hill's (1992) reformulation for paradoxical techniques. Her method of invoking paradox includes giving the client as much information as possible about the proposed intervention. She believes that "clients are perfectly capable of knowing that what they are doing is somehow 'playing a trick' on themselves without it interfering in the least with the impact of that trick" (p. 290). In addition, she often collaborates with her clients in designing the paradoxical task itself. She calls her technique "open paradox."

Training family therapists in a feminist orientation has been explored in at least two articles. Okun (1983) wrote one of the first. She believes that a family therapist needs both instrumental and expressive behaviors. In her view, gender differences are both biologically and culturally determined and each sex must learn the behaviors associated with the other. Female therapists must learn instrumental behaviors and male therapists must learn expressive behaviors. Okun recommends training exercises, experience, and supervision that help trainees "become aware of their implicit as well as their explicit gender values and behaviors" (p. 55) and helps them develop those modes of expression unfamiliar to their gender role.

Leslie and Clossick (1992) outlined another approach for teaching family therapy from a feminist framework. They begin with the premise that there is no existing model of feminist family therapy, only suggestions for adapting existent models to a feminist perspective. Consequently the authors extrapolated five more-or-less agreed upon tenets from feminist family therapy writings and outlined specific strategies for teaching these principles to students. For example, their first tenet is that there is no such thing as value-free therapy. Thus the "teaching objective" is to help students identify their own values. This might be done through observing videotapes of their own work and "deducing" what their values are from the comments and interventions they make. The authors also address specific issues in teaching from a feminist perspective. Among these are: Should feminist principles be taught integratively throughout

all courses or as a specific-topic class? What should it be called -- feminist? non-sexist? Finally, the authors advocate greater attention to men's experience so that feminist family therapy does not replicate for men what the male models have done to women in families.

Treating Violence in the Family. Feminists are critical of traditional family therapy's assumptions about incest and violence in the family. The standard approach, in the feminist view, blames the victim and exonerates the perpetrator, or simply diffuses responsibility for violence in the family.

Incest. In response to an article published in *Family Process* describing incest as the result of a closed family system, Carter, Papp, Silverstein, and Walters (1986) tackle a specific instance of when systems theory ignores gender and social context. Carter et al., assert that the underlying structure of the incestuous family is not the result of geographical isolation (as claimed in the original article), but is the result of a patriarchal father who tyrannically dominates the family in every respect. Incest must be examined in the context of a society, culture, and political system that "sets the stage for it" (p. 302). Therapeutic intervention must address the offending individual, the family system, *and* the social system. The offender must take personal responsibility for his actions and commit himself to changing his behavior and views. "Individual or family therapy that proceeds with 'business as usual,' expecting the abuse to cease as a result of the sessions, will become

part of the problem" (p. 303). If the offender returns to the family, the mother and father must confront and change the patriarchal structure of their marriage.

Reviewing the predominant thinking in family therapy about incest, James and MacKinnon (1990) outline four "facts" in the literature that are really theories for the cause of incest. They regard as myths:

1. Pathological fathers and inadequate mothers;
2. Family fears of separation and loss;
3. Family isolation;
4. Systemic responsibility for incest (p. 73).

In their view, such theories (or myths) have been imposed on the data. For example, an isolated, enmeshed, and rigid family may be the result of years of incest rather than its cause. The authors believe that feminist analyses do not provide a clinical methodology for treating incest. Therefore, they provide criteria for a clinical model. First, any clinical approach should consider the interventions provided by other helping and social control agencies (e.g., child protective services) and what impact these interventions have on the family. Second, theories should be hypotheses and data used to explicate consistencies and inconsistencies in the theory. Third, a useful clinical methodology would account for everyone's perspective -- victim, perpetrator, and other family members. Fourth, a clinical approach needs an understanding of the elements of patriarchy that undergird the behavior of perpetrators who are predominantly male and of women who involve themselves in abusive relationships. On this last point, they note that it is not enough to say that incest

is an extreme example of patriarchy in action. This does not explain why most men do not commit incest or other acts of violence. Rather, a clinical approach should analyze "the construction of men and masculinity, women and femininity, within a patriarchal culture" (p. 87) and within an interactional framework.

Barrett, Trepper, and Fish (1990) proposed a feminist model for treating incest. They believe that family therapy is crucial to treating incest; if interventions are not made at the family level, the system which maintains the cycle will not be interrupted and changed. However, treatment must be approached in a different way. Their model combines individual, group, and conjoint family therapy. The goals of this model are: (a) to help the victim feel less helpless; (b) to restructure the family in a more egalitarian form, elevating the status of the mother; (c) to move the father to admit his actions and take responsibility for them, and reduce the "sex-affection" link in his mind; (d) to teach the father an appropriate parenting role. At all times the primary concern is to protect the incest victim.

By combining social constructivism and feminism, Sheinberg (1992) proposes that three dilemmas typically facing therapists when treating an incestuous family can be made into therapeutic opportunities. When the judicial system requires therapists to report back to them, therapists become, in part, agents of social control. This additional role can place them in jeopardy with the family, who may no longer see them as therapists. Sheinberg suggests that the therapist and family coauthor any required report, focusing in the document on

how the family plans to change. A second dilemma occurs when families deny or minimize incest. Labeling incest the "shameful story" and eliciting from the family other aspects of family life through a "family continuity story" are ways around this potential impasse. In each case, questions to the family are posed from a feminist perspective. For example, "who in the family believes that girls and women are better able to endure emotional pain?" and "what would happen to the males in this family if the women openly empathized with the victim?" (p. 209).

Frequently, therapists must work with mothers who are not supporting their abused daughters or who are providing ambivalent support. Sheinberg notes that women are torn between culturally ingrained messages: be loyal to and protect men; protect and be loyal to your children. In her therapy with such women, Sheinberg believes that it is important for a woman confused by these messages to have therapeutic time to talk about her negative feelings toward her partner and those things about him which she loves and values. Otherwise, the woman's positive feelings about her partner become "shameful confusion." When a therapist hears, nonjudgmentally, how a woman cared for her abusing partner, it allows the woman to move fully into protecting her daughter. She no longer has to view herself as crazy or sick for having cared for and been attached to such a man.

Throughout therapy, Sheinberg draws on Gilligan's notions of a "care" and "justice" orientation to morality. Her goal is to get family members,

especially abusing fathers, to have both a sense of the wrongness of the abuse and empathy for the victim and other family members.

Wife Abuse. Perhaps the greatest point of contention among feminists is *how* to treat family violence. Should it be treated individually or in marital/family therapy? In the case of wife abuse, James and McIntyre (1990) propose that couples therapy is acceptable. However, examining the relationship dyad is only a starting point. Therapist and clients must move on to focusing on the socio-political system that condones male violence toward women and "unsettle the couple's predominantly psychological understanding of their situation" (p. 72).

McGregor (1990) faults James and McIntrye for their approach. She believes couples therapy is never appropriate for wife abuse because it will always, in some way, blame the victim. The only appropriate therapy for perpetrator and victim is individual treatment for each. She stresses that individual therapy is the only format in which the victim can learn that she is in no way responsible for the violence done to her.

In a four-year project with violent couples who requested conjoint therapy, Goldner, Penn, Sheinberg, and Walker (1990) began their work with three assumptions. First, they believe that women are both victims and participants in a complementary relationship pattern. Second, the abuser is responsible for his violence and the woman is responsible for protecting herself as much as she can. And, third, as much as possible, they separate their work from the activities

of social control. They describe their position as "both-and," explaining that violence "may be 'explainable,' but it is not excusable" (p. 345). These authors think from multiple perspectives, including psychodynamic, social learning theory, sociopolitical analysis, and systemic concepts. The approach rests heavily on deconstructing rigid gender role beliefs that clients have incorporated into their relationship. When that has been accomplished, clients can work toward changing the relationship or leaving their partner if change is not possible.

Gutsche and Murray (1991) believe that there is a place for conjoint therapy, although it is not suitable for every couple. They will not provide conjoint therapy when one or both partners is a substance abuser and simultaneously refuses to deal with that issue; or when the instigator of violence will not agree to be nonviolent, or fails to live up to an agreement to refrain from violence. The cornerstone of their work with violent couples is the "Peace Agreement." They tailor this document for each couple, outlining the couple's triggers for violence, steps they should take at early warning signs of impending violence, and positive reminders that counseling is their first step in creating a new, nonviolent, relationship.

Discussions of gender role training, particularly as learned in the couple's own family, are emphasized during therapy. These therapists maintain constant vigilance about where their own beliefs come from and how their beliefs may be influencing their interactions and interventions with clients. From the beginning

of therapy, Gutsche and Murray work to reduce any cycle of blame and recrimination in the couple and in the couple's communication with family and friends who know about the past violent behaviors. In their opinion, often it is most difficult to affect change in the family and friends who do not want to alter their view of the violent couple.

The Problem with the "Standard" Approaches. What is it exactly that challenges the systems approach to family violence? Bograd (1992) drew on research in fields outside family therapy to argue for a change in the way family therapists think about and treat violent couples. She notes that neither a feminist/political view nor a therapeutically neutral view alone is sufficient for change with men who abuse their partners. Bograd points out that therapy is social control. She asks why therapists would take one viewpoint for violence inflicted from outside the family and another point of view for violence from within the family. Either way, the violence is a crime.

Bograd points to research and work with batterers outside the family therapy field that demonstrates that therapy alone or legal action alone does not change abusive men. Both are necessary. Without legal and social consequences, battering men may give up the use of physical force, but may continue to abuse their partners verbally and psychologically. Therapists need to work with the legal system rather than ignoring it. Bograd urges therapists to provide the most conservative form of treatment because abused women may be unable to assess accurately their own level of safety with an abusive partner. In

closing, she urges others not to reduce wife battering to a lone argument about individual versus conjoint therapy. Although an important issue, it is just one issue in a complex situation and she believes that it should not be used as a distraction to avoid facing other issues.

In Avis' (1992) view, family therapy has paid scant attention to the problem of abuse and violence in families. Between 1990 and June 1991 in two of family therapy's major journals (*Journal of Marital and Family Therapy* and *Family Process*), Avis notes that only one article on incest and one article on wife abuse were published. She presents this information against the backdrop of data on sexual abuse and violence. For example:

* One in three American women experience sexual abuse before age 18 and 20% of these women are sexually abused by a family member; 95% of their abusers are male (p. 227).

* Among boys, more than 13% are sexually abused and are more often abused by people outside of their families; 80% of their abusers are male (p. 227).

* One out of six American women are abused each year by their male partner (p. 227)

* In one out of 14 marriages severe, repeated violence occurs (p. 227).

* Between 1967 and 1973, during the Vietnam war, 39,000 American soldiers were killed; in that same period, 17,500 American women and children were killed by family members (p. 228).

* Children are present during 80% of wife assault incidents (p. 228); 75% of men who abuse their wives observed violence between their own parents (p. 226).

As if these numbers were not disturbing enough, Avis points out that 60-75% of male sexual abuse and assault offenders have no history of childhood or adolescent abuse themselves. Avis believes that the family therapy field has difficulty facing the notion that violence directed by men against women is more than culturally sanctioned -- it is a part of male socialization in a patriarchy.

Avis calls on family therapists to hold abusive men responsible and accountable; to focus "on changing the violent behavior itself,...its impact on others, and on the belief system which supports it" (p. 229); and to work in tandem with the judicial system. When training students, she urges the family therapy field to balance systemic theories (which effect a diffusion of responsibility) with an understanding of patriarchal culture and power dynamics. As evidence of the importance of such training, Avis writes that when students in her university's family therapy training program learned to assess families for violence and incest, the reported rate quadrupled in their clinic.

In a recent article, Jacobson (1994) outlines his views on researching domestic violence. Describing his framework as "feminist, scientific, and contextual" (p. 82), Jacobson wishes that there would be friendly cooperation between advocates and researchers, and that research would be approached from a contextual perspective. He writes that "should we find that our ability to predict and control battering is increased by understanding the relationships between battering and things that the wife says or does, we are not in any way implying that the wife has caused the battering" (pp. 82-83). He views the

knowledge gained from advocacy agencies and that gained from scientific research as potentially "synergistic." However, Jacobson emphasizes that scientific research has nothing to do with advocacy: "....the goal of basic research on wife abuse must be controlled, systematic, and dispassionate observation" (p. 83). Simultaneously, he proposes that researching from a contextual perspective would help identify "factors that predict and influence the onset, offset, intensification, deintensification, frequency, and duration of violence" (p. 84). The discovery of these factors would then lead directly to altered clinical interventions.

Two responses to Jacobson's article appear in the same issue of *Family Process*. In the first rejoinder, Avis (1994) disagrees with Jacobson's assumptions that empirical research is value-free, bias-free and the only method that produces valid knowledge. She believes that researchers devalue and label "nonexpert" the knowledge and understanding that advocates have. Meanwhile scientific knowledge is given greater status and credibility. This stance reproduces the current social order: "Since advocates are almost entirely female and researchers mostly male, it is women's knowledge that becomes subjugated by the dominant scientific (male) discourse" (p. 89). The second response, from Gelles (1994), who thinks of himself as a feminist, argues for keeping research, clinical work, and advocacy as separate paradigms and enterprises. In his view, "it is not necessary or even productive for all three groups to agree and get along" (p. 94). His views rest on a belief that research is inherently objective;

science has little impact on clinical work; and that "researchers study the world as it is; advocates argue for a world as it should be" (p. 95).

Concerns about Family Therapy's Response to Feminism. Since the mid-1980s, feminist family therapists have been attentive to how the family therapy field responds to the feminist agenda. Their concerns began with the need for women to meet without men and, to date, ends with women still needing to convene without men in attendance. In between, there has been commentary about feminism being co-opted and then dismissed by the family therapy field; the ways in which feminists are personally attacked; and responses to the criticism that feminism imposes its values on families.

In Australia, 1984 marked the Fifth Australian Family Therapy Conference. A few days before that conference, The Sydney Women and Family Therapy Group met to talk about family therapy and women. They were requested to "report back" during the conference about that meeting. They declined to do so. James (1984), however, used the time allotted for reporting back to "encourage reflection both on the desire for, and the consequences of, a separate women's meeting" (p. 241). She delineated to her audience the patriarchal patterns in the wider culture, in the family, in the work place, and for women working in the field of family therapy. Tying these pieces together, James explains the necessity for an exclusive meeting:

> Women are meeting separately to face their situation at two related levels--the personal and the professional; to identify their chains of gender at the level of experience and to begin

> to develop a women centred perspective; to re-balance the male centred perspective, presently disguised as neutral. (p. 248)

For James, patriarchal socialization is so pervasive that women need to withdraw to develop their own meanings and to support each other through the identity crisis precipitated by consciousness raising.

Goldner (1985b) expressed her concern that feminism in the mid-1980's was being co-opted by "transforming feminist commentary from a threatening critique into a banal who-could-disagree, piece of liberal cant" (p. 20). From Wheeler's (1985) perspective, however, Goldner's fears are unfounded. The obstacles to being a feminist family therapist lie in the attitudes others hold about feminists -- attitudes that strike at the moral, ethical, intellectual, and sexual aspects of the feminist person.

* Feminism is still an emotionally loaded term among family therapists: It is pejorative in the sense that it implies your work is political rather than scholarly (p. 54).

* To be a feminist is...to risk being dismissed as marginal, relegated to the shadowy realms outside the boundaries of legitimacy (p. 54).

* To voice a feminist criticism is often to risk being dismissed as biased, criticized for unleashing "hostile" or "anti-male" attitudes, or to have your maturity or sexual preference questioned (p. 54).

* When we make the politics of sex roles an issue we risk being criticized for prejudicing our work, for forcing our agenda on families, or for somehow going beyond the proper boundaries of our profession. (p. 55)

Both Bograd and Lerner responded to the criticism that feminist family therapists impose their values on clients. Bograd (1986b) asks if it is right to

promote a feminist view of how families should be. In reply to her own question, she points out that accepting the social status quo of the family reinforces a traditional view of the 1950s nuclear family. Whether taking a feminist or traditional view of the "proper" family, the message behind the perspective comes through to families in therapy. Lerner (1988) echoes Bograd's sentiments, noting that there is an "implicit assumption that non-feminist therapists do not have values, beliefs, and biases that shape their therapeutic work and effect their differential reactions to each sex" (p. 56). It is as though the dominant theories of family therapy are neutral, rather than filtered through patriarchal values.

Most recently, Carter (1992) expressed her frustration with family therapy's acceptance of the feminist critique. From her viewpoint, the family therapy field still has not genuinely acknowledged that men have greater power and privilege than women do. She notes how frustrating it is to have to begin every presentation--written or verbal--with illustrations of this fact. According to Carter, family therapy has co-opted the feminist critique by transforming language (feminist becomes "gender sensitive") and by embracing the men's movement. In her view, endorsing the men's movement is tantamount to saying that men have equal but different problems with sex-role stereotyping. The inequality between women and men remains essentially unacknowledged while therapists continue to use interventions that ignore power imbalance. In the privacy of supervision and training, Carter questions how much, if any, of this

time focuses on gender inequality and power imbalance. She wonders if this fact was simply recognized if there would there be a need for the *Journal of Feminist Family Therapy*, if women would comprise at least half the editorial boards of family therapy journals, and if women would need to continue organizing their own meetings just to be heard.

Emerging Issues

Two issues in particular appear to be emerging in the feminist family therapy field. One question is whether postmodernism is helpful or harmful to the feminist agenda. A second issue is whether feminism represents the concerns of all oppressed groups of people.

Postmodernism is the most recent philosophical phenomenon to impact family therapy. Goldner (1991) defines postmodernism as:

> .....a contemporary philosophical tradition that offers a critique of all "objectivist" claims to knowledge--the belief that the "world-out-there" can be separated from the stance of the observer constructing it--and argues instead that all knowledges should be viewed as "texts" that reveal as much about their authors as about their subject (p. 118).

There are many postmodern approaches to therapy, but Hare-Mustin (1994) chose discourse theory to analyze some current issues in family therapy. She notes that "not all circulating discourses are of equal importance; some have a privileged and dominant influence on language, thought, and action" (p. 20). The therapy room, Hare-Mustin writes, is like a "mirrored room" -- only the dominant discourse that takes place within it is reflected back. And too often the

prevailing discourse is plucked from the dominant culture. The discourses of those who are marginilized (e.g., women and minorities) are not heard. Thus, Hare-Mustin concludes, therapy, by adopting the dominant discourse, acts more as social control than as a process of change.

Hare-Mustin believes, however, that therapists can use discourse theory beneficially. If they recognize a discourse, ask themselves what purpose it serves, and ask what other discourses are not being heard, then the theory provides space for other realities. Equally important, says Hare-Mustin, therapists must know and question the discourses under which they themselves operate. Postmodern views, she concludes, have the potential to transform therapy.

Hindmarsh (1993) describes four discourses currently available--Positivist, Constructivist, Critical, and Post-structural. She sees each discourse as a political theory that can be linked to various feminist theories. "Liberal feminism pairs with constructivism; radical, Marxist and socialist feminisms with critical discourse; and post-structural feminism is obviously a post-structuralist discourse" (p. 21). Hindmarsh delineates how each feminist theory has an understanding and agenda for women. Liberal feminists seek equal rights, challenge sex-role stereotypes, and try to lessen the disadvantages for women. Radical/socialist/Marxist feminists view women not as disadvantaged, but as oppressed. While radical feminists regard patriarchy as the "root cause of women's oppression,...Marxist and socialist feminists argue that...(an) analysis

of class and its relation to patriarchy is required" (p. 21). Some socialist and post-structuralist feminists, Hindmarsh notes, view racism, gender, and classism as an interrelated system of oppression. For herself, Hindmarsh chooses a discourse that best matches her political position.

Some feminists believe that feminism advocates for *all* oppressed groups and that to talk about race or class as separate issues is merely an attempt to pit minority groups one against the other. Other feminists, however, feel differently:

> It is often assumed that feminist therapy principles and feminist therapy theory broadly oppose any form of oppression or discrimination and routinely encourage the exploration of related material with clients in therapy. While feminism opposes all forms of oppression in theory, feminist theory nonetheless cites gender as the primary locus of oppression for all women. This minimizes other salient forms of oppression that transcend and shape the experience of gender and sexism. Feminist practice lags even further behind (Hall & Greene, 1994, p. 7).

Almeida (1994) echoes this view when she declares that "feminist family theory has challenged the assumptions of gender; however, the diversity of family life within race, class, and culture has remained outside of this discourse" (p. 1).

It will, no doubt, take more time and exchanges of viewpoints before a clearer picture emerges of how feminist family therapy will incorporate post-modern philosophies and how it will resolve the question of its own inclusiveness. Meanwhile, given the growing literature and practice of feminist family therapy, what are its leading proponents saying about feminist family therapy now? A recent dissertation provides some answers to this question.

Magraw (1992) used qualitative methods in her dissertation study, "Feminism and Family Therapy: An Oral History." She interviewed twelve prominent women in the field of feminist family therapy: Judith Avis, Michele Bograd, Lois Braverman, Betty Carter, Virginia Goldner, Thelma Jean Goodrich, Rachel Hare-Mustin, Harriet Lerner, Deborah Luepnitz, Monica McGoldrick, Olga Silverstein, and Marianne Walters. She asked each woman to describe the goals and techniques of a feminist family therapy; the theoretical compatibility of feminism and family therapy; how feminists work with traditional and non-traditional families, with children, and with a violent man in a couple. In addition, Magraw asked each interviewee to comment on the influence of postmodernism; psychoanalytic concepts in feminist family therapy; and their predictions for the future of feminist family therapy.

The interviews were tape recorded by Magraw and then transcribed. Each interviewee received a copy of the transcription and had the option of editing it. The interviewee's responses to the content areas listed above were then collated and qualitatively analyzed. Magraw's interviews provide a wealth of material on the similarities and differences in the theories and practices that comprise, broadly, feminist family therapy. Apparent areas of consensus and divergence, drawn from these interviews, and the feminist family therapy literature already reviewed, follow.

Areas of Apparent Consensus

Women's Cultural Role. Many feminists believe that "woman as caretaker" and "man as doer" is perpetuated by the tradition of women having the exclusive responsibility for child rearing (Layton, 1984; Osborne, 1983). Women are raised to be the guardians of all relationships (McGoldrick, 1988), to their own, and men's, disadvantage. Women are taught to value connection and intimacy with others. Unfortunately, family therapy theory regards these ingrained values as dysfunctional because they do not measure up to male ideals of individuation and separation (Bograd, 1988a). The modern-day family is one of the prime vehicles for perpetuation of sex role stereotypes and the subordination of women (Hare-Mustin, 1978; Simon, 1984). Family systems therapy does not challenge society's definition of family, it only perpetuates the status quo. Family therapy has failed to understand that "motherhood and fatherhood are ideological categories, and not states of nature" (Goldner, 1985a, p. 32).

Family therapy ignores research outside the family therapy field. Studies on the mental and physical health of married women and men clearly document that the benefits of marriage are far greater for men than for women (Pilalis & Anderton, 1986). Women's unequal status in marriage and family is routinely ignored by family therapists who use the wife/mother to gain access to the family and then blame her for the family's difficulties. All hopes are pinned on the father in the belief that he will rescue the family (Goldner, 1985a).

Family Therapy Ignores Gender Issues. Family systems theory ignores gender differences through a theory and set of interventions targeted toward the problem rather than the person; treatment is nondifferential (Bograd, 1986a; Taggart, 1985). A nondifferential stance does not allow for consideration of the impact of sex role indoctrination (Layton, 1984). Even when a family therapist sees that sex role stereotyping may have something to do with the presenting problem, she or he is likely to believe that sex roles are something that can be manipulated instead of understanding that sex roles are an organizing principle of all social relationships (Goldner, 1985a). The "asexual, diagrammatic view of the family" results directly from the domination of men in the development of family systems theory (Simon, 1984).

