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Review

Feminist therapy: A brief integrative review of theory, empirical support, and call for new directions

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ABSTRACT

The present review integrates theory and empirical research supporting the tenets of feminist therapy. Specifically, I review feminist theorists' views on the key therapeutic domains of (a) healthy and unhealthy development and (b) therapeutic change, in addition to uncovering empirical support within and beyond feminist scholarship. Finally, practical implications, new directions for future research, and interdisciplinary scholarship are discussed.

Contents

Feminist therapy theory arose out of second-wave feminist activism throughout the 1960's and 1970's. Specifically, consciousness-raising groups inspired the application of feminist values and insights to the therapy room (Brown & Brodsky, 1992; Enns, 2012), and shared therapy concepts developed more formally through conferences and workshops (Brown & Brodsky, 1992). These shared concepts emerged from a critique of traditional forms of therapy that were viewed as unsupportive to women (Israeli & Santor, 2000). However, during the 1980's and 1990's, early theorists were criticized for exclusivity, focusing mainly on the experiences of White middle-class women (Enns, 2012; Enns & Williams, 2012).

Multicultural feminism with attention to intersecting forms of oppression emerged from this critique, with the focus on *intersectionality* originating from early Black feminist activists and scholars (see Collins, 1990; Crenshaw, 1991), and remains the dominant perspective of theorists today (e.g., Enns, 2012; Enns & Williams, 2012). Thus, modern feminist therapy theory operates from the core principles of resistance to power imbalances and oppression, affirmation of diversity, egalitarianism, and empowerment (Brown, 2006; Enns, 2012). Therapists are encouraged to draw upon a variety of treatment modalities within this broader theoretical framework (Brown & Brodsky, 1992).

Healthy and unhealthy development

Unhealthy environment

Feminist therapy theory views healthy and unhealthy development as inseparable from an individual's sociocultural context. Feminist theorists believe that *the personal is political*, or that unhealthy environmental factors such as oppression can create distress, which may be adaptive

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(Brown, 2006; Brown, 2010; Enns, 2012; Enns & Williams, 2012). Feminist diagnostic thinking critiques the "disordering of distress" (Brown, 2006, p. 19) common in traditional diagnostic practices, and instead incorporates a diagnosis of "the distress and dysfunction of the context in which [a] person lives" (Brown, 2006, p. 19). Feminist theory also reflects a social constructionist worldview (Brown, 2006; Enns, 2012), and calls attention to the *subjective* nature of diagnostic terms such as "healthy" and "unhealthy." Relatedly, feminist therapy theorists argue that examining personal biases and assumptions is a crucial step in diagnosis and assessment (Brown, 2006; Enns & Williams, 2012). Taken together, feminist theorists consider development to be complex, avoiding models of biological reductionism and viewing clients in context, as opposed to relying on straightforward symptom-checklists (Brown & Brodsky, 1992). These critiques do not suggest that feminist theory necessarily advocates dismissal of diagnosis, but that diagnosis may be one piece of the puzzle, among many others (Enns, 2012).

Healthy empowerment

The primary goal of feminist therapy is *empowerment* (Brown, 2006; Brown, 2010). Enns (2012) defines empowerment as "helping individuals see themselves as active agents in personal, interpersonal, and political contexts" (Enns, 2012, p. 446). Healthy development in the form of empowerment challenges acceptance of oppression, encourages resistance, and recognizes external causes of distress, which may bring about new resources, coping strategies, and sources of social support for clients (Enns, 2012; Hill & Ballou, 1998). Worell (2001) and Johnson, Worell, and Chandler (2005) describe the specific goals of empowerment to include: self-esteem and self-efficacy, assertiveness, self-nurturance, positive comfort-distress ratio in daily life, increased flexibility and problem-solving capabilities, cultural awareness, resource access, and activism.

Therapeutic change

According to Enns (2012), there are three central components of feminist therapy: 1.) The personal is political, 2.) An egalitarian therapeutic relationship, and 3.) Diversity.

The personal is political

From the view of feminist theory, attention to clients' contexts and issues of power and oppression can create change at multiple levels, including individual and sociopolitical (Brown, 2004; Enns, 2012). Enns (2012) outlines the strengths-based approach of feminist therapy in reframing clients' distress as adaptive responses (not unhealthy) to oppression (e.g., sexism, racism, heterosexism), helping clients cultivate an active role in confronting inequalities, and emphasizing resiliency. The feminist therapy technique of *social identity analysis*, or analysis of the ways in which various cultural identities shape experiences, is one way to increase self- and cultural-awareness and reduce internal attributions of distress (e.g., self-blame; Enns, 2012). Taken together, feminist therapists view consciousness-raising and development of critical-consciousness as routes toward client empowerment in the face of environmental barriers.

Other strategies feminist therapists use to counteract oppression include advocacy, allyship, and social activism (see Beck, Rausch, & Wood, 2014 for counselor advocacy and allyship strategies; Enns, 2012; Israeli & Santor, 2000). Advocacy, allyship, and activism on the part of the therapist, and sometimes the client, are techniques aimed at promotion of change at the broader, sociopolitical level (Enns, 2012).

Egalitarian therapeutic relationship

Feminist therapists work to empower clients through resisting and minimizing power imbalances not only in broader society, but also within the therapeutic relationship. Attention to power dynamics is especially important given the value placed on affirmation of minority identities, which hold less societal power (Rader & Gilbert, 2005). Worell and Johnson (1997) state that there are 16 core tenets of feminist therapy, many of which highlight the