Power. Feminist family therapists agree that family systems theory does not address power issues in either marital/family life or in the roles of therapist and client. Family systems theory itself allows the question of power to be circumvented (Bograd, 1986a). Power is simply reframed away; for example, describing violent interactions between a couple as their way of getting close (Taggart, 1985). Whatever power women have in the home, in their marriages, and with their children, is only power by proxy; husbands delegate power to their wives (Goodrich, 1991). This is made possible through a culture that says men are dominant over women and children (Penfold, 1989). Yet, women are viewed by some family therapists as too powerful and therapeutic interventions "operate as if women's power were somehow toxic to children" (Layton, 1984, p. 24).

Feminist family therapists take a dim view of "tricks and deception" in therapeutic interventions; these are viewed as an exercise of therapist power over the families they treat (Osborne, 1983).

Circularity. To feminists, the concept of circularity is just a fancy way of blaming the victim. Circularity is a theory of problem maintenance and not problem causality (Avis, 1988). Problems are assumed to be maintained through the equal participation of all those involved. With such a stance, questions about inequality in relationships and power differentials cannot be asked (Goodrich, 1991). For example, women are assumed to be co-responsible for their victimization in abusive relationships (Simola, 1992). The influence of social forces on the family is not recognized or accounted for in family therapy's conception of circularity (Goldner, 1985a).

Neutrality. The notion that family therapists and systems theory are neutral is an absurd idea to feminists. Avis (1986) describes therapeutic neutrality as "an impossible and dangerous myth." Bograd (1986a) notes that the punctuation of behavioral sequences is male-defined and therefore not a neutral description of a system. Yet, "if a family therapist violates the principle of neutrality, the conceptual framework for therapy is also violated because the session becomes focused on persons rather than on circular processes" (Simola, 1992, p. 397).

Feminists say that all therapy is value laden (Ault-Riche, 1986; Lerner, 1985) and that family structure is not inherently "neutral" in United States culture

(Simon, 1984). It is the therapist's responsibility to carefully consider where her or his values lie and to determine how they influence problem definition and interventions (Barrett et al., 1990). Otherwise, a therapist's "neutrality" is likely only to reinforce the status quo (Ault-Riche, 1986).

Sexist Bias in Family Therapy Language. Feminists maintain that it is critical to pay attention to the language we use; therapists should use non-sexist language (Pilalis & Anderton, 1986). "Language is not simply descriptive but prescriptive: as we narrate an event, we imply what it should be" (Bograd, 1988a, p. 66). For example, Bograd (1988a) suggests that the term enmeshment be replaced with interdependence, intimacy, or capacity for communion. She believes that enmeshment has shifted from a descriptive label of functioning to a descriptive label for a personality style or characteristic (Bograd, 1988a). Language can also remove agency, as in the phrase "mutually sustained interactional pattern" (Simola, 1992).

Preserving the System At The Expense of the Individual. The "no-fault" view in family therapy often means that the powerless family members (most often women and children) are victimized (Bograd, 1986a). The comparison of the family to a thermostat implies that intrinsic to every family is a striving for harmony; but no one asks at whose expense such harmony is achieved (Goodrich, 1991). What is best for the maintenance of the system is *not* always what is best for the individual (Barrett et al., 1990, p. 155). Given the

inherent biases in family therapy, it is not unreasonable to ask whether family therapy serves women well (Taggart, 1985; Wheeler, 1985).

The apparent areas of consensus among feminist family therapists are relatively easy to spot in the literature. Real differences of opinion are sometimes more difficult to discern. However, Magraw's (1992) interviews with 12 leading feminist family therapists provides clear documentation of key differences in beliefs and practice among feminist family therapists.

Dimensions of Difference

The differences of opinion among feminist family therapists stem from what "school" of feminism a practitioner embraces, how she continues to be influenced by the evolving discourse in feminism, and the model of family therapy in which she was trained.

The various schools of feminism each define a locus of causality for the oppression of women. For example, Marxist feminists emphasize class as the means of women's oppression, while radical feminists view the greater power accorded to men as the primary vehicle of oppression (Ault-Riche, 1986). Liberal feminists are those who would, for instance, push for passage of the ERA; it is society's laws and customs that oppress women (Avis, 1988). Feminism is further divided by those who highlight the similarities between women and men and those who stress the differences (Luepnitz, 1988). The views a feminist adopts influences how she will apply feminism to family therapy

and even determine whether she believes that combining feminism and family therapy is possible and desirable.

Compatibility of Systems Theory and Feminist Therapy. James and McIntyre (1983) were among the first to declare feminism and systems theory incompatible because, in their view, sexist approaches to family therapy are in keeping with its theoretical foundations. Goldner (1985b) initially agreed with this position because she believed family therapy to be unwilling to incorporate some theory of the self, and reluctant to acknowledge the social structure and impact of gender roles. She changed her opinion and now believes that feminism and family systems theory are "two parallel traditions instead of two oppositions" (Goldner, 1991, p. 118).

Some feminists believe that the problem of systems theory discounting the possibility of unequal power within the family can be overcome. However, simply incorporating a feminist lens to interventions ignores a basic problem: family therapy is not systemic enough (Bograd, 1986b). Simola (1992) agreed and argued that examination of where the ideology comes from (in the larger system) is in keeping with the theoretical basis of systems theory. General systems theory is supposed to look at those systems that exist both higher than and lower than the family system. "Recognition of the way in which broader structural issues impinge on family functioning is not just consistent with but also required by the theoretical tenets of family therapy" (p. 399).

Is Therapy Social Change? Political action on personal and social levels is a central tenet of feminism. Yet, there is disagreement among feminists about whether therapy itself constitutes political action and change. Some feminist family therapists think that therapy is *not* social change; therapy, in this view, is too insignificant and only a massive social upheaval will bring about real changes in the patriarchy (Goldner, 1985a, p. 44). Family therapy for others is a unique form of therapy especially conducive to promoting social change (Hare-Mustin, 1978). Another segment of opinion holds that all therapy is political because every therapy incorporates values, whether the values are acknowledged or not (Ault-Riche, 1986; Pilalis & Anderton, 1986). A middle ground is taken by feminist therapists who regard therapy as a weak strategy for creating social change (Luepnitz, 1988).

Goals of Feminist Family Therapy. For some feminist family therapists the goal of their therapy is the same as for any other family therapist: symptom remission (Magraw, 1992). For others, the therapeutic goal may not be the one the family had in mind (Magraw, 1992). Some place feminist goals for therapy in the broad context of the family: to have each person examine power, equality, and exploitation as it exists in the family (Magraw, 1992). Others emphasize the woman in the family, striving to help her increase her range of options and encourage others in the family to respond to her differently (Magraw, 1992).

Who should be the target of feminist interventions? Closely tied to the goals of feminist therapy is the question of to whom energy and effort should

be directed. There are feminist family therapists who view feminism as equally important for women and men (Magraw, 1992). The therapist should not focus solely on the woman's position in the family, but attend to each person in the family (Hare-Mustin, 1978). Others maintain that because women occupy a subordinate position in this society that feminism should be targeted more toward women than men (Magraw, 1992). In this view, the injuries of a patriarchal society are greater to women than to men (Goodrich et al., 1988).

Therapist Position. Generic feminist therapy seeks to reduce power and hierarchical status between therapist and client (Hill, 1992). Some feminist family therapists share that view (Magraw, 1992), reducing hierarchical distance through appropriate therapist self-disclosure, acting as a role model for the family, sharing the process of therapy with clients, and assuming a facilitator-educator role. Others feel that taking a non-directive, egalitarian approach in therapy is irresponsible and harmful (Riche, 1984; Goldner, 1991). In this view, clients are paying for and expecting expertise from their therapist. The therapist should take charge and direct the course of therapy.

Adaptability of Family Therapy Schools. Among feminist family therapists, there are those who believe that any family therapy school and technique is adaptable to feminism and there are others who find that only certain ones are suitable for adaptation (Magraw, 1992). Strategic family therapy is cited most often as incompatible with feminism. Some see the goal of problem resolution without insight as antithetical to feminism (Luepnitz, 1988).

Others regard strategic therapy as "exploitive and mystifying" (Riche, 1984). Still others believe that strategic therapy has the potential for adaptation to feminism but that it is more vulnerable to misuse (Magraw, 1992). Structural family therapy is criticized on the same grounds as strategic: it does not allow for the creation of low hierarchy between therapist and client (Magraw, 1992). Further, the marking of boundaries in structural therapy is viewed by some as an attempt to "protect hierarchies in the family" (Goodrich et al., 1988). Bowen family therapy terminology is criticized severely for its perceived idealization of male ways of relating (i.e., differentiation and unemotionality) and frequently regarded as incompatible with feminism. Lerner (1988), however, has re-worked Bowen family therapy to incorporate feminist values. Feminist family therapists disagree, however, about the value of history taking common in transgenerational therapies. Walters, for example, finds history taking in the early phases of therapy abusive to clients (Magraw, 1992).

The Psychoanalytic Perspective. There are some feminist family therapists who believe that family therapy is incomplete without some theory of the individual. The argument is that an understanding of gender requires an understanding of individuals (Magraw, 1992). These therapists have tended to incorporate psychoanalytic perspectives, particularly object relations, into their work with families. Other feminists believe that the psychoanalytic tradition and feminism are incompatible: psychoanalytic theory indulges in mother-blaming and narrows the focus on the individual, taking her or him out of the social

context (Magraw, 1992). A few feminist family therapists admit that they think intrapsychically, but they are not sure that such concepts should be incorporated into family systems theory (Magraw, 1992).

Modern Family Structure, Love and Intimacy. Most feminist family therapists have expressed the opinion that the family, in its present form, is "the principle arena for the exploitation of women" (Simon, 1984, p. 32) and an institution that perpetuates the subordination of women. One lone feminist voice has described the family as neither "inherently 'bad' nor 'good', rather families...have potential for *relative* goodness or badness" (Pilalis & Anderston, 1986, p. 103). A relatively "good" family allows each person the freedom to negotiate with other family members for an equitable meeting of needs. When it comes to heterosexual relationships, intimacy between women and men is regarded as "inherently problematic and disturbed" (Goldner, 1985b). In the views of some feminists, there is not much chance for a heterosexual couple to create an egalitarian relationship in a sexist culture (Magraw, 1992). Others assume that such a relationship is possible through raising awareness of gender issues in therapy (Goodrich et al., 1988).

Working with Violence and Incest in the Family. Feminist family therapists are divided on the best way to treat violence and incest in families. One view is that therapists should see a violent couple separately, rather than conjointly, when violence is still occurring (Avis, 1988). "The unit of treatment conveys a powerful message about responsibility and blame: treatment of the

whole family suggests that all family members play a role in maintaining the incest or battering" (Bograd, 1986a, p. 42). Others think that the therapist must decide with each case whether conjoint/family therapy is appropriate (Magraw, 1992). How violence is understood varies by a feminist's theoretical orientation. Feminist therapists with a psychoanalytic bent work with perpetrators and victims to help them understand the intrapsychic forces within the individual; other feminists understand violence and incest through an analysis of power within the culture and the family (Magraw, 1992). At least one feminist family therapist believes that women participate in their own abuse, although not as an equal (Luepnitz, 1988).

Influence of Postmodernism. Magraw's (1992) interviewees differed in their opinions about postmodernism. Some of the women were interested by the ideas contained in postmodernism, but did not like the narrative movement in family systems. For these women, one story is not always as good as any other. Social reality influences what story can be told. Other women believe that postmodernism is not antithetical to feminism, but can instead "...provide space for alternative viewpoints and skepticism about categories that are widely accepted....it makes space by saying that one set of categories, like the marginalized ones, is as legitimate as the dominant ones" (Magraw, 1992, p. 176).

Critique of Feminism and Family Therapy

While feminists debate among themselves about the relative merits of postmodernism, those inside and outside of academia have had something to say about the feminist movement. Kaminer (1993) offered a thoughtful critique of the feminist movement, both past and present. She believes that feminism is suffering from a major identity crisis. Historically, feminism used the notion of special "feminine virtues" to gain access to the wider social sphere (i.e., as the caretakers of society). In Kaminer's view, this eventually led to the position women now find themselves in: low-paying, low status jobs. The feminine virtues which initially got women out of the house were used to keep women out of higher-paying, more demanding jobs.

Among the foibles of feminism, Kaminer notes that the women's movement has an image problem: feminism is associated with being unfeminine. Citing polls conducted over the last three years, she notes that a majority of women support feminist ideals but that the majority also are reluctant to identify themselves as feminists. The problem is that feminism did not in the past, and does not now, promote a vision for men as well as for women nor does it seek ways to join with minorities. There is a prevailing view that feminism is for white, upper-income, urban professional women. Women of color may be more concerned about battling racism than working for gender equality. If feminism addressed the agendas of minorities and offered a vision for women *and* men as

caretakers of society, working mothers of all races would not feel compelled to work the "double shift."

Besides being insensitive to the plight of double-shift women, feminism has managed to alienate women who choose the "traditional" path of homemaker. Kaminer regards feminism's condemnation of homemaking and volunteer work 20 years ago as, if nothing else, a major tactical error in the women's movement. Today, feminism is hitching its wagon to the recovery movement; this is another alarming tactical error in Kaminer's view. The recovery movement is under growing debate, both in the popular press and in academia (see for example Loftus, 1993). Feminism, she says, is running the risk of associating itself with a movement that, for some, appears to irresponsibly hypnotize women into believing they were victims of child sexual abuse. Worse, the recovery movement makes people feel vulnerable and fragile. "Women need a feminist movement that makes them feel strong" (p. 66), not a movement that encourages helplessness and victimization.

The "sameness-difference" debate, whether to emphasize the similarities or the differences between women and men, has infiltrated the popular media. Carol Gilligan's successful book, *In A Different Voice*, extols the "ethic of caring" in women and, in a return to early feminist days, highlights women's "special virtues." Kaminer believes that "Gilliganism" translates into special protection for women, again confusing the issues of gender equality, social responsibility,

and sex-role stereotypes. Although some academic feminists criticize Gilligan's work, the public has not been privy to this debate between scholarly feminists.

Some family therapists are critical of the feminist movement. Reviewing Deborah Tannen's book, *You Just Don't Understand*, Nichols (1991) decries the "difference" side of gender studies. Like Kaminer, Nichols views publications that glorify the differences between men and women as adding to society's confusion about innate versus learned gender differences. The clear winner of the "difference" side of the debate is men: "Men may be the real victors of the women's movement; they have been liberated from the responsibility to marry, stay married, and support their families, but not from the old rights and prerogatives of male power" (p. 81). Nichols urges feminists to stop exaggerating the differences between women and men.

Others are uncertain about the impact of feminism on family therapy. Hoffman (1990) worries that feminism "may create another set of labels for mental pathology to add to the ones we already have, and a new kind of 'expert' to tell families how they ought to be" (pp. 7-8). Despite this reservation, Hoffman applauds feminism's role as a consciousness-raising device for family therapists. But, Hoffman doubts that family therapy from a feminist viewpoint is effective in changing the family as we know it in the larger culture. Political action in the form of social policy, according to Hoffman, holds out greater hope for real change.

Coyne (1992) offered his critique of feminism in a letter to the editor of the *Family Therapy Networker* (commenting on Carter's article, "Stonewalling Feminism"). In his view, feminists in the family therapy field address only sexism and ignore issues of class and race. He believes that the brand of feminism offered by feminist family therapists is applicable only to select women -- those whom he believes are the "generic" feminist family therapists: "white, upper middle class and oblivious to living in a racist society" (p. 7). He blames feminists within AFTA (American Family Therapy Association) for choosing meeting sites which "buffer participants from the inequalities of American life" (p. 7).

In a family therapy journal, an exchange of views occurred between feminist family therapists and a critic. Kingston (1986) commented on Pilalis and Anderton's (1986) model of socialist feminism and family therapy. He criticized both their model in particular and feminism in general. Of their model, he doubts that socialism is much different in practice than capitalism and therefore not an answer to women's problems. Further, family therapy can only effect change at the micro-social level; it cannot change "wider institutions" unless a broader systems perspective is taken. Kingston takes issue with feminists' punctuation of the abortion debate, i.e., that by advocating for the decision to be solely the woman's, men are relieved of all responsibility for their part in conception. To Kingston's way of thinking, "ageism is, in some ways, currently more destructive than sexism in Western societies, because it is much less recognized and

because there is therefore no collective challenge to it" (p. 116). Kingston concludes that for him, "Spirit, Higher Consciousness, Universal Self or God....is more fundamental than socialism or feminism, because all socialists and feminists are, like the rest of us, subject to the illusion of self" (p. 118).

Summary

Feminist family therapists seem to agree that family therapy discounts the negative influence of patriarchal culture on women and that it does not take this inculturation into account in its theory or its interventions. Power, circularity, and neutrality appear to be problematic for feminists in family therapy theory. Feminists question the use of sexist language and the emphasis on preserving the family at the expense of individuals within a family.

They diverge on such issues as the compatibility of systems theory and feminism, which schools of family therapy fit with feminism, and whether therapy itself is social change. There is disagreement on whether a feminist family therapist is hierarchical or egalitarian with her clients, and to which gender she should focus her attention. Some feminists believe psychoanalytic concepts provide a necessary understanding of the individual; others heartily disagree. The viability of present family and couple arrangements is viewed by some as hopeless, by others as remediable. Sharp division about the best way to work with violent and incestuous families abounds. Post-modernism is viewed with skepticism by some feminists and embraced by others.

Feminism itself is under review for its accomplishments and failings, both past and present. Within the family therapy field, some traditional family therapists are critical of a feminist movement that they regard as limited in scope and only applicable to a small segment of society. Others deplore the brand of feminism that emphasizes gender differences. Feminist family therapists are accused of imposing their values on families and creating new pathologies. At least one family therapist dismisses the feminist movement within family therapy as a useless tool for effecting any kind of significant change in the family at the macro-level of society.

If one wants to make sense of the apparent areas of consensus and divergence amongst feminist family therapists, and the commentary from their critics, a worthwhile question is: "Can research help us understand what it all means?" McNamee (1994) argues that researchers should attempt to construct their studies in a way that considers multiple points of view. She writes that rather than asking, "What are the characteristics of X?' (questions of essence)" that we might ask instead, how do the interactions between people give rise to "certain interpretations, explanations, descriptions and lines of action...and gain viability and sustainability?" (p. 81). A survey of feminist family therapists would answer "questions of essence" -- the characteristics of feminist family therapy. But a survey would not provide insight into McNamee's central questions about the multiplicity of perspectives and what they might mean. Q-Methodology,

however, is a research method that provides an exemplary means of identifying and comparing differing viewpoints.

Q-Methodology

Contrasting perspectives, versions of reality, and implicit or explicit values are the ingredients of a discourse. A discourse may be described as the "conversation" about a topic that people engage in; it is found in journal articles, books, essays, newspaper and magazine articles, presentations, commentary, interviews. In whatever format people choose to express themselves, the discourse can be located and studied. Q-methodology is an empirical method that allows comprehensible access to the inherent structure in a discourse, and a quantifiable way to study the relationships among points of view.

Why would we want to know how a discourse is structured? Why not simply attempt to determine what the various viewpoints "out there" are and survey the appropriate people? A survey can answer certain questions, like *how many* people endorse a particular belief. But a survey cannot answer questions such as how various beliefs are tied together (or not) nor can it profile how a viewpoint forms a comprehensive whole. A survey allows the researcher to compare between individuals, but it does not allow a comparison of responses within the individual. When a researcher wants to discover how comparisons are made within persons, Q-methodology provides the means for doing just that (Nunnally, 1978).

Q-methodology makes it possible to determine what ideas sustain a viewpoint and to compare and contrast the ideas or opinions within and between different points of view. Q reveals not only the extent of differences of opinion, it also makes the similarities apparent. The various perspectives can be analyzed and studied; further dialogue and research can be initiated based on the results of a Q-sort. A description of Q-methodology will help clarify the technique and make the objectives of the method apparent.

The first step in Q-technique is to collect a sample of statements from a discourse. As much as possible, the statements chosen for the Q-sample are in the words of those who have contributed to the dialogue (Brown, 1992). Using direct quotations from contributors helps prevent the researcher from imposing his or her own interpretation on the statements. Although a Q-sample can be selected without reference to categorization, a structured Q-sample allows the researcher to select items that test hypotheses about points of view. The content in a structured Q-sort is thus narrowed down from the larger discourse, facilitating item selection and providing a design that allows testing of hypotheses built into the selection of items (Nunnally, 1978). For instance, in a Q-sort study of attitudes toward sex education in public schools, items could be selected from published opinions and interviews containing beliefs about sex education delaying or promoting adolescents' sexual activity, conservative beliefs about sex in general, and liberal attitudes toward sex.

Once a sample of statements is collected, each statement is typed onto a card and randomly numbered. Persons who are believed to represent different views are then asked to rank order the statements on a continuum, for example from "most agree" to "least agree." Typically, respondents are asked to sort the statements into the continuum along a normal distribution. For instance, suppose there are 45 statements which are to be sorted along a continuum of +5 (agree) to -5 (disagree). Only three statements could be sorted into each of the extreme ends of the continuum; as the individual approaches the peak of the curve from either end of the continuum, the number of statements sorted into a ranking increases (in this case, five statements each in +1, 0, -1). Note that the task for sorters is a relative versus absolute ranking of the statements. If the theory about points of view that is being tested is valid, and the selected statements adequately represent the theory, then the Q-sorts should demonstrate the validity of the hypotheses built into the selection of items (Kerlinger, 1973).

Data analysis of the Q-sorts begins with computing correlation coefficients for the sorts. This shows who has sorted the statements in similar and different fashions. The correlation matrix is then factor analyzed. The number of factors only becomes known once the data is analyzed and is a result of how divergent sorters were in their views (Brown, 1992). Factor analysis reveals how many "broad classes" of Q sorts there are -- "the number of distinct ways in which the statements were sorted" (Brown, 1986). A composite Q-sort is

constructed from those persons who loaded significantly on each factor. For example, if six people have sorted the items in a highly similar way, their responses to each item are weighted and a Q-sort which represents their collective viewpoint is constructed. That viewpoint becomes Factor A. Suppose the next six people sorted the items in a similar way, but differently from the first six people. Their collective Q-sort becomes Factor B. The Q factors then represent, generally, how persons of that "type" think about the topic under discussion (Brown, 1986). Each factor represents a hypothetical or ideal person (Berry & Lewis-Beck, 1986).

Interpretation of the factors is accomplished through the factor scores. Factor scores are the scores calculated for each statement in each factor (these were the weighted scores used to formulate each "collective" Q-sort). Factor loadings are the correlation between a respondent and a specific factor (for example, does Person 1 load more highly on Factor A or Factor B?). The central ideas which support a viewpoint, or factor, are understood in terms of the highest and lowest factor scores for items comprising the extremes of that viewpoint. Items can then be compared and contrasted within and between the factors or viewpoints.

A look at the differences between Q- and R-methodology also helps elucidate what is unique about Q. The most important difference is conceptual: factor analysis in each serves a different purpose (Berry & Lewis-Beck, 1986). In R-methodology, large numbers of people are needed to obtain statistical

significance for the variables being tested; many more people than variables are needed for adequate data analysis. Factors in R are interpreted through the factor loadings; correlations are across variables. For example, if a researcher wants to determine whether anxiety and depression are elements of neuroticism, she might give a large number of respondents a standardized measure of depression, a standardized measure of anxiety, and a standardized measure of neuroticism. The researcher hypothesizes that two factors will emerge from a factor analysis of the items on the standardized scales: anxiety and depression. Further, she anticipates that the items loading on each factor will correlate with the measure of neuroticism. The researcher is hypothesizing about the variables and *not* about the respondents who fill out the standardized scales. R-methodology answers questions about "theories concerning factors among variables" (Nunnally, 1978, p. 428).

In contrast, Q-methodology asks a different kind of question. When one wants to test theories about similarities and differences among persons, then Q technique is the proper method (Nunnally, 1978). Because factors in Q represent a hypothetical type of person or viewpoint, large numbers of respondents are not needed for Q-technique. As long as a factor emerges, it makes no difference whether that factor emerges from the responses of five people or twenty people (Brown, 1980). Correlations in Q are among the persons and not the variables. Factor loadings are the persons (not the items); the loadings of persons on factors "specify to what extent they are mixtures of

the various types" (Nunnally, 1978, p. 429). The researcher compares and contrasts the opinions, as represented in the factor arrays, with each other (Brown, 1986). The hypotheses tested concern whether the a priori determination of similarities and differences between persons' viewpoints holds out.

Two examples of Q-sort studies will help illustrate the applicability and methods of Q. Brown (1986) employed Q-methodology to study how differences of public opinion were segmented on the June 1982 Israeli invasion of Lebanon. He gathered opinions from public sources and private interviews, and structured a theoretical model of the discourse. Brown modeled the debate according to statements' denotation of an Israeli, Arab, or "Other" perspective and whether a statement expressed a particular bias, a desired outcome, or a policy recommendation that presupposed a bias or desired result (thus creating a 3 x 3 factorial design). Fifteen people who were thought to hold different opinions on the debate sorted the statements.

Factor analysis of the Q-sort correlation matrix revealed the number of essentially different Q-sorts completed by the participants. In this case, three distinct views (factors) on the invasion emerged. Participants one through five sorted the statements in a similar fashion: their Q-sorts loaded on Factor A, a pro-Israeli stance. The next five respondents shared a common viewpoint in their sorting of the statements, and they loaded on Factor B, a pro-Arab view.

The last five persons sorted their statements in a like manner and loaded on Factor C, a viewpoint Brown interpreted as a "uniquely American view."

An example of a Q-study in psychology shows how factors are interpreted. Rohrbaugh, Shoham and Spungen (1995) developed a systemic intervention for treating alcoholism in couples. As part of their study, they wanted to compare and contrast the differing viewpoints among three conceptual models of alcohol treatment. Fifty Q-sort items were structured with the intent of sampling opinions about and treatment for alcoholism. They were selected from family systems, 12-step, and cognitive-behavioral views. Statement were sorted by twenty people associated with the study and an additional 20 professionals who identified themselves as adopting, to some degree, the 12-step approach. Factor analysis of the Q-sorts revealed three primary components, conforming to the three models of treatment.

Similarities and differences in viewpoints between the family-systems and 12-step models were interpreted through significant factor scores for items on each factor. For example, both family-systems and 12-step viewpoints agreed that "alcoholism should not be an excuse for irresponsible or illegal behavior" (p. 33). However, these two viewpoints differed on the disease model of alcoholism. The family-systems view highly endorsed the belief that "problem drinking is a better term than alcoholism" while the 12-step factor subscribed to "once an alcoholic, always an alcoholic" (p.33). Although both the family-system and 12-step views ranked moderately high the statement, "The member of the family

who exhibits alcoholic symptoms is the 'identified patient'; the real patient is the entire family" they disagreed about whom should be the target of treatment. "The locus of a drinking problem transcends the individual drinker; treatment should therefore focus on the relationships in which drinking is embedded" (p. 33) was a view endorsed highly by family systems, but ranked moderate to low by the 12-step view.

Q-methodology has limitations as well as advantages. Because respondents in a Q-sort study are not selected randomly, results cannot be generalized to the population (Kerlinger, 1973). The respondents for a Q-sort are chosen purposefully -- because they are experts or contributors to the discourse under study. It is anticipated that the respondents selected will represent different views rather than representing a segment of the population. Q cannot inform the researcher of how many persons in a population are represented by a factor or viewpoint (Brown, 1992). Q is a small-sample method designed to determine what some viewpoints may be. The question of how many people hold a particular viewpoint is best answered through survey methodology (Brown, 1992). Neither do the factors revealed in a Q-sort study define every possible viewpoint (Brown, 1992). The selection of items for inclusion in a Q-sample determine, to some extent, the range of opinion that can be expressed by respondents. What Q can do, however, is allow the researcher to compare and contrast distinctive ways of thinking that do exist within a discourse.

There are several advantages to Q-methodology. The fact that it employs small samples means that it is an economical method. The researcher need not spend numerous hours collecting data from a large number of people, enter volumes of data for analysis, nor must she or he duplicate hundreds of copies of the materials used in a study. The method is "economical" for respondents too; most Q-sorts can be completed by participants in about 30 minutes or so. Q-methodology's strength is in its provision of a framework for understanding the construction of viewpoints and the means to compare and contrast them. Further, it is possible for a Q-sort to reveal an unanticipated view. In essence, Q-methodology allows the data to speak for itself.

Purpose of the Present Study

Feminist family therapy has developed sufficiently to contain a substantial range of opinion on the approach and goals of the therapy. It is, however, difficult to discern through a reading of the literature what the convergence and divergence of opinions means when a therapist labels her- or himself a "feminist family therapist."

The present study used Q-methodology to identify emergent views about feminist family therapy among a sample of feminist family therapists who were presumed to represent different viewpoints. Through this study it was possible to obtain a clearer picture of the practices and philosophies of feminist family therapists. Other persons who were surmised to hold disparate opinions from the feminist experts were included to compare their viewpoints with the feminists.

Chapter 2

Method

Overview

A loosely structured Q-sort instrument consisting of 60 statements drawn from the relevant literature sampled a range of opinions on feminist family therapy. The Q-sort items were ranked by a convenience sample comprised of experts in feminist family therapy and others in the family therapy field. Eight of the respondents were nationally recognized experts in feminist family therapy; four respondents were self-identified feminist family therapists. Of the remaining participants, eleven were family therapists and six were novice family therapists. The 29 Q-sorts were correlated and factor analyzed to identify emergent person factors, or points of view. Factor score patterns indicating items ranking high and low on each factor were then used to compare and contrast the emergent viewpoints.

Construction of the Q Sample

The Q-sort instrument consisted of 60 statements drawn from the relevant literature. The item pool was initially quite large -- over 300 statements were collected from both published and unpublished literature. Magraw's (1992) interviews with 12 leading feminist family therapists served as a primary source

for structuring the Q-sort. From her interviews, hypothesized areas of consensus and divergence among feminist family therapists were developed, based upon similarities and differences in opinion among those interviewed. The original item pool was reduced by selecting those items which were thought to represent the hypothesized areas in the most succinct fashion. In the resulting Q-sort instrument, many of the statements came from Magraw's interviews; other statements were from the published literature on feminist family therapy. A small segment of items were drawn from academic and popular literature to represent critiques of both feminist family therapy in particular and, more generally, feminism in the broader culture.

A provisional pool of items was given to four feminist family therapy experts. These reviewers were known to the author. Specifically, they were asked to review the item pool for how well the statements represented the field. This was to ensure that none of the hypothesized areas of convergence and divergence were under- or over-represented in the statement sample and that there were no obvious gaps in the content. Some deletions, additions, and modifications in the content of the statements were made based upon suggestions provided by these experts.

The Q-sort instrument was loosely structured to provide a basis for analyzing and comparing the a priori hypothetical considerations. There were 22 statements drawn from areas of hypothesized commonalities, 26 statements from hypothetical dimensions of difference, and 12 statements concerning

criticisms of feminist family therapy and the feminist movement. Appendix A contains the 60 Q-sort items.

Selecting and Recruiting Respondents

Although the respondents were primarily a sample of convenience, eight of the participants were nationally recognized experts in the field of feminist family therapy. The expert participants were recruited specifically because they write about feminist family therapy and are considered leaders in the field. They are among the people who make significant contributions to the feminist family therapy discourse. One expert (FFT Expert 1), was a university professor in a family studies program and has published on feminism. Four of the participants were self-identified feminist family therapists who were known to the author or whose names were given to her by others. The remaining respondents included both experienced and novice family therapists who were selected because they were presumed to hold a variety of views about feminist family therapy.

Potential expert respondents were selected for recruitment because they have contributed to the literature on feminist family therapy or identified themselves as feminist family therapists. They were contacted by letter or by telephone. Five experts who were contacted declined to participate in the present study. Three other experts agreed to participate, but never returned their Q-sorts. The non-expert participants who were recruited were either known to the researcher or recruited through her contacts. Everyone who was

contacted agreed to participate; only two of these respondents did not return their Q-sorts.

Table 1 details the respondents' characteristics. In this table, the participants are grouped by their categorization -- i.e., feminist family therapist (FFT), family therapist, or graduate student. For each person the table lists their sex, denoted by F (female) or M (male); their discipline; their professional identification; the number of years of clinical experience; the highest educational degree earned; their rating to the question, "To what extent do you consider yourself a feminist? ["not at all" (1) to "very much" (9)]; and whether or not the respondent has published in the feminist family therapy field and/or family therapy.

Respondents' professional identifications include psychology, social work, and psychiatry, with clinical experience ranging from 0 to 25 years. Seventeen of the participants hold advanced graduate degrees; eight earned a master's level degree; and four have bachelor's degrees. Ten of the respondents have published articles/books on feminist family therapy, and eight are authors of publications in family therapy.

Materials and Procedures

Potential participants were contacted by telephone, in person, or by mail. Those who agreed to participate in the study were sent a packet of materials. The materials were a letter introducing the study and containing instructions for completing the Q-sort (Appendix B); a consent form (Appendix C); a Q-deck

Table 1

Characteristics of the Q-sorters

Respondent	Sex	Profession	Years Clinical Experience	Highest Degree	Extent ID Fem	Pub FFT	Pub FT
FFT Expert 1	F	Family Studies Professor	0	PhD	9	N	N
FFT Expert 2	F	Clinical Psychologist	17	PhD	9	Y	Y
FFT Expert 3	F	Clinical Psychologist	15	PhD	9	Y	Y
FFT Expert 4	F	Clinical Social Worker		ACSW	9	Y	Y
FFT Expert 5	F	Clinical Psychologist	15	PsyD	9	Y	Y
FFT Expert 6	F	Clinical Psychologist	16	PhD	9	Y	Y
FFT Expert 7	F	Clinical Psychologist	25	PhD	9	Y	Y
FFT Expert 8	F	Clinical Social Worker	25	MSW	9	Y	Y
FFT Expert 9	F	Clinical Psychologist	16	PhD	9	Y	Y
FFT Expert 10	F	Clinical Psychologist	3	PhD	9	Y	N
FFT Expert 11	F	Clinical Psychologist	12	PhD	8	N	N
FFT Expert 12	F	Clinical Psychologist	16	PhD	9	N	Y
Family Therapist 1	M	Clinical Psychologist	23	EdD	7	N	N
Family Therapist 2	M	Clinical Psychologist	20	PsyD	7	N	Y
Family Therapist 3	M	Clinical Psychologist	20	PsyD	3	N	Y
Family Therapist 4	M	Psychology Professor	24	PhD	4	N	Y
Family Therapist 5	M	Psychiatrist	20	MD	5	N	Y
Family Therapist 6	F	Clinical Social Worker	15	MA	7	N	Y
Family Therapist 7	M	Psychiatric Nurse	15	BSN	8	N	N
Family Therapist 8	F	Clinical Psychologist	12	PhD	8	N	Y
Family Therapist 9	F	Clinical Social Worker	20	MSW	9	N	Y
Family Therapist 10	F	Clinical Social Worker	20	MSW	7	N	N
Professor	F	Psychology Professor	.5	PhD	7	N	N
Graduate Student 1	F	Clinical Psychologist	1	BA	7	N	N
Graduate Student 2	F	Clinical Psychologist	1	BA	7	N	N
Graduate Student 3	F	Clinical Psychologist	1	BS	7	N	N
Graduate Student 4	F	Clinical Psychologist	1.5	MA	9	N	N
Graduate Student 5	F	Clinical Psychologist	5	MA	8	N	N
Graduate Student 6	F	Family Sociologist	0	MA	8	Y	Y

containing the statement items; a response sheet (Appendix D); and a stamped, addressed, return envelope.

Chapter 3

Results

Factor Analysis: Identifying Emergent Viewpoints

Correlations among the 29 Q-sorts were first calculated using Pearson's product-moment coefficient. The full correlation matrix showing who sorted the statements in similar and different fashions appears in Appendix E. The correlation matrix was then factor analyzed using a Principal Axis extraction method. A scree test suggested using six factors with *eigenvalues* of greater than 1.02, which together accounted for 69 percent of the total variance.

Table 2 shows factor loadings of the 29 participants, organized by magnitude of primary loading. A participant's loading on a factor indicates that s/he sorted the statements in a corresponding fashion to others on the same factor. Therefore, persons on a factor share a similar viewpoint with each other. Secondary loadings greater than .30 indicate that a participant shared to some extent the views on another factor.

Interestingly, eleven of the twelve feminist family therapist experts had primary loadings on either Factor 1 or Factor 2. Even Feminist Expert #12, whose primary loading was on Factor 5, had a strong secondary loading (.47) on Factor 1. Five of the six feminist experts who loaded on Factor 2 also had

Table 2

Participants' Factor Loadings

	F	R	FAC 1	FAC 2	FAC 3	FAC 4	FAC 5	FAC 6
FFT Expert 1	9	-	.79				.31	
FFT Expert 2	9	6	.77					
FFT Expert 3	9	1	.73					
FFT Expert 4	9	6	.46			.33		
FFT Expert 5	9	7	.34					
FFT Expert 6	9	6		.76				
FFT Expert 7	9	6	.45	.67				
FFT Expert 8	9	5	.51	.61				
FFT Expert 9	9	7	.52	.60				
FFT Expert 10	9	5	.52	.55				
FFT Expert 11	8	6		.55		.30		
Family Therapist 1	7	7		.60				
Graduate Student 1	7	6		.49				.46
Graduate Student 2	7	7			.72			
Graduate Student 3	7	5		.32	.57			
Family Therapist 2	7	7			.57		.31	
Family Therapist 3	3	6		-.30	.50	.31		
Counselor	7	5			.50	.41		
Graduate Student 4	9	7	.44		.44			
Family Therapist 4	4	7				.78		
Graduate Student 5	8	7			.52	.71		
Family Therapist 5	5	9				.50	.35	
Family Therapist 6	7	-			.32	.50		.37
FFT Expert 12	9	7	.47				.70	
Family Therapist 7	8	7					.62	
Family Therapist 8	8	5			.38	.39	.60	
Family Therapist 9	9	8					.46	
Graduate Student 6	8	-			.32			.74
Family Therapist 10	7	7		.30		.38		

secondary loadings on Factor 1. Thus, the feminist experts appear to have some common ground, as indicated by the secondary loadings, as well as distinct viewpoints evidenced by the emergence of two factors. Only two other respondents loaded on either of these factors; a graduate student and a family therapist both loaded on Factor 2.

The remaining sixteen respondents were scattered across Factors 3 though 6; twelve of the participants had secondary loadings. Factor 3 was comprised of two family therapists, a counselor, and three graduate students. On Factor 4, there were three family therapists and one graduate student. As noted above, one feminist family therapy expert loaded primarily on Factor 5, along with three family therapists. A family therapist and a graduate student loaded on Factor 6. There was at least one person with 16 or more years of clinical experience loaded on each of Factors 3 through 6.

Participants' ratings on a 1 to 9 scale to the question, "How well does the ranking of these 60 statements express your point of view?" were correlated with the factor loadings. None of the correlations were significant. There did not appear to be any systematic relationship between how satisfied participants were with their sort and their factor loading. The full correlation matrix appears in Appendix F.

Correlations were also computed for participants' response to the question, "To what extent do you consider yourself a feminist?" Three of these correlations were significant. Factor 1 correlated .70 and Factor 2 correlated .48

with this question. One factor had a significant negative correlation: Factor 4 correlated -.57. These correlations suggest that Factor 4 participants do not consider themselves to be feminists and that the first two factors are feminist views. The full correlation matrix appears in Appendix F.

A second analysis was performed using only the Q-sorts of the feminist experts to evaluate the possible influence of including the full 29 Q-sorts on the two emergent feminist viewpoints. A principal axis factorization of the 12 feminist experts' sorts again resulted in two factors (see Appendix G). Compared with the analysis of all the Q-sorts, Feminist Expert Factor 1 correlated .91 with Factor 1 of the combined analysis. Feminist Expert Factor 2 correlated .94 with Factor 2 of the combined Q-sort analysis (see Appendix H). Thus, the two feminist viewpoints were essentially similar, regardless of whether the experts' Q-sorts were factored alone or in combination with the others. Interpretation of the factors was therefore based on factor scores from the first analysis of the 29 Q-sorts.

Interpretation of the Factors

Interpretation of the six factors was based on examining the factor array defining each viewpoint. The complete array of items defining each factor appear in Appendices I-N. A factor array is a composite Q-sort calculated from the combined Q-sorts of participants who loaded on a given factor. It is a ranking of the 60 items according to their factor scores, using the distribution categories of the original Q-sort. Thus, in the present study, for a given factor

the six statements with the highest factor scores were assigned a score of "10"; the next six highest received a score of "9", the next six a score of "8", and so on.

Factor scores are calculated by weighting the score assigned to each of the 60 statements by each person who loaded on a given factor. The weighted scores for each statement from each participant on a factor are then summed, resulting in one weighted score for each of the 60 statements.[3] So that one can easily compare the ranking of statements *between* factors (the number of person's loading on each factor varies as do the totals for each statement), the weighted sums are then converted to *z* scores (+2 to -2). Hence, the *z* score represents the factor score for each statement. The 60 statements are then arrayed in the format of the original Q-sort, according to the magnitude of the factor score. This creates the composite Q-sort, exemplifying the factor's viewpoint. The factor scores also are given a category score representative of the format in which the statements were originally ranked.

In the results presented below, two tables appear for each viewpoint. In the first table, those items ranked highest and lowest for the factor are listed, along with the factor score (*z* score) and category score. These items are the ones that define a factor or viewpoint. The second table for each factor lists

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[3] Each person's loading on a factor is not perfect (that is, 1.00). For example, as one can observe in Table 1, FFT Expert 1 loads (or "correlates") .79 on Factor 1 while FFT Expert 4 loads .46 on this factor. To reflect this difference in the two experts' alignment with the factor, their scores for each statement are weighted.

those items that differentiate it from the other factors. The highlighted column in these tables shows the category score for the distinguishing items for that factor; the other factors' category scores for those items are also listed for comparison. By convention (Brown, 1992), a category score difference of two or more, either above or below, other factor's category scores defines distinguishing items.

As an example of how the interpretation was accomplished, one can see in Table 3 that statement #60 was ranked high (category score 10) by Factor 1. In contrast, Table 5 shows that this statement was ranked quite low (category score 2) by Factor 2. And in Table 4 it is apparent that this same statement was one of those which differentiated Factor 1 from all the other factors.

The factor interpretation begins with a description of the views contained in each of the six factors, based upon the items which define and distinguish them. For each interpretive statement, the item numbers which support it follow in parentheses. Although the results indicate a variety of viewpoints, of most interest is that all the feminist family therapy experts did not align on one factor. Therefore, more attention is focused on the two feminist viewpoints that emerged from the data. Those statements with which the two feminist views disagreed, and those on which they agreed, are presented. The main differences between the combined feminist views and the other four viewpoints are summarized. Finally, the hypothesized areas of convergence and divergence among feminist family therapists are considered.

The Six Viewpoints

On Factor 1, five of the items with the highest scores, and one item with a low score, relate to issues about neutrality. The feminist respondents on this factor are both defined, and distinguished from other respondents, by their rejection of neutrality in the culture and in therapy (Table 3, item 2; Tables 3 & 4, items 60, 3, 15, 17, 50). Thus, racial, gender, and therapeutic issues cannot be separated from the larger patriarchal context. The outlook of Factor 1 respondents is further defined and distinguished by their high ranking of the item, "Feminist energy should be directed more toward women than toward men because women are in a societally disempowered position" (Tables 3 & 4, item 5). In no way do these respondents view feminism as an angry crusade (Tables 3 & 4, item 56) nor do they see it as harmful to women or families (Table 3, item 57, 53). Factor 1 participants regard therapists as potential agents of social change (Table 3 & 4, item 49).

The belief that there is no neutral space leads the respondents on this factor to advocate for women by challenging power arrangements in the family (Table 3, items 45, 7, 33; Table 4, item 37). Their view of power domination in cases of abuse (Table 3, item 36) is an issue which also distinguishes this factor from other viewpoints. Factor 1 respondents adopt a firm position that victims of abuse are indeed victims and should be protected in therapy (Tables 3 & 4, items 6, 34; Table 4, item 35). It is possible that these respondents do not endorse hierarchy in families because it may lead to abuses of power (Table 4,

Table 3

Items Defining Factor 1

	Factor Score	Category Score
"Most Agree"		
45. An important goal of therapy is to challenge oppression and unfair power arrangements within the family.	1.39	10
02. Language is not simply descriptive but prescriptive: as we narrate an event, we imply what should be.	1.38	10
15. A therapist's behavior will always either reinforce or challenge a family's assumptions about gender.	1.37	10
60. For women of color, fighting racial discrimination takes precedence over contending with gender inequities.	1.37	10
03. The symbolic dimensions of patriarchy are embedded in language, culture, and experience--and thus, from the moment of birth, subtly communicated and internalized.	1.36	10
17. Therapeutic neutrality is an impossible and dangerous myth.	1.33	10
07. The ways in which women are oppressed and exploited in the larger society are reflected in family relationships.	1.20	9
05. Feminist energy should be directed more toward women than toward men because women are in a societally disempowered position.	1.13	9
36. Taking a feminist position in relation to male power means taking a non-neutral position, challenging male control and domination, naming the abuse, and naming the abuser.	1.09	9
19. Therapists should be aware of their own values and how those values are reflected in their interventions.	1.07	9
40. Therapists should be explicit about their own values, sharing and discussing these with the family without imposing them.	1.00	9
33. Whatever the presenting problem, it is important to assess how the power is distributed in family relationships, particularly spousal relationships.	.91	9
"Least Agree"		
28. The psychoanalytic tradition provides a stronger and more suitable scaffolding than general systems theory for a feminist psychotherapy with families.	-1.00	2
44. The goals that a good therapist sets for a family are not necessarily the same as the goals the family would set for itself.	-1.10	2
32. A therapist should not encourage a woman to go out to work without helping the family negotiate a reduction in her work load at home.	-1.11	2
57. Feminism helps to make women feel vulnerable and victimized.	-1.14	2
48. Because the traditional family is best for children, therapists should do whatever they can to prevent divorce.	-1.22	2
24. Social "science" has little relevance to feminism or feminist family therapy.	-1.26	2

Table 3 Continued

34. Conjoint therapy is not always contraindicated in cases of abuse -- you have to decide on a case by case basis.	-1.34	1
56. Much as they dislike admitting it, feminists generally harbor or have harbored categorical anger toward men.	-1.52	1
50. A therapist preoccupied with gender or power limits the potential range of his or her observations and interventions.	-1.54	1
49. Family therapists need not be agents of social change.	-1.58	1
53. In declaring war on gender-linked structures in families, feminists may create another set of labels for mental pathology to add to the ones we already have, and a new kind of "expert" to tell families how they ought to be.	-1.64	1
06. Women do participate in their own abuse, but not as equals.	-1.78	1

Table 4

Items Differentiating Factor 1

	Factor Category Scores					
Higher Ranked	**1**	**2**	**3**	**4**	**5**	**6**
60. For women of color, fighting racial discrimination takes precedence over contending with gender inequities.	10	2	5	2	5	7
03. The symbolic dimensions of patriarchy are embedded in language, culture, and experience--and thus, from the moment of birth, subtly communicated and internalized.	10	9	8	7	8	8
15. A therapist's behavior will always either reinforce or challenge a family's assumptions about gender.	10	7	2	8	1	9
17. Therapeutic neutrality is an impossible and dangerous myth.	10	9	9	2	3	6
45. An important goal of therapy is to challenge oppression and unfair power arrangements within the family.	10	7	1	9	4	5
05. Feminist energy should be directed more toward women than toward men because women are in a societally disempowered position.	9	3	3	8	4	1
35. It is best to avoid conjoint therapy in cases of wife abuse.	8	2	7	3	2	3
Lower Ranked						
37. Family therapists should avoid overstating gender differences while at the same time not ignoring the differences.	3	5	9	8	5	4
11. There is a place for hierarchy in families--at least between parents and children.	3	10	8	10	8	7
34. Conjoint therapy is not always contraindicated in cases of abuse -- you have to decide on a case by case basis.	1	8	6	9	9	7
06. Women do participate in their own abuse, but not as equals.	1	10	7	4	5	5
56. Much as they dislike admitting it, feminists generally harbor or have harbored categorical anger toward men.	1	3	3	2	6	4
50. A therapist preoccupied with gender or power limits the potential range of his or her observations and interventions.	1	2	10	6	7	4
49. Family therapists need not be agents of social change.	1	5	4	10	2	4

item 11). Their "no neutrality" stance has other therapeutic implications. These respondents believe that therapists should be aware of their own values, even sharing them with clients (Table 3, items 19, 40), but without imposing their values on families (Table 3, items 44, 32, 48). The value of being open is also reflected in their dismissal of traditional psychoanalytic theory and endorsement of current social science (Table 3, items 28, 24).

The viewpoint of Factor 1 respondents leans towards the radical school of feminism. Radical feminism centers on the belief that gender oppression is the fundamental oppression (Avis, 1988). This belief is reflected in Factor 1 respondents by their endorsement that feminist energy should be directed more toward women and by their ranking of items related to men's power over women. Further, their therapeutic stance tends to be more open and less hierarchical than traditional therapy dictates.

Respondents' views on Factor 2 are heavily defined and distinguished by the prominent scores they gave to items describing the family and the politics of therapy. In the opinion of Factor 2 participants, the social construction of the family is connected to women's oppression in society (Tables 5 & 6, items 8, 7), and therapy thus becomes political (Tables 5 & 6, item 21). The politics of therapy, for these respondents, include recognizing the influence of patriarchy (Table 5, item 3, 54), rejecting therapeutic neutrality (Table 5, item 17, 14) and focusing on the larger social system (Tables 5 & 6, item 18). Factor 2 respondents are distinguished from others by their inclusion of women as active

Table 5

Items Defining Factor 2

	Factor Score	Category Score
"Most Agree"		
08. There is something fundamentally wrong with the social institution of the family itself, at least as it is currently constituted.	1.93	10
06. Women do participate in their own abuse, but not as equals.	1.82	10
11. There is a place for hierarchy in families--at least between parents and children.	1.37	10
07. The ways in which women are oppressed and exploited in the larger society are reflected in family relationships.	1.36	10
21. Therapy is a political act and cannot be separated from the social issues in which the family is embedded.	1.36	10
18. Family therapists take a non-neutral position by centering their attention on the family microsystem rather than the larger social system.	1.31	10
17. Therapeutic neutrality is an impossible and dangerous myth.	1.17	9
04. Feminism is important for both women and men.	1.08	9
54. Most differences between women and men are attributable to culture, not nature.	.93	9
01. The feminist aim is not to save or promote any particular form of family but to ensure that the needs of every individual are well-served.	.90	9
14. Family therapists too often fail to recognize gender inequality in the traditional family.	.81	9
03. The symbolic dimensions of patriarchy are embedded in language, culture, and experience--and thus, from the moment of birth, subtly communicated and internalized.	.75	9
"Least Agree"		
50. A therapist preoccupied with gender or power limits the potential range of his or her observations and interventions.	-1.03	2
39. A therapist should be open with clients about the process of therapy, explaining what is happening stage by stage, rather than using "strategies" and "tactics."	-1.17	2
35. It is best to avoid conjoint therapy in cases of wife abuse.	-1.20	2
40. Therapists should be explicit about their own values, sharing and discussing these with the family without imposing them.	-1.20	2
57. Feminism helps to make women feel vulnerable and victimized.	-1.29	2
60. For women of color, fighting racial discrimination takes precedence over contending with gender inequities.	-1.30	2
59. White, middle-class feminism too often excludes, silences, and distorts the experiences of women of color.	-1.38	1
52. Feminist family therapy writers do not sufficiently address the practical matters of how, when, and under what circumstances therapists should address gender bias with families.	-1.41	1

Table 5 Continued

58. The uniting of feminism and the recovery movement is one of the most disturbing developments in the feminist movement today.	-1.46	1
53. In declaring war on gender-linked structures in families, feminists may create another set of labels for mental pathology to add to the ones we already have, and a new kind of "expert" to tell families how they ought to be.	-1.47	1
31. Postmodernism fits well with feminism by providing space for alternative viewpoints.	-1.48	1
47. Therapists should avoid the unsavory business of encouraging suspected victims of abuse to "retrieve" their buried childhood memories.	-1.77	1

Table 6

Items Differentiating Factor 2

	Factor Category Scores					
Higher Ranked	1	2	3	4	5	6
07. The ways in which women are oppressed and exploited in the larger society are reflected in family relationships.	9	10	8	4	6	4
08. There is something fundamentally wrong with the social institution of the family itself, at least as it is currently constituted.	5	10	1	3	2	8
21. Therapy is a political act and cannot be separated from the social issues in which the family is embedded.	8	10	9	1	5	1
18. Family therapists take a non-neutral position by centering their attention on the family microsystem rather than the larger social system.	5	10	6	1	4	5
06. Women do participate in their own abuse, but not as equals.	1	10	7	4	5	5
Lower Ranked						
39. A therapist should be open with clients about the process of therapy, explaining what is happening stage by stage, rather than using "strategies" and "tactics."	6	2	4	5	10	9
31. Postmodernism fits well with feminism by providing space for alternative viewpoints.	8	1	8	5	10	6
59. White, middle-class feminism too often excludes, silences, and distorts the experiences of women of color.	6	1	4	4	6	9
52. Feminist family therapy writers do not sufficiently address the practical matters of how, when, and under what circumstances therapists should address gender bias with families.	5	1	6	3	9	8
58. The uniting of feminism and the recovery movement is one of the most disturbing developments in the feminist movement today.	4	1	6	4	2	7

participants in the patriarchal system, even in cases of abuse (Tables 5 & 6, item 6; Table 5, item 35). In keeping with their systems view, they advocate feminism for both women and men (Table 5, item 4). Yet, Factor 2 respondents also retain a focus on the individual (Table 5, items 1, 47), rather than preserving or protecting a system for its own sake.

In the view of Factor 2 respondents, hierarchy has a role in the family (Table 5, item 11), and in therapy (Table 5, item 40). These respondents are partly defined and distinguished by their belief that a feminist family therapist can practice strategic therapy (Tables 5 & 6, item 39). Three defining and distinguishing items that were given very low scores on this factor pertained to criticisms of feminism and feminist family therapy (Tables 5 & 6, items 59, 52, 58) -- commentary that they may believe is meant to divide or distract feminists. For these participants, their view on postmodernism defines and distinguishes them; they appear to view it as another potential threat to feminism (31). Factor 2 respondents regard feminism as a pragmatic philosophy that advocates for everyone, regardless of sex, race, or class (Table 5, items 50, 53, 57, 60).

In general, the viewpoint expressed on Factor 2 could be described as leaning towards the liberal school of feminism. Liberal feminism focuses on the "legal constraints and social policies" that disadvantage women (Avis, 1988, p. 24). Feminists of this school work toward equalizing the power balance between women and men within the existing social structure. Although not a "pure" liberal feminist outlook, the views on Factor 2 align most closely with this school

of feminism. In accordance with working within existing structures, Factor 2 respondents advocate directing feminist energy toward both women and men. These participants would conduct conjoint therapy in cases of abuse, although deciding whether that is appropriate on a case-by-case basis. As therapists, they are more inclined to maintain hierarchical status and to remain "closed" to their clients, thus retaining and working within more traditional therapy values.

Participants characterizing Factor 3 gave prominent scores, that both define and distinguish their views, to items concerning gender and power inequities in the family. Factor 3 participants do not regard traditional families and couples as fraught with gender and/or power issues (Tables 7 & 8, items 8, 13; Table 8, item 9). Thus, they do not agree with feminists that power inequities are a central problem in families (Tables 7 & 8, items 45, 14; Table 7, item 15). However, they appear to take a "middle-of-the-road" position toward these issues (Tables 7 & 8, items 37, 50; Table 7, items 25, 51, 43), regarding gender and power inequities as occasional issues. Factor 3 respondents are additionally defined and distinguished by working with whatever problem the family presents (Tables 7 & 8, items 44, 48; Table 8, item 18; Table 7, item 32), although maintaining a hierarchical therapeutic stance (Table 7, items 38, 41; Table 8, items 42, 40) and working toward family change rather than adjustment (Table 8, item 46).

Respondents on Factor 3 endorse a number of feminist ideas, for example being value-aware, rejecting therapeutic neutrality, and viewing therapy

Table 7

Items Defining Factor 3

	Factor Score	Category Score
"Most Agree"		
53. In declaring war on gender-linked structures in families, feminists may create another set of labels for mental pathology to add to the ones we already have, and a new kind of "expert" to tell families how they ought to be.	1.73	10
50. A therapist preoccupied with gender or power limits the potential range of his or her observations and interventions.	1.63	10
19. Therapists should be aware of their own values and how those values are reflected in their interventions.	1.51	10
02. Language is not simply descriptive but prescriptive: as we narrate an event, we imply what should be.	1.47	10
23. Labeling feminist theory as "linear" and family systems theory as "circular" creates a false dichotomy.	1.45	10
51. It is important to remember that families do not always present problems that are traceable to gender inequities.	1.36	10
43. Good therapy often has nothing to do with getting a woman to realize that she is "oppressed": It is enough to intervene in a way that empowers her.	1.33	9
37. Family therapists should avoid overstating gender differences while at the same time not ignoring the differences.	1.29	9
17. Therapeutic neutrality is an impossible and dangerous myth.	1.29	9
54. Most differences between women and men are attributable to culture, not nature.	1.22	9
38. It is naive, and perhaps irresponsible, to say that the therapist should not direct the course of treatment.	1.12	9
21. Therapy is a political act and cannot be separated from the social issues in which the family is embedded.	.86	9
"Least Agree"		
41. Reducing the hierarchical distance between the therapist and client is an essential part of being a feminist family therapist.	-.86	2
32. A therapist should not encourage a woman to go out to work without helping the family negotiate a reduction in her work load at home.	-.91	2
40. Therapists should be explicit about their own values, sharing and discussing these with the family without imposing them.	-.93	2
14. Family therapists too often fail to recognize gender inequality in the traditional family.	-.99	2
25. Compared to traditional family therapists, family therapists who are lesbians work more effectively with gender issues because lesbians are more often connected to feminist networks.	-1.07	2
15. A therapist's behavior will always either reinforce or challenge a family's assumptions about gender.	-1.08	2

Table 7 Continued

44. The goals that a good therapist sets for a family are not necessarily the same as the goals the family would set for itself.	-1.12	1
24. Social "science" has little relevance to feminism or feminist family therapy.	-1.17	1
08. There is something fundamentally wrong with the social institution of the family itself, at least as it is currently constituted.	-1.40	1
13. The problems of most couples cannot be rationally addressed or solved until the core inequality of the relationship is acknowledged.	-1.45	1
45. An important goal of therapy is to challenge oppression and unfair power arrangements within the family.	-1.54	1
48. Because the traditional family is best for children, therapists should do whatever they can to prevent divorce.	-1.79	1

Table 8

Items Differentiating Factor 3

	Factor Category Scores					
Higher Ranked	**1**	**2**	**3**	**4**	**5**	**6**
50. A therapist preoccupied with gender or power limits the potential range of his or her observations and interventions.	1	2	10	6	7	4
23. Labeling feminist theory as "linear" and family systems theory as "circular" creates a false dichotomy.	8	6	10	5	6	2
37. Family therapists should avoid overstating gender differences while at the same time not ignoring the differences.	3	5	9	8	5	4
42. It is usually not a good idea for a therapist to tell clients that she is a "feminist."	4	4	8	7	1	2
30. Some schools of family therapy are much more compatible with feminism than others.	6	6	8	4	7	4
57. Feminism helps to make women feel vulnerable and victimized.	2	2	7	3	2	3
18. Family therapists take a non-neutral position by centering their attention on the family microsystem rather than the larger social system.	5	10	6	1	4	5
46. The goal of family therapy is change, not adjustment.	6	7	4	5	8	8
Lower Ranked						
04. Feminism is important for both women and men.	6	9	3	6	10	10
09. It is important to view women as individuals in families rather than as the family anchor.	7	8	3	9	7	9
14. Family therapists too often fail to recognize gender inequality in the traditional family.	7	9	2	5	6	10
45. An important goal of therapy is to challenge oppression and unfair power arrangements within the family.	10	7	1	9	4	5
08. There is something fundamentally wrong with the social institution of the family itself, at least as it is currently constituted.	5	10	1	3	2	8
48. Because the traditional family is best for children, therapists should do whatever they can to prevent divorce.	2	3	1	6	3	5
44. The goals that a good therapist sets for a family are not necessarily the same as the goals the family would set for itself.	2	8	1	10	4	2
13. The problems of most couples cannot be rationally addressed or solved until the core inequality of the relationship is acknowledged.	7	7	1	2	7	7

as political (Table 7, items 19, 2, 17, 21). Although they view gender differences as cultural (Table 7, item 54), they do not believe that feminism is important for both sexes (Table 8, item 4), and in fact, see feminism as harmful to women (Table 8, item 57). Although they agree that feminism does fit with systems theory, some schools of family therapy, and social science (Table 7, items 23, 24; Table 8, item 30), they appear to be critical of feminist family therapy, believing that feminists are attempting to dictate how families "should" be (Table 7, item 53).

Factor 4 is defined and distinguished by a traditional view of therapy -- that is, a therapist who is hierarchical, neutral, and whose work stays within the confines of the therapy room (Tables 9 & 10, items 44, 43, 17, 25, 18, 49; Table 9, items 21, 34). Yet, these respondents also believe that family therapy could have an impact on the culture outside of the consulting room (Table 9, item 20). Maintaining hierarchy in the family is important to these participants (Tables 9 & 10, item 10; Table 9, item 11), as is a leaning toward preserving families (Table 10, item 48). Factor 4 respondents are also distinguished by their belief that women are essentially different from men (Tables 9 & 10, item 55), although they seem to attribute gender differences to cultural training (Table 9, item 54) and see no harm in feminism (Table 9, item 57).

In the view of Factor 4 respondents, feminism blends with social science as well as with family systems and psychoanalytic orientations (Table 9, item 24; Tables 9 & 10, items 29, 27). However, they do not subscribe to the prominent

Table 9

Items Defining Factor 4

	Factor Score	Category Score
"Most Agree"		
44. The goals that a good therapist sets for a family are not necessarily the same as the goals the family would set for itself.	2.17	10
51. It is important to remember that families do not always present problems that are traceable to gender inequities.	1.80	10
49. Family therapists need not be agents of social change.	1.61	10
43. Good therapy often has nothing to do with getting a woman to realize that she is "oppressed": It is enough to intervene in a way that empowers her.	1.31	10
11. There is a place for hierarchy in families--at least between parents and children.	1.31	10
55. Women share a "different voice" and different moral sensibilities than men.	1.20	10
33. Whatever the presenting problem, it is important to assess how the power is distributed in family relationships, particularly spousal relationships.	1.12	9
09. It is important to view women as individuals in families rather than as the family anchor.	1.10	9
29. Feminism and feminist values can be superimposed on any family systems approach.	1.08	9
54. Most differences between women and men are attributable to culture, not nature.	1.03	9
45. An important goal of therapy is to challenge oppression and unfair power arrangements within the family.	1.02	9
34. Conjoint therapy is not always contraindicated in cases of abuse -- you have to decide on a case by case basis.	.98	9
"Least Agree"		
57. Feminism helps to make women feel vulnerable and victimized.	-.82	2
17. Therapeutic neutrality is an impossible and dangerous myth.	-.83	2
60. For women of color, fighting racial discrimination takes precedence over contending with gender inequities.	-.87	2
10. A family does not need a hierarchical structure to make it work.	-.89	2
13. The problems of most couples cannot be rationally addressed or solved until the core inequality of the relationship is acknowledged.	-.90	2
25. Compared to traditional family therapists, family therapists who are lesbians work more effectively with gender issues because lesbians are more often connected to feminist networks.	-1.01	2
21. Therapy is a political act and cannot be separated from the social issues in which the family is embedded.	-1.10	1
27. Feminism and psychoanalytic theory are contradictory.	-1.13	1

Table 9 Continued

20. Family therapy is not likely to have much impact on the culture at large.	-1.14	1
24. Social "science" has little relevance to feminism or feminist family therapy.	-1.19	1
18. Family therapists take a non-neutral position by centering their attention on the family microsystem rather than the larger social system.	-1.26	1
22. The systemic sine qua non of circular causality is a sophisticated version of blaming the victim.	-1.67	1

Table 10

Items Differentiating Factor 4

	Factor Category Scores					
Higher Ranked	1	2	3	4	5	6
44. The goals that a good therapist sets for a family are not necessarily the same as the goals the family would set for itself.	2	8	1	10	4	2
43. Good therapy often has nothing to do with getting a woman to realize that she is "oppressed": It is enough to intervene in a way that empowers her.	3	4	9	10	3	9
55. Women share a "different voice" and different moral sensibilities than men.	5	3	4	10	3	1
49. Family therapists need not be agents of social change.	1	5	4	10	2	4
29. Feminism and feminist values can be superimposed on any family systems approach.	3	4	6	9	8	2
48. Because the traditional family is best for children, therapists should do whatever they can to prevent divorce.	2	3	1	6	3	5
Lower Ranked						
12. The economic balance determines the power balance in most couple relationships.	4	8	5	3	7	8
17. Therapeutic neutrality is an impossible and dangerous myth.	10	9	9	2	3	6
10. A family does not need a hierarchical structure to make it work.	4	5	4	2	4	3
27. Feminism and psychoanalytic theory are contradictory.	5	3	6	1	9	6
18. Family therapists take a non-neutral position by centering their attention on the family microsystem rather than the larger social system.	5	10	6	1	4	5
22. The systemic sine qua non of circular causality is a sophisticated version of blaming the victim.	7	7	5	1	3	6

feminist family therapy critique that circular causality blames the victim (Table 9 & 10, item 22). Nor do they view racial inequities as superseding gender inequities (Table 9, item 60).

Respondents on Factor 4 give a mixed message about power relations between women and men. While ranking highly the item, "It is important to remember that families do not always present problems that are traceable to gender inequities" (Table 9, item 51), they also rank highly items describing the assessment and challenging of inequitable power arrangements (Table 9, items 33, 45). They do not see any sort of "core" inequity in couple relationships (Table 9, item 13; Table 10, item 12), but at the same time they endorse the importance of viewing women as individuals within the family (Table 9, item 9).

Factor 5 is defined and distinguished by a viewpoint that emphasizes an open and less hierarchical therapist stance with clients (Tables 11 & 12, items 41, 40, 39, 42, 38; Table 11, item 19). In accordance with this position, respondents view postmodernism as a better philosophical fit with feminism than the hierarchical, "closed," concepts of psychoanalytic theory (Tables 11 & 12, items 27, 31; Table 11, item 28). Factor 5 respondents believe that the differences between women and men are cultural (Table 12, item 54). In their view, feminism is important to both sexes (Table 11, item 4), and is an empowering philosophy for women (Table 11, items 57, 58). In their therapy, Factor 5 participants assess power in relationships and challenge male power in cases of abuse (Table 11, item 33, 36, 47), but take a systems approach toward

Table 11

Items Defining Factor 5

	Factor Score	Category Score
"Most Agree"		
41. Reducing the hierarchical distance between the therapist and client is an essential part of being a feminist family therapist.	1.93	10
40. Therapists should be explicit about their own values, sharing and discussing these with the family without imposing them.	1.77	10
04. Feminism is important for both women and men.	1.69	10
53. In declaring war on gender-linked structures in families, feminists may create another set of labels for mental pathology to add to the ones we already have, and a new kind of "expert" to tell families how they ought to be.	1.46	10
39. A therapist should be open with clients about the process of therapy, explaining what is happening stage by stage, rather than using "strategies" and "tactics."	1.23	10
31. Postmodernism fits well with feminism by providing space for alternative viewpoints.	1.15	10
33. Whatever the presenting problem, it is important to assess how the power is distributed in family relationships, particularly spousal relationships.	1.14	9
34. Conjoint therapy is not always contraindicated in cases of abuse -- you have to decide on a case by case basis.	1.12	9
52. Feminist family therapy writers do not sufficiently address the practical matters of how, when, and under what circumstances therapists should address gender bias with families.	1.05	9
27. Feminism and psychoanalytic theory are contradictory.	.83	9
19. Therapists should be aware of their own values and how those values are reflected in their interventions.	.79	9
36. Taking a feminist position in relation to male power means taking a non-neutral position, challenging male control and domination, naming the abuse, and naming the abuser.	.77	9
"Least Agree"		
57. Feminism helps to make women feel vulnerable and victimized.	-.95	2
58. The uniting of feminism and the recovery movement is one of the most disturbing developments in the feminist movement today.	-.99	2
08. There is something fundamentally wrong with the social institution of the family itself, at least as it is currently constituted.	-1.00	2
25. Compared to traditional family therapists, family therapists who are lesbians work more effectively with gender issues because lesbians are more often connected to feminist networks.	-1.01	2
49. Family therapists need not be agents of social change.	-1.02	2
35. It is best to avoid conjoint therapy in cases of wife abuse.	-1.12	2
20. Family therapy is not likely to have much impact on the culture at large.	-1.31	1

Table 11 Continued

42. It is usually not a good idea for a therapist to tell clients that she is a "feminist."	-1.42	1
38. It is naive, and perhaps irresponsible, to say that the therapist should not direct the course of treatment.	-1.45	1
15. A therapist's behavior will always either reinforce or challenge a family's assumptions about gender.	-1.59	1
47. Therapists should avoid the unsavory business of encouraging suspected victims of abuse to "retrieve" their buried childhood memories.	-1.61	1
28. The psychoanalytic tradition provides a stronger and more suitable scaffolding than general systems theory for a feminist psychotherapy with families.	-1.74	1

Table 12

Items Differentiating Factor 5

	Factor Category Scores					
Higher Ranked	1	2	3	4	5	6
39. A therapist should be open with clients about the process of therapy, explaining what is happening stage by stage, rather than using "strategies" and "tactics."	6	2	4	5	10	9
31. Postmodernism fits well with feminism by providing space for alternative viewpoints.	8	1	8	5	10	6
40. Therapists should be explicit about their own values, sharing and discussing these with the family without imposing them.	9	2	2	4	10	3
41. Reducing the hierarchical distance between the therapist and client is an essential part of being a feminist family therapist.	7	4	2	7	10	1
52. Feminist family therapy writers do not sufficiently address the practical matters of how, when, and under what circumstances therapists should address gender bias with families.	5	1	6	3	9	8
27. Feminism and psychoanalytic theory are contradictory.	5	3	6	1	9	6
56. Much as they dislike admitting it, feminists generally harbor or have harbored categorical anger toward men.	1	3	3	2	6	4
02. Language is not simply descriptive but prescriptive: as we narrate an event, we imply what should be.	10	7	10	7	5	7
Lower Ranked						
54. Most differences between women and men are attributable to culture, not nature.	8	9	9	9	4	6
38. It is naive, and perhaps irresponsible, to say that the therapist should not direct the course of treatment.	4	6	9	8	1	10
15. A therapist's behavior will always either reinforce or challenge a family's assumptions about gender.	10	7	2	8	1	9
42. It is usually not a good idea for a therapist to tell clients that she is a "feminist."	4	4	8	7	1	2

treatment in such cases (Table 11, items 34, 35). For these participants, therapists are agents of social change (Table 11, item 49) as is the therapy itself for the wider culture (Table 11, item 20).

Strongly mitigating against a purely feminist definition of this factor are the participants' belief in therapeutic neutrality (Tables 11 & 12, item 15; Table 11, item 25; Table 12, item 2). Feminist family therapy is regarded with a critical eye by Factor 5 respondents. They ranked highly items describing feminist family therapy as not pragmatic enough and its practitioners as a new kind of expert directing families (Tables 11 & 12, item 52; Table 11, item 53). In the view of these respondents, there is not anything inherently problematic with the traditional family (Table 11, item 8). Further, they suspect feminists of harboring anger towards men (Table 12, item 56).

The interpretation of Factor 6 is tentative. This factor is the weakest, accounting for only four percent of the total variance. It may be a factor that would not replicate. Participants on Factor 6 are partly defined and distinguished from others by their view of feminism. Women are not essentially different from men (Tables 13 & 14, item 55) and it is important to direct feminism toward both sexes (Tables 13 & 14, item 5; Table 13, item 4). However, they perceive feminism as exclusive (Table 13 & 14, items 59, 26; Table 13, item 25) and headed in a disturbing direction (Table 14, item 58). Further, feminism does not fit, for these participants, with all therapy orientations (Tables 13 & 14, items 29, 23; Table 13, item 28). Factor 6 respondents view

Table 13

Items Defining Factor 6

	Factor Score	Category Score
"Most Agree"		
47. Therapists should avoid the unsavory business of encouraging suspected victims of abuse to "retrieve" their buried childhood memories.	2.45	10
04. Feminism is important for both women and men.	1.71	10
32. A therapist should not encourage a woman to go out to work without helping the family negotiate a reduction in her work load at home.	1.45	10
38. It is naive, and perhaps irresponsible, to say that the therapist should not direct the course of treatment.	1.39	10
01. The feminist aim is not to save or promote any particular form of family but to ensure that the needs of every individual are well-served.	1.15	10
14. Family therapists too often fail to recognize gender inequality in the traditional family.	1.12	10
43. Good therapy often has nothing to do with getting a woman to realize that she is "oppressed": It is enough to intervene in a way that empowers her.	1.11	9
15. A therapist's behavior will always either reinforce or challenge a family's assumptions about gender.	1.06	9
09. It is important to view women as individuals in families rather than as the family anchor.	1.03	9
59. White, middle-class feminism too often excludes, silences, and distorts the experiences of women of color.	.99	9
39. A therapist should be open with clients about the process of therapy, explaining what is happening stage by stage, rather than using "strategies" and "tactics."	.87	9
20. Family therapy is not likely to have much impact on the culture at large.	.87	
"Least Agree"		
42. It is usually not a good idea for a therapist to tell clients that she is a "feminist."	-.74	2
25. Compared to traditional family therapists, family therapists who are lesbians work more effectively with gender issues because lesbians are more often connected to feminist networks.	-.87	2
29. Feminism and feminist values can be superimposed on any family systems approach.	-.90	2
24. Social "science" has little relevance to feminism or feminist family therapy.	-.94	2
23. Labeling feminist theory as "linear" and family systems theory as "circular" creates a false dichotomy.	-.99	2
28. The psychoanalytic tradition provides a stronger and more suitable scaffolding than general systems theory for a feminist psychotherapy with families.	-1.18	2
44. The goals that a good therapist sets for a family are not necessarily the same as the goals the family would set for itself.	-1.18	1

Table 13 Continued

55. Women share a "different voice" and different moral sensibilities than men.	-1.21	1
41. Reducing the hierarchical distance between the therapist and client is an essential part of being a feminist family therapist.	-1.28	1
21. Therapy is a political act and cannot be separated from the social issues in which the family is embedded.	-1.48	1
05. Feminist energy should be directed more toward women than toward men because women are in a societally disempowered position.	-1.83	1
36. Taking a feminist position in relation to male power means taking a non-neutral position, challenging male control and domination, naming the abuse, and naming the abuser.	-1.94	1

Table 14

Items Differentiating Factor 6

	Factor Category Scores					
Higher Ranked	**1**	**2**	**3**	**4**	**5**	**6**
14. Family therapists too often fail to recognize gender inequality in the traditional family.	7	9	2	5	6	10
38. It is naive, and perhaps irresponsible, to say that the therapist should not direct the course of treatment.	4	6	9	8	1	10
01. The feminist aim is not to save or promote any particular form of family but to ensure that the needs of every individual are well-served.	5	9	7	6	7	10
32. A therapist should not encourage a woman to go out to work without helping the family negotiate a reduction in her work load at home.	2	8	2	6	8	10
47. Therapists should avoid the unsavory business of encouraging suspected victims of abuse to "retrieve" their buried childhood memories.	6	1	3	7	1	10
59. White, middle-class feminism too often excludes, silences, and distorts the experiences of women of color.	6	1	4	4	6	9
20. Family therapy is not likely to have much impact on the culture at large.	4	6	7	1	1	9
58. The uniting of feminism and the recovery movement is one of the most disturbing developments in the feminist movement today.	4	1	6	4	2	7
19. Therapists should be aware of their own values and how those values are reflected in their interventions.	9	8	10	8	9	6
Lower Ranked						
26. Feminist family therapists are tolerant of diverse family forms, including gay and lesbian couples.	8	4	7	8	8	3
23. Labeling feminist theory as "linear" and family systems theory as "circular" creates a false dichotomy.	8	6	10	5	6	2
29. Feminism and feminist values can be superimposed on any family systems approach.	3	4	6	9	8	2
55. Women share a "different voice" and different moral sensibilities than men.	5	3	4	10	3	1
36. Taking a feminist position in relation to male power means taking a non-neutral position, challenging male control and domination, naming the abuse, and naming the abuser.	9	6	3	6	9	1
41. Reducing the hierarchical distance between the therapist and client is an essential part of being a feminist family therapist.	7	4	2	7	10	1
05. Feminist energy should be directed more toward women than toward men because women are in a societally disempowered position.	9	3	3	8	4	1

therapy as apolitical and unable to change the larger culture (Tables 13 & 14, item 20; Table 13, item 21).

In the view of these respondents, a feminist family therapist need not reduce hierarchical distance in the consulting room nor directly challenge male power (Tables 13 & 14, items 41, 36). Although a therapist should be directive, she should not set the goals for families or individuals (Tables 13 & 14, items 38, 47; Table 13, item 44); she should be "open" without using strategies (Table 13 items 39, 42). A therapist should be aware of gender inequities in the family, serve individuals in the family system, and be aware of how therapist behavior will influence a family's assumptions (Tables 13 & 14, items 14, 1; Table 13, item 9, 15; Table 14, item 19). However, it is acceptable for a therapist to empower a woman without explicitly stating that as a goal and without that goal being stated by the client (Table 13, item 43; Tables 13 & 14, item 32).

Comparing the Two Feminist Viewpoints

In this study two distinctly feminist, but different, views of feminist family therapy emerged. The statements with which the two feminist factors agreed and disagreed reveal their similarities and differences. Those items on which their opinions converge may signify a common ground from which they begin a feminist family therapy. On the other hand, those items that they ranked in opposition to one another illustrate the areas where they diverge in their perspectives. The items on which they agreed and differed also provide data for examining the hypothesized areas of consensus and divergence.

Divergence Between the Feminist Viewpoints. Although the feminist viewpoints have areas of agreement, more importantly they also have differences (Table 15). While both factors emphasize the importance of analyzing men's power over women, they take different directions from that point on. The most notable difference between the two factors is the view that each takes about working with clients who are in abusive relationships. Three of the ten items (35, 6, 34) that draw a line between the two factors are related to this issue. Feminists on Factor 1 believe that feminist energy should be directed more toward women (5). Hence, in an effort to advocate for women, these respondents will not work conjointly with a battering man or incestuous father. To do so would imply that the victim played a contributory role in the abuse. In contrast to Factor 1, respondents on Factor 2 adopt a systemic view of abuse, regarding women as unequal participants in an abusive relational system. Although they do not give a carte blanche to conjoint therapy, they consider it appropriate in some cases. The underlying belief may be that to change a system one has to work with all the players in that system.

Another issue that sharply divides the two viewpoints relates to gender and race (60). Factor 1 respondents are sensitive to the fact that white women have greater status and power in United States culture than do women of color. They may not view the idea that all women do not start on a level playing field as necessarily divisive for feminism. Factor 2 participants see gender as a common

Table 15

Difference Items Between Feminist Factors 1 & 2

	Fac 1	Fac 2	Diff
60. For women of color, fighting racial discrimination takes precedence over contending with gender inequities.	10	2	8
40. Therapists should be explicit about their own values, sharing and discussing these with the family without imposing them.	9	2	7
31. Postmodernism fits well with feminism by providing space for alternative viewpoints.	8	1	7
05. Feminist energy should be directed more toward women than toward men because women are in a societally disempowered position.	9	3	6
35. It is best to avoid conjoint therapy in cases of wife abuse.	8	2	6
06. Women do participate in their own abuse, but not as equals.	1	10	9
34. Conjoint therapy is not always contraindicated in cases of abuse -- you have to decide on a case by case basis.	1	8	7
11. There is a place for hierarchy in families--at least between parents and children.	3	10	7
44. The goals that a good therapist sets for a family are not necessarily the same as the goals the family would set for itself.	2	8	6
32. A therapist should not encourage a woman to go out to work without helping the family negotiate a reduction in her work load at home.	2	8	6

uniting bond, regardless of race. Factor 2 representatives appear to believe that feminism does address the concerns of, and advocates for, all women.

A third area that distinguishes the two feminist factors concerns hierarchy, both in therapy and in the family. Factor 1 respondents reduce hierarchy between client and therapist by being open with their clients about their own values (40). Congruent with that attitude, these therapists would not set different, hidden, goals for a family (44) nor place themselves in the position of orchestrating what the family does (32). Even hierarchy between parents and children (11) is not viewed as essential by Factor 1. In comparison, Factor 2 respondents hold a different opinion on hierarchy. These participants subscribe to hierarchy between therapist and client and between parents and children. Their endorsement of hierarchy could reflect the feminist distinction between referent and expert power.

The final statement distinguishing the two feminist viewpoints relates to postmodernism (31). In the view of Factor 1 respondents, postmodernism provides space for expressing a feminist perspective. Factor 2 participants disagreed with this item, perhaps concerned about dominant viewpoints being the only ones to be given a voice in postmodernism.

Consensus Between the Feminist Viewpoints. Table 16 lists the items related to therapy upon which the two feminist factors agreed. The centerpiece of a feminist family therapy appears to be a firm rejection of neutrality (17, 15). Because in the feminist view patriarchy is embedded in all aspect of life (3, 2)--

Table 16

Consensus Items Between Feminist Factors 1 & 2

	Category Score
17. Therapeutic neutrality is an impossible and dangerous myth.	9.5
21. Therapy is a political act and cannot be separated from the social issues in which the family is embedded.	9.5
07. The ways in which women are oppressed and exploited in the larger society are reflected in family relationships.	9.5
03. The symbolic dimensions of patriarchy are embedded in language, culture, and experience--and thus, from the moment of birth, subtly communicated and internalized.	9.5
54. Many differences between women and men are attributable to culture, not nature.	8.5
45. An important goal of therapy is to challenge oppression and unfair power arrangements within the family.	8.5
15. A therapist's behavior will always either reinforce or challenge a family's assumptions about gender.	8.5
02. Language is not simply descriptive but prescriptive: as we narrate an event, we imply what should be.	8.5
14. Family therapists too often fail to recognize gender inequality in the traditional family.	8.0
48. For the sake of children, therapists should do whatever they can to prevent divorce.	2.5

even replicated in the traditional family structure (7)--therapy is a political act for these respondents (21). One either works toward ameliorating the oppression of women or reinforces the status quo of patriarchal organization. The feminists in this study emphasize that differences between women and men are cultural, rather than innate (54). Thus, challenging cultural arrangement of power within the family becomes a fundamental goal of feminist family therapy (45). These respondents agree that traditional family therapy typically does not address such power imbalances (14). The respondents on the two feminist viewpoints also disagree with the idea that families should be preserved for the sake of children (48). Attempts to circumvent divorce would be indicative of preserving the system at the expense of individuals within that system.

The participants on the two feminist viewpoints also converged on their disagreement with many of the outside criticisms of feminism and feminist family therapy (Table 17). The feminist respondents' rejection of neutrality leads them to firmly repudiate the idea that there is anything impartial about current labels for mental pathology (53) or traditional family structure (51). Both, congruent with an analysis of patriarchy, disagree that a focus on gender and power limits a therapist's interventions or her understanding of problems in families (50). They further disagree that the feminist movement is an angry crusade that ultimately disempowers women (58, 57, 56).

Table 17

Feminist Factors 1 & 2 Consensus Response to Outside Critique

	Category Score
51. It is important to remember that families do not always present problems that are traceable to gender inequities.	3.0
58. The uniting of feminism and the recovery movement is one of the most disturbing developments in the feminist movement today.	2.5
57. Feminism helps to make women feel vulnerable and victimized.	2.0
56. Much as they dislike admitting it, feminists generally harbor or have harbored categorical anger toward men.	2.0
50. A therapist preoccupied with gender or power limits the potential range of his or her observations and interventions.	1.5
53. In declaring war on gender-linked structures in families, feminists may create another set of labels for mental pathology to add to the ones we already have, and a new kind of "expert" to tell families how they ought to be.	1.0

Differences Between the Feminist and Other Viewpoints

Feminist family therapy is not one unified school of family therapy. Those who identify themselves as feminist family therapists may practice quite differently from each other. This is not surprising when feminist family therapy is placed within the context of the broader feminist movement. Just as there are various schools of feminist thought, there are different feminist approaches to family therapy. Nevertheless, as described above, the two feminist factors did have areas of consensus, or a common springboard. What makes feminist family therapy unique, in general, was discerned by examining the items on which the respondents on the feminist factors and the other four factors disagreed.

The top half of Table 18 lists the items ranked high by respondents on the two combined feminist factors. In contrast, these items were given low rankings by participants on the other four factors combined. Following each statement is the category score assigned by each group and a difference score. The bottom half of Table 18 lists the items that the feminists ranked low and that were ranked high on the other four factors.

The principle difference between the feminist respondents and the other participants is the position each takes on neutrality. For feminists, neutrality is not possible (17, 15, 18, 36, 22) and therefore therapy is political (21). A therapist either works toward change or reinforces the status quo. In contrast,

Table 18

Items Most Differentiating Feminist Factors From Other Factors

	Factors 1-2	Factors 3-6	Diff
Higher Rank on Feminist Factors			
21. Therapy is a political act and cannot be separated from the social issues in which the family is embedded.	9.0	4.0	5.0
17. Therapeutic neutrality is an impossible and dangerous myth.	9.5	5.0	4.5
07. The ways in which women are oppressed and exploited in the larger society are reflected in family relationships.	9.5	5.5	4.0
08. There is something fundamentally wrong with the social institution of the family itself, at least as it is currently constituted.	7.5	3.5	4.0
45. An important goal of therapy is to challenge oppression and unfair power arrangements within the family.	8.5	4.8	3.8
15. A therapist's behavior will always either reinforce or challenge a family's assumptions about gender.	8.5	5.0	3.5
18. Family therapists take a non-neutral position by centering their attention on the family microsystem rather than the larger social system.	7.5	4.0	3.5
22. The systemic sine qua non of circular causality is a sophisticated version of blaming the victim.	7.0	3.8	3.3
13. The problems of most couples cannot be rationally addressed or solved until the core inequality of the relationship is acknowledged.	7.0	4.3	2.8
36. Taking a feminist position in relation to male power means taking a non-neutral position, challenging male control and domination, naming the abuse, and naming the abuser.	7.5	4.8	2.8
Lower Rank on Feminist Factors			
53. In declaring war on gender-linked structures in families, feminists may create another set of labels for mental pathology to add to the ones we already have, and a new kind of "expert" to tell families how they ought to be.	1.0	7.8	-6.8
50. A therapist preoccupied with gender or power limits the potential range of his or her observations and interventions.	1.5	6.8	-5.3
51. It is important to remember that families do not always present problems that are traceable to gender inequities.	3.0	7.8	-4.8
43. Good therapy often has nothing to do with getting a woman to realize that she is "oppressed": It is enough to intervene in a way that empowers her.	3.5	7.8	-4.3
52. Feminist family therapy writers do not sufficiently address the practical matters of how, when, and under what circumstances therapists should address gender bias with families.	3.0	6.5	-3.5
34. Conjoint therapy is not always contraindicated in cases of abuse -- you have to decide on a case by case basis.	4.5	7.8	-3.3

Table 18 Continued

39. A therapist should be open with clients about the process of therapy, explaining what is happening stage by stage, rather than using "strategies" and "tactics."	4.0	7.0	-3.0
31. Postmodernism fits well with feminism by providing space for alternative viewpoints.	4.5	7.3	-2.8
29. Feminism and feminist values can be superimposed on any family systems approach.	3.5	6.3	-2.8

the other respondents tend to believe that neutrality is possible and do not see themselves as agents of *social* change.

The issue of neutrality has implications for feminists in their view of women, the family, and therapy. They see the current social setup as problematic for women (7, 8) and advocate for women in therapy (45, 13, 43). The other respondents, unlike the feminists, do not see gender inequity as *central* to problems in families, or problems between women and men (50, 51).

The opposing viewpoints represented by the feminist perspective and the other four viewpoints lead to different conclusions for each type of respondent about feminist family therapy. Feminists do not see themselves as pugnacious reformers of the family (53); and they believe that they have been pragmatic in their writings about how to handle power and gender issues in the family (52). For the other respondents, it is not at all clear to them what feminist family therapists want them to do nor how. Perhaps because of their faith in neutrality, participants on Factors 3 through 6 view feminist family therapy as biased and reformist in an unpleasant way. Feminists would probably understand this viewpoint as resting on the assumption that patriarchy is neutral.

Hypothesized Areas of Convergence and Divergence

The Q-sort items were loosely structured to explore areas of hypothesized consensus and divergence among feminist family therapists. Most of the areas of hypothesized convergence were verified. Referring back to Table 15, the two feminist factors agreed that women's cultural role is in part perpetuated and

reproduced in the traditional family setup (7). The critique that family therapy ignores gender issues is evident in their endorsement of item 14. The two factors agreed on the problem of unequal power in the family (45) and endorsed three items reflecting their stand against neutrality (17, 15, and 3). They also concurred that sexism is transmitted and reinforced through word choice and language (2). The low ranking the feminists gave on item 48--preventing divorce for the sake of children--would seem to indicate a consensus that the family system should not be preserved at the expense of individuals within it.

The concept of circular causality was hypothesized to be another area of consensus. However, the item describing the critique of circular causality was not among those that was ranked highly by both feminist factors. It may be that it was not considered as important an issue as the content in some of the other statements. A surprising finding was that the two feminist factors agreed that therapy is political (21). It was thought that this would be an item on which they would disagree. Item 54, concerning the differences between women and men, was conceptualized as an outside criticism of feminism. It appears that for this sample of feminists the origins of difference between the sexes is an important issue. The fact that this item stands out as one of consensus may be related to the "sameness-difference" debate within feminism generally.

Five of the ten hypothesized areas of divergence were confirmed in this sample. (The items on which they disagreed are in Table 17.) The two feminist factors held differing opinions on who should set the goals in therapy (44); to

whom feminist energy should be directed (5); the hierarchical position of the therapist (40, 32); how to treat violence and abuse in families (35, 35, 34); and the fit of postmodernism with feminism (31).

The feminist factors disagreed about the need for hierarchy between parents and children (11). This may reflect a difference of opinion about power differentials between adults and children rather than a more general commentary on marital and family relationships. Three areas that were hypothesized to elicit a difference of opinion did not rate as primary areas of divergence. These were: the compatibility of feminism and systems theory; the adaptability of family therapy schools to feminism; and whether or not there is a place for a psychoanalytic perspective in feminist family therapy. As noted earlier, it was thought that the feminists would diverge on the statement describing therapy as a political act; it was, instead, an item upon which they agreed. Item 60, addressing the issue of race versus gender, was a statement categorized as an outside critique of feminism. The feminist experts in this study diverged on this issue.

Chapter 4

Discussion

Analysis of experts' Q-sorts revealed two related but distinct viewpoints about feminist family therapy. Feminist experts who aligned with the Factor 1 viewpoint, firmly reject the possibility of neutrality in a therapeutic relationship. Proponents of this view adopt an outlook and therapeutic practice of strongly advocating for women. Respondents on Factor 2 regard patriarchy as a system in which both women and men participate. They focus their energies on redressing power imbalances and gender inequities with all the players in a system.

The two feminist viewpoints diverged on approaches toward treating violence and incest in families; to whom feminist attention should be focused; hierarchy in families and in the therapist stance; the fit of postmodernism with feminism; and racial versus gender issues. Only one of these issues--the question of race taking precedence over gender issues for women of color--was not originally hypothesized to be an area of disagreement. Three areas of hypothesized disagreement, all relating to feminism's fit with family therapy, did not emerge as important issues of difference in this study. Although the feminist

perspectives diverged on the question of hierarchy in families, other statements commenting more generally on current family arrangements did not surface as a significant area of agreement as hypothesized.

Although different from one another, the two feminist viewpoints have a common starting point of disavowing neutrality, analyzing power in relationships, and viewing therapy as political. These issues were all hypothesized areas of agreement. Other hypothesized areas they agreed upon included the pervasiveness of patriarchy and family therapy's tendency to preserve the system at the expense of the individual. In contradiction to one hypothesized area of disagreement, the feminists instead agreed that therapy is political. A statement pertaining to the cultural origins of sex differences was also one of high agreement between the two feminist viewpoints. The feminists in this sample believe that gender is socially constructed rather than innately determined.

The other four viewpoints all endorsed some feminist beliefs, but none of them were distinctly feminist positions. Respondents on Factor 3 express sentiments that suggest ambivalence towards feminism and feminist family therapy. Although the participants who aligned with this viewpoint agree with many feminist beliefs, they ultimately view feminism as potentially detrimental to women, therapy, and therapists. Factor 4 participants retain a traditional view of the family and of therapy practice. However, they view feminism as compatible with all schools of family therapy.

A "nearly-feminist" perspective was expressed by respondents on Factor 5. One of the feminist family therapist experts had a primary loading on this factor (her secondary loading was on Factor 1). These participants' endorsement of numerous feminist opinions was, however, allayed by their faith in the soundness of the traditional family and their belief in neutrality. Factor 6 respondents focus their opinions on what therapists should and should not do. Although they endorsed feminism as important for both sexes, they suggested that feminism is exclusive.

A comparison of the combined feminist viewpoints versus the other four viewpoints sketched the main differences between feminist family therapists and other family therapists. The feminist viewpoint regards patriarchy as a significant problem for women and the root cause of the problems people bring to therapy. The other four viewpoints, as a group, do not consider gender and power inequities as key to the problems brought to therapy by families and couples. While the feminist viewpoints regard therapy as political, the other viewpoints do not regard themselves as social reformers and, as group, retain a belief in neutrality.

Placing Feminist Family Therapy in Context

This study began by asking, in general, "What is feminist family therapy?" The feminist family therapy experts who participated in this study voiced different opinions in answer to that question. Clearly, feminist family therapy is not one unified school of therapy. To understand the similarities and differences

expressed by those who practice feminist family therapy, it is helpful to place it in the context of feminism and the broader cultural discussions of feminism.

A brief note is in order at this juncture. In Q-methodological studies, researchers often give a descriptive label to factors. Although the two feminist factors in the present study were interpreted in the context of feminist schools, the factors were not labeled according to each's fit with a particular school of feminism. The reason for this was twofold. First, neither of the feminist viewpoints aligned perfectly with a school of feminism. Second, labels can become constraining devices. For example, political labels such as those associated with schools of feminism may obscure other relevant aspects of a viewpoint. There is also the risk that upon reading a label, a person may make assumptions about a viewpoint based upon the label alone. Thus the factors were not labeled, but they were interpreted in the context of feminist schools.

Feminism has several different schools of thought. From a common starting point that "women suffer systematic social injustice because of their sex" (Pilalis & Anderton, 1986, p. 101), the various schools of feminism diverge on the source of sexism and the appropriate target to eliminate sexism. Avis (1988) described three major schools of feminism: liberal, socialist, and radical. In this study, the views of those who allied with Factor 1 seem largely consistent with radical feminism, while the viewpoint represented on Factor 2 roughly aligns with liberal feminism.

Neither of the feminist viewpoints in the present study were congruous with socialist feminism. Proponents of this school of feminism analyze how societies are organized, and, principally, how economic class effects the distribution of power. Added to the Marxist analysis of class, socialist feminists also ask why women of every class are dominated (Avis, 1988). Of the statements included in this study, only one related to economics (#12: "The economic balance determines the power balance in most couple relationships"). This item may have been too subtle to extract a socialist view. Respondents on Factor 1 gave a category ranking of "4" to this item. Participants on the Factor 2 came closer to recognizing the power associated with money and ranked this item an "8."

Radical feminism locates the subjugation of women as the primary oppression. In accordance with this view, Factor 1 respondents believe that feminist energy should be directed more toward women. They ranked highly items pertaining to the oppression of women. For example, they believe it is important to assess power relationships in families and challenge unfair arrangements regardless of the presenting problem. The belief that the oppression of women is primary, strongly influences their opinions about interventions, particularly in cases of abuse. These respondents believe it is important to confront male abusers and to avoid conjoint therapy in such cases. The radical school of feminism does not regard women's "neurotic" behavior as "sick." Instead, such behavior is viewed as a response to living in and adapting

to a patriarchal system. In harmony with this idea, the experts on Factor 1 strongly disagreed with the item, "Women do participate in their own abuse, but not as equals."

The radical school of feminism's motto could be, "the personal is the political." Meaning that "what happens in the private sphere, in women's personal lives, is an expression of their oppression in the wider public sphere" (Avis, 1988, p. 25). Respondents on Factor 1 ranked highly an item reflecting the content of that motto. They believe that "the ways in which women are oppressed and exploited in the larger society are reflected in family relationships" (item 7). Factor 1 respondents appear to apply that same idea in the therapy room when they ranked highly the statement, "A therapist's behavior will always either reinforce or challenge a family's assumptions about gender" (item 15). What happens in the privacy of the consulting room is an extension of what happens in the wider culture. Additionally, Factor 1 respondents' belief in the embededdness of patriarchy (item 3) is reflective of the tenets of radical feminism. Their high ranking of the item concerning racial versus sex discrimination represents a move closer to the emerging feminist philosophy of interrelated systems of oppression.

According to Avis (1988) liberal feminism emphasizes gaining equal rights and opportunities for women. Women's oppression can be eradicated by reforming discriminatory legal and social policies. Liberal feminists, thus, focus less on the personal lives of women and more on their public lives. The

viewpoint of respondents on Factor 2 does not align completely with liberal feminism. They ranked highly some "radical" items, such as the embeddness of patriarchy and the exploitation of women in families. This is not greatly surprising, however, given that half of these respondents had secondary loadings on Factor 1. Nevertheless, their overall attitudes come closest to liberal feminist philosophy.

In correspondence with the liberal feminist tradition of gaining equality with men, participants on Factor 2 highly endorsed focusing feminist energies on both women and men. Further, they believe that feminism addresses the concerns of all oppressed groups. An attitude of looking toward the public sphere is reflected in their high rankings of two items (18, 21) that relate to the larger social system--the social politics of therapy and looking beyond the family microcosm. To some extent, the philosophy of liberal feminism implies adopting the values of a patriarchal system, for example hierarchy. Factor 2 respondents appear to value hierarchy in family arrangements; that is, they believe there is a place for hierarchy in families (item 11). Two items to which these respondents gave low rankings relate to reducing hierarchy between therapist and client. They did not agree that therapists should be open about the process of therapy nor share their values with clients.

Although it is helpful to have a frame of reference for understanding the different feminist family therapy viewpoints, it is important to keep in mind that feminism itself continues to evolve. The traditional historical division of feminist

schools may be undergoing a gradual change. As far back as 1984, Hooks wrote persuasively about the limitations of mainstream feminism, particularly for poor people and women of color. Only now is her case for oppression as an interrelated system involving race, sex, and class beginning to emerge in the feminist family therapy literature (Almeida, 1994; Hall & Greene, 1994). In the present study, the issue of racism versus sexism was a subject of difference between the respondents on the two feminist viewpoints. Factor 1 participants highly agreed with the statement, "For women of color, fighting racial discrimination takes precedence over contending with gender inequities." In contrast, respondents on Factor 2 strongly disagreed with that item.

Recent philosophical movements also influence the development of feminist family therapy. Postmodernism is the most current movement and an issue that divides the two feminist viewpoints. Factor 1 respondents endorsed postmodernism as a good fit with feminism; Factor 2 participants highly disagreed that the two philosophies are a good match. Thus, developments in both feminist thought and emerging philosophical movements will continue to interact with and contribute to the multiplicity of ways feminist family therapists view their field.

Turning to the wider cultural discourse on feminism, some feminists espouse the view that there is an essential difference between women and men. This discourse on the "sameness-difference" debate (that is, whether women and men are essentially different or similar to each other) has taken place most

visibly in the popular media. Gilligan's book, *In a Different Voice*, is often cited in these discussions. However, as Faludi (1991) notes in her book, *Backlash*, Gilligan's work has been widely misrepresented in the broader culture. Nevertheless, a backlash on feminism has occurred, most of it, according to Faludi, generated by the popular press and based upon works like Gilligan's. Interestingly, the feminists in the present study had a high degree of convergence on the item, "Most differences between women and men are attributable to culture, not nature." Despite their differences, the Factor 1 and Factor 2 participants in this study may be expressing jointly the view that focusing on an essential, "kinder," ethic of women does not serve women, or the feminist cause, well.

Limitations of the Study

There are limitations and methodological issues that require attention in the present study. The purpose of this study, and the empirical method employed, was not to survey every technique a feminist family therapist might use nor was it designed to analyze any one issue in depth. Rather, its purpose was to identify viewpoints and explore the relationship between differing points of view. Thus, the content of the Q-sort items was necessarily circumscribed to represent the main issues on which it was hypothesized that there might be consensus or divergence. It is possible that there are other prominent issues that were not addressed in the Q-sort items.

Q-methodology typically employs a small sample of people, as did this study. Therefore, the generalizability of the results may be limited. The viewpoints described in the present study do not represent every viewpoint "out there." Neither is it possible to determine from the present study what proportion of feminist family therapists would align with Factor 1 or Factor 2 or some other point of view. However, it is possible that at least some of the viewpoints that emerged in this study would replicate.

Thomas and Baas (1992/1993) refer to a type of generalization that they call "reliable schematics." An example helps convey the meaning of their term. Suppose an independent investigator read through the feminist family therapy literature and devised a Q-sort instrument structured into hypothesized areas of convergence and divergence, and critiques of feminist family therapy and feminism. Then the investigator administers her or his Q-sort to a different, but similarly composed, sample of respondents. At least some of the perspectives that are substantially the same as those in the present study may well emerge from that Q-sort. Thus, the distinction Thomas and Baas are drawing is one between generalizability to populations versus generalizability about a phenomenon (p. 22). Based on their argument, there is reason to believe that the results of the present study are not wholly idiosyncratic. Despite the fact that there are obvious particularities in the present study, there remains the possibility that one or more of the viewpoints are substantive perspectives.

The results of the present study suggest questions for future research. For example, it was evident that the respondents on the two feminist factors had differing viewpoints on how to work with families involved in incest and/or wife abuse. What other pragmatic (or behavioral) differences might there be in the therapy room between the two groups of feminist respondents? Is the particular feminist philosophy of a feminist family therapist reflected in how she intervenes with families? Another question might be, would the respondents on the two feminist viewpoints differ in the scope of change that they expect? Participants on Factor 1 appeared to emphasize a more educational approach while respondents on Factor 2 seemed more strategic and focused on pragmatics. For each group, when would therapy be considered complete?

Conclusions

Therapists who are not trained in family therapy may understand the label "family therapist" as someone who "works with families." For those who are well-versed in the different schools of family therapy, that simple definition falls far short of describing how any given family therapist may work. In the same way, describing a feminist family therapist as one who "works with gender issues in mind" only vaguely describes feminist family therapy.

The results of this study suggest that feminist family therapists may need to educate their readers, both in terms of the schools of feminism and the differences in opinion amongst feminist family therapists. Phrases such as "using the lens of feminist theory" or "from a feminist perspective" are common in

the feminist family therapy literature. However, it is rare to find even a brief synopsis of what an author means by "feminist." Those who publish on feminist family therapy may want to consider routinely including at the beginning of publications a short summary of the school of feminism from which s/he operates. For those who are not grounded in feminist theories, such a review would provide the reader with a better understanding of the different schools of feminism and the particular context from which an author writes.

There does not appear to be much discussion in the feminist family therapy literature about the differences amongst feminists. This may be due to feminist concerns of being "divided and conquered" by people who are unsympathetic toward the feminist cause. The cost of such silence, however, is that feminism and feminist family therapy is at risk of being regarded as a monolithic entity. Rather, as this study indicates, there is flexibility and room for difference in the practice of feminist family therapy. Further, without such discussion, the field risks stagnation.

References

Almeida, R. V. (1994). Introduction. Journal of Feminist Family Therapy, 5(3/4), 1-3.

Ault-Riche, M. (Ed.) (1986). Women and Family Therapy. The Family Therapy Collections (J. C. Hansen, series editor). Rockville, MD: Aspen Systems Corp.

Avis, J. M. (1986). Feminist issues in family therapy. In F. P. Piercy & D. H. Sprenkle, Family Therapy Sourcebook (pp. 213-242). New York: Guilford press.

Avis, J. M. (1988). Deepening awareness: A private study guide to feminism and family therapy. In L. Braverman (Ed.), A Guide to Feminist Family Therapy (pp. 15-46). London: Harrington Park Press.

Avis, J. M. (1989). Book reviews. Journal of Feminist Family Therapy, 1(1), 93-100.

Avis, J. M. (1991). Politics and empowerment in my therapy. Journal of Feminist Family Therapy, 3(1/2), 141-153.

Avis, J. M. (1992). Where are all the family therapists? Abuse and violence within families and family therapy's response. Journal of Marital and Family Therapy, 18, 225-232.

Avis, J. M. (1994). Advocates versus researchers--A false dichotomy? A feminist, social constructionist response to Jacobson. Family Process, 33, 87-91.

Barrett, M. J., Trepper, T. S., & Fish, L. S. (1990). Feminist-informed family therapy for the treatment of intrafamily child sexual abuse. Journal of Family Psychology, 4, 151-166.

Bepko, C. (1985). Mary and John. Power, power, who's got the power? Family Therapy Networker, 9, 47-49.

Berry, W. D., & Lewis-Beck, M. S. (1986). Introduction. In W. D. Berry and M. S. Lewis-Beck (Eds.), New tools for social scientists (pp. 13-21). Beverly Hills, CA: Sage.

Black, L., & Piercy, F. (1991). A feminist family therapy scale. Journal of Marital and Family Therapy, 17, 111-120.

Bograd, M. (1986a). A feminist examination of family systems models of violence against women in the family. In M. Ault-Riche (Ed)., Women and Family Therapy (pp. 34-50). Rockville, MD: Aspen Systems.

Bograd, M. (1986b). A feminist examination of family therapy: What is women's place? Women and Therapy, 5 (2-3), 95-106.

Bograd, M. (1988a). Enmeshment, fusion or relatedness? A conceptual analysis. In L. Braverman (Ed.), A Guide to Feminist Family Therapy (pp. 65-80). London: Harrington Park Press.

Bograd, M. (1988b). Power, gender, and the family: Feminist Perspectives on family systems theory. In M. Dutton-Douglas & L. E. A. Walker (Eds.), Feminist psychotherapies: Integration of therapeutic and feminist systems (pp. 118-133). Norwood, NJ: Ablex Publishing.

Bograd, M. (1990). Feminist approaches for men in family therapy. Journal of Feminist Family Therapy, 2(3/4).

Bograd, M. (1992). Values in conflict: Challenges to family therapists' thinking. Journal of Marital and Family Therapy, 18, 245-256.

Brown, S. R. (1980). Political subjectivity: Applications of Q-methodology in political science. New Haven: Yale University Press.

Brown, S. R. (1986). Q technique and method. Principles and procedures. In W. D. Berry and M. S. Lewis-Beck (Eds.), New tools for social scientists (pp. 57-76). Beverly Hills, CA: Sage.

Brown, S. R. (1992). Q Methodology [108 paragraphs]. Q Methodology Network [On-line serial]. Available E-mail: q-method@kentvm.kent.bitnet.

Candib, L. M. (1989). Family life cycle theory: A feminist critique. Family Systems Medicine, 7, 473-487.

Carter, B. (1992). Stonewalling feminism. Family Therapy Networker, 16, 64-69.

Carter, B., Papp, P., Silverstein, O., & Walters M. (1986). The procrustean bed. Family Process, 25, 301-304.

Chaney, S. E., & Piercy, F. P. (1988). A feminist family therapist behavior checklist. American Journal of Family Therapy, 16, 305-318.

Coyne, J. C. (1992, May/June). Stonewalling feminism [Letter to the editor]. Family Therapy Networker, 16, p. 7.

Enns, C. Z. (1988). Dilemmas of power and equality in marital and family counseling: Proposals for a feminist perspective. Journal of Counseling and Development, 67, 242-248.

Faludi, S. (1991). Backlash: The undeclared war against American women. New York: Crown Publishers.

Fish, L. S. (1989). Comparing structural, strategic, and feminist-informed family therapies: Two Delphi studies. American Journal of Family Therapy, 17, 303-314.

Gelles, R. J. (1994). Research and advocacy: Can one wear two hats? Family Process, 33, 93-95.

Gilligan, C. (1982). In a different voice. Cambridge: Harvard University Press.

Goldner, V. (1985a). Feminism and family therapy. Family Process, 24, 31-47.

Goldner, V. (1985b). Warning: Family therapy may be hazardous to your health. Family Therapy Networker, 9, 19-23.

Goldner, V. (1987). Instrumentalism, feminism, and the limits of family therapy. Journal of Family Psychology, 1, 109-116.

Goldner, V., Penn, P., Sheinberg, M., & Walker, G. (1990). Love and violence: Gender paradoxes in volatile attachments. Family Process, 29, 343-364.

Goldner, V. (1991). Feminism and systemic practice: Two critical traditions in transition. Journal of Strategic and Systemic Therapies, 10, 118-126.

Goodrich, T. J. (1991). Women, power, and family therapy: What's wrong with this picture? Journal of Feminist Family Therapy, 3(1/2), 5-37.

Goodrich, T. J., Rampage, C., Ellman, B., & Halstead, K. (1985). Angie and Hank. Learning to stop singing the blues. Family Therapy Networker, 9, 50-52 & 70-71.

Goodrich, T. J., Rampage, C., Ellman, B., & Halstead, K. (1988). Feminist family therapy. A casebook. New York: W.W. Norton.

Grunebaum, J. (1987). Multidirected partiality and the "parental imperative." Psychotherapy, 24, 646-656.

Gutsche, S., & Murray, M. (1991). The feminist meets the cybernetician: An integrated approach to spousal violence. Journal of Strategic and Systemic Therapies, 10, 76-91.

Hall, R. L., & Greene, B. (1994). Cultural competence in feminist family therapy: An ethical mandate. Journal of Feminist Family Therapy, 6(3), 5-28.

Hare-Mustin, R. T. (1978). A feminist approach to family therapy. Family Process, 17, 181-194.

Hare-Mustin, R. T. (1979). Family therapy and sex role stereotypes. Counseling Psychologist, 8, 31-32.

Hare-Mustin, R. T. (1980). Family therapy may be dangerous for your health. Professional Psychology, 11, 935-938.

Hare-Mustin, R. T. (1987). The problem of gender in family therapy theory. Family Process, 26, 15-27.

Hare-Mustin, R. T. (1988). Family change and gender differences: Implications for theory and practice. Family Relations, 37, 36-41.

Hare-Mustin, R. T. (1994). Discourses in the mirrored room: A postmodern analysis of therapy. Family Process, 33, 19-35.

Hill, M. (1992). A feminist model for the use of paradoxical techniques in psychotherapy. Professional Psychology: Research and Practice, 23, 287-292.

Hindmarsh, J. H. (1993). Alternative family therapy discourses: It is time to reflect (critically). Journal of Feminist Family Therapy, 5(2), 5-28.

Hoffman, L. (1990). Constructing realities: An art of lenses. Family Process, 29, 1-12.

Hooks, Bell. (1984). Feminist theory from margin to center. Boston: South End Press.

Imber-Black, E. (1986). Families, larger systems and the wider social context. Journal of Strategic and Systemic Therapies, 5, 29-35.

Ivey, D. C., & Conoley, C. W. (1994). Influence of gender in family evaluations: A comparison of trained and untrained observer perceptions of matriarchal and patriarchal family interviews. Journal of Family Psychology, 8, 336-346.

Jacobson, N. S. (1994). Rewards and dangers in researching domestic violence. Family Process, 33, 81-85.

James, K. (1984). Breaking the chains of gender: Family therapy's position? Australian Journal of Family Therapy, 5, 241-248.

James, K., & McIntyre, D. (1983). The reproduction of families: The social role of family therapy? Journal of Marital and Family Therapy, 9, 119-129.

James, K., & MacKinnon, L. (1990). The "incestuous family" revisited: A critical analysis of family therapy myths. Journal of Marital and Family Therapy, 16, 71-88.

James, K., & McIntyre, D. (1990). Is psychology a crime, too? Further reflections on violence, relationships, and therapeutic responses. Australia and New Zealand Journal of Family Therapy, 11, 71-73.

Kaminer, W. (1993, October). Feminism's identity crisis. Atlantic Monthly, 272, 51-68.

Kaschak, E. (1990). How to be a failure as a family therapist: A feminist perspective. In H. Lerman & N. Porter (Eds.), Feminist ethics in psychotherapy (pp. 70-81). New York: Springer.

Kerlinger, F. N. (1973). Foundations of behavioral research (2nd ed.). New York: Holt, Rinehart and Winston, Inc.

Kingston, P. (1986). Socialist feminism: Necessary but insufficient. Comment on feminism and family therapy--A possible meeting point, by J. Pilalis and J. Anderton. Journal of Family Therapy, 8, 115-119.

Layton, M. (1984). Tipping the therapeutic balance--masculine, feminine, or neuter? Family Therapy Networker, 8, 20-27.

Layton, M. (1985). Paula and Don. A marriage in search of a nag. Family Therapy Networker, 9, 40-41 & 44-46.

Lerner, H. G. (1985). Dianna and Lillie. Can a feminist still like Murray Bowen? Family Therapy Networker, 9, 36-39.

Lerner, H. G. (1988). Is family systems theory really systemic? A feminist communication. In L. Braverman (Ed.), A guide to feminist family therapy (pp. 47-63). London: Harrington Park Press.

Leslie, L. A., & Clossick, M. L. (1992). Changing set: Teaching family therapy from a feminist perspective. Family Relations, 41, 256-263.

Libow, J. A., Raskin, P. A., & Caust, B. L. (1982). Feminist and family systems therapy: Are they irreconcilable? American Journal of Family Therapy, 10, 3-12.

Loftus, E. F. (1993). The reality of repressed memories. American Psychologist, 48, 518-537.

Lopez, F. G. (1989). Is society "sick"? Journal of Counseling and Development, 67, 582-584.

Luepnitz, D. A. (1988). The family interpreted. Feminist theory in clinical practice. New York: Basic Books.

MacKinnon, L. K., & Miller, D. (1987). The new epistemology and the Milan approach: Feminist and sociopolitical considerations. Journal of Marital and Family Therapy, 13, 139-155.

Magraw, S. (1992). Feminism and family therapy: An oral history. Unpublished doctoral dissertation, California School of Professional Psychology, Berkeley, CA.

Mason, B., & Mason, E. (1990). Masculinity and family work. In R.J. Perelberg and A.C. Miller (Eds.), Gender and power in families (pp. 209-217). New York: Tavistock/Routledge.

McCollum, E. E., & Russell, C. S. (1992). Mother-blaming in family therapy: An empirical investigation. American Journal of Family Therapy, 20, 71-76.

McGoldrick, M. (1988, October). Marital therapy in context. Paper presented at the plenary meeting of the American Association of Marriage and Family Therapy, New Orleans, LA.

McGregor, H. (1990). Yes, psychology is a crime (metaphorically speaking!) If it means that victims of violence are blamed or implicated in the violence perpetrated against them. Australia and New Zealand Journal of Family Therapy, 11, 73.

McKeown, B., & Thomas, D. (1988). Q methodology. Sage University Paper series on Quantitative Applications in the Social Sciences, series no. 07-066. Beverly Hills, CA: Sage Publications.

McNamee, S. (1994). Research as relationally situated activity: Ethical implications. Journal of Feminist Family Therapy, 6(3), 69-83.

Nichols, M. (1985). Checking our biases. Family Therapy Networker, 9, 75-77.

Nichols, M. P. (1991). Deconstructing gender. Family Therapy Networker, 15, 81-82.

Nunnally, J. C. (1978). Psychometric theory. New York: McGraw-Hill.

Okun, B. F. (1983). Gender issues of family systems therapists. In B.F. Okun & S.T. Gladding (Eds.), Issues in training marriage and family therapists (pp. 45-57). Ann Arbor, MI: ERIC/CAPS.

O'Brien, M. (1990). The place of men in gender-sensitive therapy. In R.J. Perelberg and A.C. Miller (Eds.), Gender and power in families (pp. 195-208). New York: Tavistock/Routledge.

Osborne, K. (1983). Women in families: Feminist therapy and family systems. Journal of Family Therapy, 5, 1-10.

Penfold, P. S. (1989). Family therapy: Critique from a feminist perspective. Canadian Journal of Psychiatry, 34, 311-315.

Pilalis, J., & Anderton, J. (1986). Feminism and family therapy--a possible meeting point. Journal of Family Therapy, 8, 99-114.

Riche, M. (1984). The systemic feminist. Family Therapy Networker, 8, 43-44.

Rice, D. G., & Rice, J. K. (1977). Non-sexist martial therapy. Journal of Marriage and Family Counseling, 3, 3-10.

Rohrbaugh, M., Shoham, V., & Spungen, C. (1995). Family systems therapy in practice: A systemic couples therapy for problem drinking. In B. Bongar & L. Beutler (Eds.), Foundations of psychotherapy.

Sheinberg, M. & Penn, P. (1991). Gender dilemmas, gender questions, and the gender mantra. Journal of Marital and Family Therapy, 17, 33-44.

Sheinberg, M. (1992). Navigating treatment impasses at the disclosure of incest: Combining ideas from feminism and social constructionism. Family Process, 31, 201-216.

Silverstein, O. (1985). Mrs. Gray and Susan. Beyond mother bashing. Family Therapy Networker, 9, 72-74.

Simola, S. K. (1992). Differences among sexist, nonsexist, and feminist family therapies. Professional Psychology: Research and Practice, 23, 397-403.

Simon, R. (1984). From ideology to practice: The women's project in family therapy. Family Therapy Networker, 8, 29-32 & 38-40.

Simon, R. (Ed.) (1985). Putting feminism into practice. Five case studies. Family Therapy Networker, 9, 35-41 & 44-52 & 70-74.

Stephenson, W. (1953). The study of behavior. Chicago: University of Chicago Press.

Taggart, M. (1985). The feminist critique in epistemological perspective: Questions of context in family therapy. Journal of Marital and Family Therapy, 11, 113-126.

Terry, L. L. (1992). Gender and family therapy: Adding a bi-level belief systems component to assessment. Contemporary Family Therapy, 14, 199-210.

Thomas, D. B., & Baas, L. R. (1992/1993). The issue of generalization in Q methodology: "Reliable schematics" revisited. Operant Subjectivity, 16, 18-36.

Walters, M., Carter, B., Papp, P., & Silverstein, O. (1988). The invisible web. New York: Guilford Press.

Wheeler, D. (1985). The fear of feminism in family therapy. Family Therapy Networker, 9, 53-55.

Appendix A

Q-sort Items

01. The feminist aim is not to save or promote any particular form of family but to ensure that the needs of every individual are well-served.

02. Language is not simply descriptive but prescriptive: as we narrate an event, we imply what should be.

03. The symbolic dimensions of patriarchy are embedded in language, culture, and experience--and thus, from the moment of birth, subtly communicated and internalized.

04. Feminism is important for both women and men.

05. Feminist energy should be directed more toward women than toward men because women are in a societally disempowered position.

06. Women do participate in their own abuse, but not as equals.

07. The ways in which women are oppressed and exploited in the larger society are reflected in family relationships.

08. There is something fundamentally wrong with the social institution of the family itself, at least as it is currently constituted.

09. It is important to view women as individuals in families.

10. A family does not need a hierarchical structure to make it work.

11. There is a place for hierarchy in families--at least between parents and children.

12. The economic balance determines the power balance in most couple relationships.

13. The problems of most couples cannot be rationally addressed or solved until the core inequality of the relationship is acknowledged.

14. Family therapists too often fail to recognize gender inequality in the traditional family.

15. A therapist's behavior will always either reinforce or challenge a family's assumptions about gender.

16. Traditional family therapy undervalues the importance of connection and intimacy skills.

17. Therapeutic neutrality is an impossible and dangerous myth.

18. Family therapists take a non-neutral position by centering their attention on the family microsystem rather than the larger social system.

19. Therapists should be aware of their own values and how those values are reflected in their interventions.

20. Family therapy is not likely to have much impact on the culture at large.

21. Therapy is a political act and cannot be separated from the social issues in which the family is embedded.

22. The systemic sine qua non of circular causality is a sophisticated version of blaming the victim.

23. Labeling feminist theory as "linear" and family systems theory as "circular" creates a false dichotomy.

24. Social "science" has little relevance to feminism or feminist family therapy.

25. Compared to traditional family therapists, family therapists who are lesbians work more effectively with gender issues because lesbians are more often connected to feminist networks.

26. Feminist family therapists are tolerant of diverse family forms, including gay and lesbian couples.

27. Feminism and psychoanalytic theory are contradictory.

28. The psychoanalytic tradition provides a stronger and more suitable scaffolding than general systems theory for a feminist psychotherapy with families.

29. Feminism and feminist values can be superimposed on any family systems approach.

30. Some schools of family therapy are much more compatible with feminism than others.

31. Postmodernism fits well with feminism by providing space for alternative viewpoints.

32. A therapist should not encourage a woman to go out to work without helping the family negotiate a reduction in her work load at home.

33. Whatever the presenting problem, it is important to assess how the power is distributed in family relationships, particularly spousal relationships.

34. Conjoint therapy is not always contraindicated in cases of abuse -- you have to decide on a case by case basis.

35. It is best to avoid conjoint therapy in cases of wife abuse.

36. Taking a feminist position in relation to male power means taking a non-neutral position, challenging male control and domination, naming the abuse, and naming the abuser.

37. Family therapists should avoid overstating gender differences while at the same time not ignoring the differences.

38. It is naive, and perhaps irresponsible, to say that the therapist should not direct the course of treatment.

39. A therapist should be open with clients about the process of therapy, explaining what is happening stage by stage, rather than using "strategies" and "tactics."

40. Therapists should be explicit about their own values, sharing and discussing these with the family without imposing them.

41. Reducing the hierarchical distance between the therapist and client is an essential part of being a feminist family therapist.

42. It is usually not a good idea for a therapist to tell clients that she is a "feminist."

43. Good therapy often has nothing to do with getting a woman to realize that she is "oppressed": It is enough to intervene in a way that empowers her.

44. The goals that a good therapist sets for a family are not necessarily the same as the goals the family would set for itself.

45. An important goal of therapy is to challenge oppression and unfair power arrangements within the family.

46. The goal of family therapy is change, not adjustment.

47. Therapists should avoid the unsavory business of encouraging suspected victims of abuse to "retrieve" their buried childhood memories.

48. For the sake of children, therapists should do whatever they can to prevent divorce.

49. Family therapists need not be agents of social change.

50. A therapist preoccupied with gender or power limits the potential range of his or her observations and interventions.

51. It is important to remember that families do not always present problems that are traceable to gender inequities.

52. Feminist family therapy writers do not sufficiently address the practical matters of how, when, and under what circumstances therapists should address gender bias with families.

53. In declaring war on gender-linked structures in families, feminists may create another set of labels for mental pathology to add to the ones we already have, and a new kind of "expert" to tell families how they ought to be.

54. Many differences between women and men are attributable to culture, not nature.

55. Women share a "different voice" and different moral sensibilities than men.

56. Much as they dislike admitting it, feminists generally harbor or have harbored categorical anger toward men.

57. Feminism helps to make women feel vulnerable and victimized.

58. The uniting of feminism and the recovery movement is one of the most disturbing developments in the feminist movement today.

59. Feminist family therapy appeals mostly to middle-class white women, not to poor women or women of color.

60. For women of color, fighting racial discrimination takes precedence over contending with gender inequities.

Appendix B

Introductory Letter and Instructions

Feminist Family Therapy Q-Sort Instructions

June 15, 1994

Dear Colleague,

We are conducting a Q-sort study of feminist family therapy and would greatly appreciate your participation.

The task is to rank 60 statements from the accompanying deck by sorting them into 10 categories according to how well they represent your own views. The categories follow a continuum from "least agree" (category 1) to "most agree" (category 10). The Q-sort is structured so that 6 statements must be placed in each category; however, the ordering of items within categories is irrelevant. Also, since sorting is a relative task, it is possible that you will agree with more statements than you disagree with, or vice versa.

To help with the sorting, the deck includes 10 category headers that can be spread out across a table. Some find it easiest to sort in stages--for example, by first arranging the items in two or three general categories, then making finer discriminations from there.

After you have sorted the slips of paper, please copy the item numbers into the corresponding boxes on the Q-sort Response Form.

Return the completed response form to Bronwen Cheek, 609-C Chelsea Place, Newport News, VA 23606 before August 20th, when she will be leaving for internship in Utah. Otherwise, send or fax the form to Michael Rohrbaugh, Division of Family Studies (FCR-210B), University of Arizona, Tucson AZ 85721 (fax: 602/544-0797).

Again, thank you for participating. If you give us your address we will send a summary of results as soon as one is ready.

Bronwen Cheek
Doctoral Candidate
Virginia Consortium for Professional Psychology

Michael Rohrbaugh
Professor of Psychology and Family Studies
University of Arizona

Enclosures (2)

Appendix C

Consent Form

I, _____, agree to participate in
(please print your name here)
a Q-sort study on feminist family therapy. The study is being conducted by Bronwen Cheek, a doctoral student at the Virginia Consortium for Professional Psychology.

(1) I understand that I am freely and voluntarily participating in this study and that I am free to discontinue my participation at any time.

(2) I understand that I will be spending approximately 30 to 45 minutes ranking 60 statements and transferring my rankings onto a response sheet.

(3) I understand that I am to return the Q-sort deck, the response sheet, and this consent form in the stamped and addressed envelope provided.

(4) I understand that my name will not be associated with any results of this study.

I have read this statement of consent and, by my signature, agree to participate in the research study described above.

_____ _____
Signature Date

If you would like a summary of the research results when the study is completed, please fill in your address:

Participant Address:

_____

_____

_____

Appendix D

Response Sheet

Feminist Family Therapy

Q-Sort Response Form

ID_____ Gender: M F Date _____

Profession_____ Highest Degree_____ Years clinical experience____

Have you published articles/books on family therapy? (circle) YES NO

Have you published articles/books on feminist family therapy? YES NO

In a few words, what is your theoretical orientation?_____

To what extent do you consider yourself a feminist?

1 2 3 4 5 6 7 8 9
not at all somewhat very much

Least agree — Most agree

1	2	3	4	5	6	7	8	9	10

How well does the ranking of these 60 statements express your point of view?

1	2	3	4	5	6	7	8	9
poorly				so-so			very well	

We would also appreciate your comments. In particular, are there important views about feminist family therapy that the Q-sort does not represent?

Appendix E

Correlation Matrix of the 29 Q-sorts

	Fac 1	Fac 2	Fac 3	Fac 4	Fac 5	Fac 6
FFT Expert 1	.78806	.23251	.01260	.14428	.30689	-.01673
FFT Expert 2	.77341	.20853	.12860	.12725	.20124	.10478
FFT Expert 3	.72885	.25586	.09782	-.06640	.03186	.22528
FFT Expert 4	.46324	.25717	.19758	.33368	.06802	.28620
FFT Expert 5	.33667	.29013	.08124	.23256	.16999	.18079
FFT Expert 6	.15635	.76361	.19660	.16142	-.07150	.00705
FFT Expert 7	.44698	.67065	.09158	.11111	.18032	.15612
FFT Expert 8	.50905	.60970	-.03475	-.16357	.18697	.27188
Fam Thrpst 1	.22946	.60303	.23996	.28261	.14776	.20886
FFT Expert 9	.52269	.60117	-.16270	.13888	.15881	-.01262
FFT Expert 10	.51830	.55209	.06057	.01420	.06528	.13305
FFT Expert 11	.20017	.54514	.03161	.30190	.28943	.02521
Grad Student 1	.22715	.49297	.06338	.07882	.01807	.45873
Grad Student 2	.15911	-.00954	.71931	.22402	.23519	.07662
Grad Student 3	.06719	.32321	.57065	.20342	.26625	.26565
Fam Thrpst 2	.10957	.16324	.57001	.05970	.31426	.22766
Fam Thrpst 3	-.07123	-.30658	.49726	.31136	-.15628	.15333
Professor	-.03495	.17382	.49661	.41414	.19424	.15667
Grad Student 4	.43942	.27684	.44321	-.05556	.00567	.06508
Fam Thrpst 4	.04989	.27924	.16574	.77830	.06179	.04978
Grad Student 5	.16985	.12242	.52390	.70985	.04850	-.18574
Fam Thrpst 5	-.01977	-.02804	.04824	.50212	.35392	.29925
Fam Thrpst 6	.15512	.18035	.31848	.50204	.11558	.36506
FFT Expert 12	.47740	.14330	.27917	-.00001	.70352	-.03292
Fam Thrpst 7	.25879	.17430	.07723	.04497	.61720	.13409
Fam Thrpst 8	-.04495	-.01325	.38158	.38614	.60293	-.00610
Fam Thrpst 9	.24208	.13126	.24852	.25464	.45823	.27468
Grad Student 6	.15191	.05520	.31883	.03027	.08289	.73839
Fam Thrpst 10	.22922	.30424	.08640	.38493	.19210	.54085

Appendix F

Correlation Matrix of Factor Loadings with Ratings of Satisfaction with Q-sort and with Feminist Identification

	F1	F2	F3	F4	F5	F6
FEM	.6969**	.4848**	-.2952	-.5727**	.2205	-.1551
SAT	-.3270	-.1552	-.0052	.3859	.2412	-.0458

* - Signif. LE .05 ** - Signif. LE .01 (2-tailed)

FEM: To what extent do you consider yourself a feminist?

SAT: How well does the ranking of these 60 statements express your point of view?

Appendix G

Factor Matrix for Feminist Experts Only

	Factor 1	Factor 2
Expert 1	.78	.37
Expert 2	.84	
Expert 3	.67	.35
Expert 4	.48	.36
Expert 5	.36	.38
Expert 6		.74
Expert 7	.43	.73
Expert 8	.47	.64
Expert 9	.41	.69
Expert 10	.42	.67
Expert 11		.57
Expert 12	.65	

Appendix H

Correlation Between 6-Factor Solution for all Subjects and 2-Factor Solution for Experts Only

	Expert Factor 1	Expert Factor 2
Factor 1 All Subjects	.9096**	.2525
Factor 2 All Subjects	.0400	.9369**
Factor 3 All Subjects	.1562	.0204
Factor 4 All Subjects	.0925	.1029
Factor 5 All Subjects	.3335**	.0408
Factor 6 All Subjects	.0959	.1256

* - Signif. LE .05 ** - Signif. LE .01 (2-tailed)

Appendix I

Factor Array for Factor 1

		Factor Score	Category Score
45.	An important goal of therapy is to challenge oppression and unfair power arrangements within the family.	1.39	10
02.	Language is not simply descriptive but prescriptive: as we narrate an event, we imply what should be.	1.38	10
15.	A therapist's behavior will always either reinforce or challenge a family's assumptions about gender.	1.37	10
60.	For women of color, fighting racial discrimination takes precedence over contending with gender inequities.	1.37	10
03.	The symbolic dimensions of patriarchy are embedded in language, culture, and experience--and thus, from the moment of birth, subtly communicated and internalized.	1.36	10
17.	Therapeutic neutrality is an impossible and dangerous myth.	1.33	10
07.	The ways in which women are oppressed and exploited in the larger society are reflected in family relationships.	1.20	9
05.	Feminist energy should be directed more toward women than toward men because women are in a societally disempowered position.	1.13	9
36.	Taking a feminist position in relation to male power means taking a non-neutral position, challenging male control and domination, naming the abuse, and naming the abuser.	1.09	9
19.	Therapists should be aware of their own values and how those values are reflected in their interventions.	1.07	9
40.	Therapists should be explicit about their own values, sharing and discussing these with the family without imposing them.	1.00	9

33.	Whatever the presenting problem, it is important to assess how the power is distributed in family relationships, particularly spousal relationships.	.91	9
31.	Postmodernism fits well with feminism by providing space for alternative viewpoints.	.89	8
35.	It is best to avoid conjoint therapy in cases of wife abuse.	.88	8
54.	Many differences between women and men are attributable to culture, not nature.	.82	8
26.	Feminist family therapists are tolerant of diverse family forms, including gay and lesbian couples.	.79	8
21.	Therapy is a political act and cannot be separated from the social issues in which the family is embedded.	.78	8
23.	Labeling feminist theory as "linear" and family systems theory as "circular" creates a false dichotomy.	.77	8
14.	Family therapists too often fail to recognize gender inequality in the traditional family.	.73	7
13.	The problems of most couples cannot be rationally addressed or solved until the core inequality of the relationship is acknowledged.	.68	7
22.	The systemic sine qua non of circular causality is a sophisticated version of blaming the victim.	.41	7
09.	It is important to view women as individuals in families rather than as the family anchor.	.32	7
41.	Reducing the hierarchical distance between the therapist and client is an essential part of being a feminist family therapist.	.31	7
16.	Traditional family therapy undervalues the importance of connection and intimacy skills.	.22	7
39.	A therapist should be open with clients about the process of therapy, explaining what is happening stage by stage, rather than using "strategies" and "tactics."	.18	6

47.	Therapists should avoid the unsavory business of encouraging suspected victims of abuse to "retrieve" their buried childhood memories.	.17	6
04.	Feminism is important for both women and men.	.13	6
30.	Some schools of family therapy are much more compatible with feminism than others.	.06	6
59.	White, middle-class feminism too often excludes, silences, and distorts the experiences of women of color.	.02	6
46.	The goal of family therapy is change, not adjustment.	.01	6
18.	Family therapists take a non-neutral position by centering their attention on the family microsystem rather than the larger social system.	-.02	5
55.	Women share a "different voice" and different moral sensibilities than men.	-.02	5
52.	Feminist family therapy writers do not sufficiently address the practical matters of how, when, and under what circumstances therapists should address gender bias with families.	-.08	5
01.	The feminist aim is not to save or promote any particular form of family but to ensure that the needs of every individual are well-served.	-.13	5
08.	There is something fundamentally wrong with the social institution of the family itself, at least as it is currently constituted.	-.18	5
27.	Feminism and psychoanalytic theory are contradictory.	-.22	5
42.	It is usually not a good idea for a therapist to tell clients that she is a "feminist."	-.23	4
58.	The uniting of feminism and the recovery movement is one of the most disturbing developments in the feminist movement today.	-.23	4
12.	The economic balance determines the power balance in most couple relationships.	-.28	4

38.	It is naive, and perhaps irresponsible, to say that the therapist should not direct the course of treatment.	-.32	4
10.	A family does not need a hierarchical structure to make it work.	-.36	4
20.	Family therapy is not likely to have much impact on the culture at large.	-.36	4
43.	Good therapy often has nothing to do with getting a woman to realize that she is "oppressed": It is enough to intervene in a way that empowers her.	-.41	3
37.	Family therapists should avoid overstating gender differences while at the same time not ignoring the differences.	-.56	3
25.	Compared to traditional family therapists, family therapists who are lesbians work more effectively with gender issues because lesbians are more often connected to feminist networks.	-.57	3
51.	It is important to remember that families do not always present problems that are traceable to gender inequities.	-.74	3
11.	There is a place for hierarchy in families--at least between parents and children.	-.92	3
29.	Feminism and feminist values can be superimposed on any family systems approach.	-.92	3
28.	The psychoanalytic tradition provides a stronger and more suitable scaffolding than general systems theory for a feminist psychotherapy with families.	-1.00	2
44.	The goals that a good therapist sets for a family are not necessarily the same as the goals the family would set for itself.	-1.10	2
32.	A therapist should not encourage a woman to go out to work without helping the family negotiate a reduction in her work load at home.	-1.11	2
57.	Feminism helps to make women feel vulnerable and victimized.	-1.14	2

48.	Because the traditional family is best for children, therapists should do whatever they can to prevent divorce.	-1.22	2
24.	Social "science" has little relevance to feminism or feminist family therapy.	-1.26	2
34.	Conjoint therapy is not always contraindicated in cases of abuse -- you have to decide on a case by case basis.	-1.34	1
56.	Much as they dislike admitting it, feminists generally harbor or have harbored categorical anger toward men.	-1.52	1
50.	A therapist preoccupied with gender or power limits the potential range of his or her observations and interventions.	-1.54	1
49.	Family therapists need not be agents of social change.	-1.58	1
53.	In declaring war on gender-linked structures in families, feminists may create another set of labels for mental pathology to add to the ones we already have, and a new kind of "expert" to tell families how they ought to be.	-1.64	1
06.	Women do participate in their own abuse, but not as equals.	-1.78	1

Appendix J

Factor Array for Factor 2

		Factor Score	Category Score
08.	There is something fundamentally wrong with the social institution of the family itself, at least as it is currently constituted.	1.93	10
06.	Women do participate in their own abuse, but not as equals.	1.82	10
11.	There is a place for hierarchy in families--at least between parents and children.	1.37	10
07.	The ways in which women are oppressed and exploited in the larger society are reflected in family relationships.	1.36	10
21.	Therapy is a political act and cannot be separated from the social issues in which the family is embedded.	1.36	10
18.	Family therapists take a non-neutral position by centering their attention on the family microsystem rather than the larger social system.	1.31	10
17.	Therapeutic neutrality is an impossible and dangerous myth.	1.17	9
04.	Feminism is important for both women and men.	1.08	9
54.	Most differences between women and men are attributable to culture, not nature.	.93	9
01.	The feminist aim is not to save or promote any particular form of family but to ensure that the needs of every individual are well-served.	.90	9
14.	Family therapists too often fail to recognize gender inequality in the traditional family.	.81	9

03.	The symbolic dimensions of patriarchy are embedded in language, culture, and experience--and thus, from the moment of birth, subtly communicated and internalized.	.75	9
44.	The goals that a good therapist sets for a family are not necessarily the same as the goals the family would set for itself.	.72	8
09.	It is important to view women as individuals in families.	.69	8
19.	Therapists should be aware of their own values and how those values are reflected in their interventions.	.67	8
12.	The economic balance determines the power balance in most couple relationships.	.66	8
32.	A therapist should not encourage a woman to go out to work without helping the family negotiate a reduction in her work load at home.	.64	8
34.	Conjoint therapy is not always contraindicated in cases of abuse -- you have to decide on a case by case basis.	.61	8
45.	An important goal of therapy is to challenge oppression and unfair power arrangements within the family.	.55	7
13.	The problems of most couples cannot be rationally addressed or solved until the core inequality of the relationship is acknowledged.	.48	7
02.	Language is not simply descriptive but prescriptive: as we narrate an event, we imply what should be.	.41	7
46.	The goal of family therapy is change, not adjustment.	.39	7
22.	The systemic sine qua non of circular causality is a sophisticated version of blaming the victim.	.29	7
15.	A therapist's behavior will always either reinforce or challenge a family's assumptions about gender.	.24	7
23.	Labeling feminist theory as "linear" and family systems theory as "circular" creates a false dichotomy.	.23	6
38.	It is naive, and perhaps irresponsible, to say that the therapist should <u>not</u> direct the course of treatment.	.21	6

36.	Taking a feminist position in relation to male power means taking a non-neutral position, challenging male control and domination, naming the abuse, and naming the abuser.	.19	6
30.	Some schools of family therapy are much more compatible with feminism than others.	.17	6
33.	Whatever the presenting problem, it is important to assess how the power is distributed in family relationships, particularly spousal relationships.	.15	6
20.	Family therapy is not likely to have much impact on the culture at large.	.14	6
24.	Social "science" has little relevance to feminism or feminist family therapy.	.12	5
10.	A family does not need a hierarchical structure to make it work.	.10	5
28.	The psychoanalytic tradition provides a stronger and more suitable scaffolding than general systems theory for a feminist psychotherapy with families.	-.05	5
37.	Family therapists should avoid overstating gender differences while at the same time not ignoring the differences.	-.08	5
16.	Traditional family therapy undervalues the importance of connection and intimacy skills.	-.10	5
49.	Family therapists need not be agents of social change.	-.20	5
26.	Feminist family therapists are tolerant of diverse family forms, including gay and lesbian couples.	-.22	4
42.	It is usually not a good idea for a therapist to tell clients that she is a "feminist."	-.25	4
43.	Good therapy often has nothing to do with getting a woman to realize that she is "oppressed": It is enough to intervene in a way that empowers her.	-.30	4
25.	Compared to traditional family therapists, family therapists who are lesbians work more effectively with gender issues because lesbians are more often connected to feminist networks.	-.31	4

41.	Reducing the hierarchical distance between the therapist and client is an essential part of being a feminist family therapist.	-.39	4
29.	Feminism and feminist values can be superimposed on any family systems approach.	-.41	4
48.	For the sake of children, therapists should do whatever they can to prevent divorce.	-.48	3
27.	Feminism and psychoanalytic theory are contradictory.	-.50	3
05.	Feminist energy should be directed more toward women than toward men because women are in a societally disempowered position.	-.58	3
56.	Much as they dislike admitting it, feminists generally harbor or have harbored categorical anger toward men.	-.61	3
55.	Women share a "different voice" and different moral sensibilities than men.	-.85	3
51.	It is important to remember that families do not always present problems that are traceable to gender inequities.	-1.01	3
50.	A therapist preoccupied with gender or power limits the potential range of his or her observations and interventions.	-1.03	2
39.	A therapist should be open with clients about the process of therapy, explaining what is happening stage by stage, rather than using "strategies" and "tactics."	-1.17	2
35.	It is best to avoid conjoint therapy in cases of wife abuse.	-1.20	2
40.	Therapists should be explicit about their own values, sharing and discussing these with the family without imposing them.	-1.20	2
57.	Feminism helps to make women feel vulnerable and victimized.	-1.29	2
60.	For women of color, fighting racial discrimination takes precedence over contending with gender inequities.	-1.30	2

59.	White, middle-class feminism too often excludes, silences, and distorts the experiences of women of color.	-1.38	1
52.	Feminist family therapy writers do not sufficiently address the practical matters of how, when, and under what circumstances therapists should address gender bias with families.	-1.41	1
58.	The uniting of feminism and the recovery movement is one of the most disturbing developments in the feminist movement today.	-1.46	1
53.	In declaring war on gender-linked structures in families, feminists may create another set of labels for mental pathology to add to the ones we already have, and a new kind of "expert" to tell families how they ought to be.	-1.47	1
31.	Postmodernism fits well with feminism by providing space for alternative viewpoints.	-1.48	1
47.	Therapists should avoid the unsavory business of encouraging suspected victims of abuse to "retrieve" their buried childhood memories.	-1.77	1

Appendix K

Factor Array for Factor 3

		Factor Score	Category Score
53.	In declaring war on gender-linked structures in families, feminists may create another set of labels for mental pathology to add to the ones we already have, and a new kind of "expert" to tell families how they ought to be.	1.73	10
50.	A therapist preoccupied with gender or power limits the potential range of his or her observations and interventions.	1.63	10
19.	Therapists should be aware of their own values and how those values are reflected in their interventions.	1.51	10
02.	Language is not simply descriptive but prescriptive: as we narrate an event, we imply what should be.	1.47	10
23.	Labeling feminist theory as "linear" and family systems theory as "circular" creates a false dichotomy.	1.45	10
51.	It is important to remember that families do not always present problems that are traceable to gender inequities.	1.36	10
43.	Good therapy often has nothing to do with getting a woman to realize that she is "oppressed": It is enough to intervene in a way that empowers her.	1.33	9
37.	Family therapists should avoid overstating gender differences while at the same time not ignoring the differences.	1.29	9
17.	Therapeutic neutrality is an impossible and dangerous myth.	1.29	9
54.	Most differences between women and men are attributable to culture, not nature.	1.22	9
38.	It is naive, and perhaps irresponsible, to say that the therapist should <u>not</u> direct the course of treatment.	1.12	9

21.	Therapy is a political act and cannot be separated from the social issues in which the family is embedded.	.86	9
07.	The ways in which women are oppressed and exploited in the larger society are reflected in family relationships.	.84	8
30.	Some schools of family therapy are much more compatible with feminism than others.	.74	8
03.	The symbolic dimensions of patriarchy are embedded in language, culture, and experience--and thus, from the moment of birth, subtly communicated and internalized.	.58	8
42.	It is usually not a good idea for a therapist to tell clients that she is a "feminist."	.53	8
31.	Postmodernism fits well with feminism by providing space for alternative viewpoints.	.50	8
11.	There is a place for hierarchy in families--at least between parents and children.	.46	8
57.	Feminism helps to make women feel vulnerable and victimized.	.46	7
20.	Family therapy is not likely to have much impact on the culture at large.	.40	7
01.	The feminist aim is not to save or promote any particular form of family but to ensure that the needs of every individual are well-served.	.19	7
26.	Feminist family therapists are tolerant of diverse family forms, including gay and lesbian couples.	.19	7
06.	Women do participate in their own abuse, but not as equals.	.16	7
35.	It is best to avoid conjoint therapy in cases of wife abuse.	.16	7
34.	Conjoint therapy is not always contraindicated in cases of abuse -- you have to decide on a case by case basis.	.15	6

18.	Family therapists take a non-neutral position by centering their attention on the family microsystem rather than the larger social system.	.13	6
29.	Feminism and feminist values can be superimposed on any family systems approach.	.05	6
27.	Feminism and psychoanalytic theory are contradictory.	.02	6
52.	Feminist family therapy writers do not sufficiently address the practical matters of how, when, and under what circumstances therapists should address gender bias with families.	.02	6
58.	The uniting of feminism and the recovery movement is one of the most disturbing developments in the feminist movement today.	-.00	6
33.	Whatever the presenting problem, it is important to assess how the power is distributed in family relationships, particularly spousal relationships.	-.02	5
16.	Traditional family therapy undervalues the importance of connection and intimacy skills.	-.16	5
22.	The systemic sine qua non of circular causality is a sophisticated version of blaming the victim.	-.17	5
28.	The psychoanalytic tradition provides a stronger and more suitable scaffolding than general systems theory for a feminist psychotherapy with families.	-.25	5
12.	The economic balance determines the power balance in most couple relationships.	-.29	5
60.	For women of color, fighting racial discrimination takes precedence over contending with gender inequities.	-.29	5
10.	A family does not need a hierarchical structure to make it work.	-.32	4
49.	Family therapists need not be agents of social change.	-.34	4
46.	The goal of family therapy is change, not adjustment.	-.43	4
39.	A therapist should be open with clients about the process of therapy, explaining what is happening stage by stage, rather than using "strategies" and "tactics."	-.44	4

59.	Feminist family therapy appeals mostly to middle-class white women, not to poor women or women of color.	-.44	4
55.	Women share a "different voice" and different moral sensibilities than men.	-.46	4
04.	Feminism is important for both women and men.	-.53	3
47.	Therapists should avoid the unsavory business of encouraging suspected victims of abuse to "retrieve" their buried childhood memories.	-.58	3
36.	Taking a feminist position in relation to male power means taking a non-neutral position, challenging male control and domination, naming the abuse, and naming the abuser.	-.63	3
09.	It is important to view women as individuals in families.	-.65	3
56.	Much as they dislike admitting it, feminists generally harbor or have harbored categorical anger toward men.	-.71	3
05.	Feminist energy should be directed more toward women than toward men because women are in a societally disempowered position.	-.81	3
41.	Reducing the hierarchical distance between the therapist and client is an essential part of being a feminist family therapist.	-.86	2
32.	A therapist should not encourage a woman to go out to work without helping the family negotiate a reduction in her work load at home.	-.91	2
40.	Therapists should be explicit about their own values, sharing and discussing these with the family without imposing them.	-.93	2
14.	Family therapists too often fail to recognize gender inequality in the traditional family.	-.99	2
25.	Compared to traditional family therapists, family therapists who are lesbians work more effectively with gender issues because lesbians are more often connected to feminist networks.	-1.07	2
15.	A therapist's behavior will always either reinforce or challenge a family's assumptions about gender.	-1.08	2

44.	The goals that a good therapist sets for a family are not necessarily the same as the goals the family would set for itself.	-1.12	1
24.	Social "science" has little relevance to feminism or feminist family therapy.	-1.17	1
08.	There is something fundamentally wrong with the social institution of the family itself, at least as it is currently constituted.	-1.40	1
13.	The problems of most couples cannot be rationally addressed or solved until the core inequality of the relationship is acknowledged.	-1.45	1
45.	An important goal of therapy is to challenge oppression and unfair power arrangements within the family.	-1.54	1
48.	Because the traditional family is best for children, therapists should do whatever they can to prevent divorce.	-1.79	1

Appendix L

Factor Array for Factor 4

		Factor Score	Category Score
44.	The goals that a good therapist sets for a family are not necessarily the same as the goals the family would set for itself.	2.17	10
51.	It is important to remember that families do not always present problems that are traceable to gender inequities.	1.80	10
49.	Family therapists need not be agents of social change.	1.61	10
43.	Good therapy often has nothing to do with getting a woman to realize that she is "oppressed": It is enough to intervene in a way that empowers her.	1.31	10
11.	There is a place for hierarchy in families--at least between parents and children.	1.31	10
55.	Women share a "different voice" and different moral sensibilities than men.	1.20	10
33.	Whatever the presenting problem, it is important to assess how the power is distributed in family relationships, particularly spousal relationships.	1.12	9
09.	It is important to view women as individuals in families rather than as the family anchor.	1.10	9
29.	Feminism and feminist values can be superimposed on any family systems approach.	1.08	9
54.	Most differences between women and men are attributable to culture, not nature.	1.03	9
45.	An important goal of therapy is to challenge oppression and unfair power arrangements within the family.	1.02	9
34.	Conjoint therapy is not always contraindicated in cases of abuse -- you have to decide on a case by case basis.	.98	9

37.	Family therapists should avoid overstating gender differences while at the same time not ignoring the differences.	.88	8
19.	Therapists should be aware of their own values and how those values are reflected in their interventions.	.87	8
15.	A therapist's behavior will always either reinforce or challenge a family's assumptions about gender.	.86	8
38.	It is naive, and perhaps irresponsible, to say that the therapist should not direct the course of treatment.	.80	8
05.	Feminist energy should be directed more toward women than toward men because women are in a societally disempowered position.	.79	8
26.	Feminist family therapists are tolerant of diverse family forms, including gay and lesbian couples.	.79	8
02.	Language is not simply descriptive but prescriptive: as we narrate an event, we imply what should be.	.76	7
03.	The symbolic dimensions of patriarchy are embedded in language, culture, and experience--and thus, from the moment of birth, subtly communicated and internalized.	.72	7
47.	Therapists should avoid the unsavory business of encouraging suspected victims of abuse to "retrieve" their buried childhood memories.	.69	7
16.	Traditional family therapy undervalues the importance of connection and intimacy skills.	.52	7
42.	It is usually not a good idea for a therapist to tell clients that she is a "feminist."	.46	7
41.	Reducing the hierarchical distance between the therapist and client is an essential part of being a feminist family therapist.	.23	7
50.	A therapist preoccupied with gender or power limits the potential range of his or her observations and interventions.	.19	6

36.	Taking a feminist position in relation to male power means taking a non-neutral position, challenging male control and domination, naming the abuse, and naming the abuser.	.16	6
48.	For the sake of children, therapists should do whatever they can to prevent divorce.	-.07	6
01.	The feminist aim is not to save or promote any particular form of family but to ensure that the needs of every individual are well-served.	-.13	6
04.	Feminism is important for both women and men.	-.17	6
32.	A therapist should not encourage a woman to go out to work without helping the family negotiate a reduction in her work load at home.	-.19	6
23.	Labeling feminist theory as "linear" and family systems theory as "circular" creates a false dichotomy.	-.33	5
39.	A therapist should be open with clients about the process of therapy, explaining what is happening stage by stage, rather than using "strategies" and "tactics."	-.35	5
14.	Family therapists too often fail to recognize gender inequality in the traditional family.	-.38	5
46.	The goal of family therapy is change, not adjustment.	-.39	5
28.	The psychoanalytic tradition provides a stronger and more suitable scaffolding than general systems theory for a feminist psychotherapy with families.	-.47	5
31.	Postmodernism fits well with feminism by providing space for alternative viewpoints.	-.53	5
40.	Therapists should be explicit about their own values, sharing and discussing these with the family without imposing them.	-.56	4
07.	The ways in which women are oppressed and exploited in the larger society are reflected in family relationships.	-.59	4
06.	Women do participate in their own abuse, but not as equals.	-.61	4

30.	Some schools of family therapy are much more compatible with feminism than others.	-.70	4
58.	The uniting of feminism and the recovery movement is one of the most disturbing developments in the feminist movement today.	-.71	4
59.	Feminist family therapy appeals mostly to middle-class white women, not to poor women or women of color.	-.72	4
12.	The economic balance determines the power balance in most couple relationships.	-.75	3
52.	Feminist family therapy writers do not sufficiently address the practical matters of how, when, and under what circumstances therapists should address gender bias with families.	-.75	3
53.	In declaring war on gender-linked structures in families, feminists may create another set of labels for mental pathology to add to the ones we already have, and a new kind of "expert" to tell families how they ought to be.	-.77	3
35.	It is best to avoid conjoint therapy in cases of wife abuse.	-.79	3
08.	There is something fundamentally wrong with the social institution of the family itself, at least as it is currently constituted.	-.82	3
56.	Much as they dislike admitting it, feminists generally harbor or have harbored categorical anger toward men.	-.82	2
57.	Feminism helps to make women feel vulnerable and victimized.	-.82	2
17.	Therapeutic neutrality is an impossible and dangerous myth.	-.83	2
60.	For women of color, fighting racial discrimination takes precedence over contending with gender inequities.	-.87	2
10.	A family does not need a hierarchical structure to make it work.	-.89	2

13.	The problems of most couples cannot be rationally addressed or solved until the core inequality of the relationship is acknowledged.	-.90	2
25.	Compared to traditional family therapists, family therapists who are lesbians work more effectively with gender issues because lesbians are more often connected to feminist networks.	-1.01	2
21.	Therapy is a political act and cannot be separated from the social issues in which the family is embedded.	-1.10	1
27.	Feminism and psychoanalytic theory are contradictory.	-1.13	1
20.	Family therapy is not likely to have much impact on the culture at large.	-1.14	1
24.	Social "science" has little relevance to feminism or feminist family therapy.	-1.19	1
18.	Family therapists take a non-neutral position by centering their attention on the family microsystem rather than the larger social system.	-1.26	1
22.	The systemic sine qua non of circular causality is a sophisticated version of blaming the victim.	-1.67	1

Appendix M

Factor Array for Factor 5

		Factor Score	Category Score
41.	Reducing the hierarchical distance between the therapist and client is an essential part of being a feminist family therapist.	1.93	10
40.	Therapists should be explicit about their own values, sharing and discussing these with the family without imposing them.	1.77	10
04.	Feminism is important for both women and men.	1.69	10
53.	In declaring war on gender-linked structures in families, feminists may create another set of labels for mental pathology to add to the ones we already have, and a new kind of "expert" to tell families how they ought to be.	1.46	10
39.	A therapist should be open with clients about the process of therapy, explaining what is happening stage by stage, rather than using "strategies" and "tactics."	1.23	10
31.	Postmodernism fits well with feminism by providing space for alternative viewpoints.	1.15	10
33.	Whatever the presenting problem, it is important to assess how the power is distributed in family relationships, particularly spousal relationships.	1.14	9
34.	Conjoint therapy is not always contraindicated in cases of abuse -- you have to decide on a case by case basis.	1.12	9
52.	Feminist family therapy writers do not sufficiently address the practical matters of how, when, and under what circumstances therapists should address gender bias with families.	1.05	9
27.	Feminism and psychoanalytic theory are contradictory.	.83	9
19.	Therapists should be aware of their own values and how those values are reflected in their interventions.	.79	9

36.	Taking a feminist position in relation to male power means taking a non-neutral position, challenging male control and domination, naming the abuse, and naming the abuser.	.77	9
46.	The goal of family therapy is change, not adjustment.	.74	8
32.	A therapist should not encourage a woman to go out to work without helping the family negotiate a reduction in her work load at home.	.72	8
26.	Feminist family therapists are tolerant of diverse family forms, including gay and lesbian couples.	.67	8
03.	The symbolic dimensions of patriarchy are embedded in language, culture, and experience--and thus, from the moment of birth, subtly communicated and internalized.	.59	8
11.	There is a place for hierarchy in families--at least between parents and children.	.58	8
29.	Feminism and feminist values can be superimposed on any family systems approach.	.56	8
09.	It is important to view women as individuals in families.	.55	7
01.	The feminist aim is not to save or promote any particular form of family but to ensure that the needs of every individual are well-served.	.51	7
12.	The economic balance determines the power balance in most couple relationships.	.46	7
50.	A therapist preoccupied with gender or power limits the potential range of his or her observations and interventions.	.46	7
30.	Some schools of family therapy are much more compatible with feminism than others.	.44	7
13.	The problems of most couples cannot be rationally addressed or solved until the core inequality of the relationship is acknowledged.	.32	7
51.	It is important to remember that families do not always present problems that are traceable to gender inequities.	.30	6

23.	Labeling feminist theory as "linear" and family systems theory as "circular" creates a false dichotomy.	.29	6
59.	Feminist family therapy appeals mostly to middle-class white women, not to poor women or women of color.	.22	6
14.	Family therapists too often fail to recognize gender inequality in the traditional family.	.14	6
07.	The ways in which women are oppressed and exploited in the larger society are reflected in family relationships.	.12	6
56.	Much as they dislike admitting it, feminists generally harbor or have harbored categorical anger toward men.	.06	6
21.	Therapy is a political act and cannot be separated from the social issues in which the family is embedded.	.00	5
24.	Social "science" has little relevance to feminism or feminist family therapy.	-.00	5
06.	Women do participate in their own abuse, but not as equals.	-.04	5
37.	Family therapists should avoid overstating gender differences while at the same time not ignoring the differences.	-.08	5
60.	For women of color, fighting racial discrimination takes precedence over contending with gender inequities.	-.18	5
02.	Language is not simply descriptive but prescriptive: as we narrate an event, we imply what should be.	-.19	5
18.	Family therapists take a non-neutral position by centering their attention on the family microsystem rather than the larger social system.	-.23	4
45.	An important goal of therapy is to challenge oppression and unfair power arrangements within the family.	-.24	4
44.	The goals that a good therapist sets for a family are not necessarily the same as the goals the family would set for itself.	-.34	4
54.	Many differences between women and men are attributable to culture, not nature.	-.39	4

10.	A family does not need a hierarchical structure to make it work.	-.53	4
05.	Feminist energy should be directed more toward women than toward men because women are in a societally disempowered position.	-.55	4
48.	For the sake of children, therapists should do whatever they can to prevent divorce.	-.64	3
55.	Women share a "different voice" and different moral sensibilities than men.	-.68	3
16.	Traditional family therapy undervalues the importance of connection and intimacy skills.	-.81	3
17.	Therapeutic neutrality is an impossible and dangerous myth.	-.82	3
22.	The systemic sine qua non of circular causality is a sophisticated version of blaming the victim.	-.86	3
43.	Good therapy often has nothing to do with getting a woman to realize that she is "oppressed": It is enough to intervene in a way that empowers her.	-.88	3
57.	Feminism helps to make women feel vulnerable and victimized.	-.95	2
58.	The uniting of feminism and the recovery movement is one of the most disturbing developments in the feminist movement today.	-.99	2
08.	There is something fundamentally wrong with the social institution of the family itself, at least as it is currently constituted.	-1.00	2
25.	Compared to traditional family therapists, family therapists who are lesbians work more effectively with gender issues because lesbians are more often connected to feminist networks.	-1.01	2
49.	Family therapists need not be agents of social change.	-1.02	2
35.	It is best to avoid conjoint therapy in cases of wife abuse.	-1.12	2

20.	Family therapy is not likely to have much impact on the culture at large.	-1.31	1
42.	It is usually not a good idea for a therapist to tell clients that she is a "feminist."	-1.42	1
38.	It is naive, and perhaps irresponsible, to say that the therapist should not direct the course of treatment.	-1.45	1
15.	A therapist's behavior will always either reinforce or challenge a family's assumptions about gender.	-1.59	1
47.	Therapists should avoid the unsavory business of encouraging suspected victims of abuse to "retrieve" their buried childhood memories.	-1.61	1
28.	The psychoanalytic tradition provides a stronger and more suitable scaffolding than general systems theory for a feminist psychotherapy with families.	-1.74	1

Appendix N

Factor Array for Factor 6

		Factor Score	Category Score
47.	Therapists should avoid the unsavory business of encouraging suspected victims of abuse to "retrieve" their buried childhood memories.	2.45	10
04.	Feminism is important for both women and men.	1.71	10
32.	A therapist should not encourage a woman to go out to work without helping the family negotiate a reduction in her work load at home.	1.45	10
38.	It is naive, and perhaps irresponsible, to say that the therapist should not direct the course of treatment.	1.39	10
01.	The feminist aim is not to save or promote any particular form of family but to ensure that the needs of every individual are well-served.	1.15	10
14.	Family therapists too often fail to recognize gender inequality in the traditional family.	1.12	10
43.	Good therapy often has nothing to do with getting a woman to realize that she is "oppressed": It is enough to intervene in a way that empowers her.	1.11	9
15.	A therapist's behavior will always either reinforce or challenge a family's assumptions about gender.	1.06	9
09.	It is important to view women as individuals in families rather than as the family anchor.	1.03	9
59.	White, middle-class feminism too often excludes, silences, and distorts the experiences of women of color.	.99	9
20.	Family therapy is not likely to have much impact on the culture at large.	.87	9
39.	A therapist should be open with clients about the process of therapy, explaining what is happening stage by stage, rather than using "strategies" and "tactics."	.87	9

08.	There is something fundamentally wrong with the social institution of the family itself, at least as it is currently constituted.	.72	8
53.	In declaring war on gender-linked structures in families, feminists may create another set of labels for mental pathology to add to the ones we already have, and a new kind of "expert" to tell families how they ought to be.	.72	8
52.	Feminist family therapy writers do not sufficiently address the practical matters of how, when, and under what circumstances therapists should address gender bias with families.	.58	8
46.	The goal of family therapy is change, not adjustment.	.57	8
12.	The economic balance determines the power balance in most couple relationships.	.56	8
03.	The symbolic dimensions of patriarchy are embedded in language, culture, and experience--and thus, from the moment of birth, subtly communicated and internalized.	.49	8
58.	The uniting of feminism and the recovery movement is one of the most disturbing developments in the feminist movement today.	.48	7
02.	Language is not simply descriptive but prescriptive: as we narrate an event, we imply what should be.	.45	7
34.	Conjoint therapy is not always contraindicated in cases of abuse -- you have to decide on a case by case basis.	.43	7
13.	The problems of most couples cannot be rationally addressed or solved until the core inequality of the relationship is acknowledged.	.38	7
11.	There is a place for hierarchy in families--at least between parents and children.	.36	7
60.	For women of color, fighting racial discrimination takes precedence over contending with gender inequities.	.32	7

54.	Many differences between women and men are attributable to culture, not nature.	.22	6
22.	The systemic sine qua non of circular causality is a sophisticated version of blaming the victim.	.08	6
19.	Therapists should be aware of their own values and how those values are reflected in their interventions.	.06	6
17.	Therapeutic neutrality is an impossible and dangerous myth.	.03	6
27.	Feminism and psychoanalytic theory are contradictory.	.03	6
31.	Postmodernism fits well with feminism by providing space for alternative viewpoints.	.03	6
18.	Family therapists take a non-neutral position by centering their attention on the family microsystem rather than the larger social system.	-.09	5
51.	It is important to remember that families do not always present problems that are traceable to gender inequities.	-.14	5
45.	An important goal of therapy is to challenge oppression and unfair power arrangements within the family.	-.20	5
06.	Women do participate in their own abuse, but not as equals.	-.21	5
33.	Whatever the presenting problem, it is important to assess how the power is distributed in family relationships, particularly spousal relationships.	-.23	5
48.	For the sake of children, therapists should do whatever they can to prevent divorce.	-.23	5
07.	The ways in which women are oppressed and exploited in the larger society are reflected in family relationships.	-.24	4
50.	A therapist preoccupied with gender or power limits the potential range of his or her observations and interventions.	-.27	4
30.	Some schools of family therapy are much more compatible with feminism than others.	-.38	4

37.	Family therapists should avoid overstating gender differences while at the same time not ignoring the differences.	-.43	4
49.	Family therapists need not be agents of social change.	-.47	4
56.	Much as they dislike admitting it, feminists generally harbor or have harbored categorical anger toward men.	-.51	4
35.	It is best to avoid conjoint therapy in cases of wife abuse.	-.58	3
16.	Traditional family therapy undervalues the importance of connection and intimacy skills.	-.60	3
10.	A family does not need a hierarchical structure to make it work.	-.61	3
57.	Feminism helps to make women feel vulnerable and victimized.	-.61	3
26.	Feminist family therapists are tolerant of diverse family forms, including gay and lesbian couples.	-.67	3
40.	Therapists should be explicit about their own values, sharing and discussing these with the family without imposing them.	-.70	3
42.	It is usually not a good idea for a therapist to tell clients that she is a "feminist."	-.74	2
25.	Compared to traditional family therapists, family therapists who are lesbians work more effectively with gender issues because lesbians are more often connected to feminist networks.	-.87	2
29.	Feminism and feminist values can be superimposed on any family systems approach.	-.90	2
24.	Social "science" has little relevance to feminism or feminist family therapy.	-.94	2
23.	Labeling feminist theory as "linear" and family systems theory as "circular" creates a false dichotomy.	-.99	2
28.	The psychoanalytic tradition provides a stronger and more suitable scaffolding than general systems theory for a feminist psychotherapy with families.	-1.18	2

44.	The goals that a good therapist sets for a family are not necessarily the same as the goals the family would set for itself.	-1.18	1
55.	Women share a "different voice" and different moral sensibilities than men.	-1.21	1
41.	Reducing the hierarchical distance between the therapist and client is an essential part of being a feminist family therapist.	-1.28	1
21.	Therapy is a political act and cannot be separated from the social issues in which the family is embedded.	-1.48	1
05.	Feminist energy should be directed more toward women than toward men because women are in a societally disempowered position.	-1.83	1
36.	Taking a feminist position in relation to male power means taking a non-neutral position, challenging male control and domination, naming the abuse, and naming the abuser.	-1.94	1

Autobiographical Statement

Bronwen Cheek was born in Washington, D.C. on April 17, 1958. In January 1982 she earned her B.A. in psychology from George Mason University. During 1985-1986, when she lived in Seattle, Bronwen completed the core curriculum in the technical writing program at the University of Washington. She is co-author with her brother, Jonathan Cheek, of *Conquering Shyness*, published by G.P. Putnam, 1989. From 1986 through 1991, Bronwen was the research coordinator for the Psychology Department at Wellesley College. She began the docotral program in clinical psychology at the Virginia Consortium for Professional Psychology in the Fall of 1991. In September 1995 Bronwen completed her internship with Valley Mental Health in Salt Lake City, UT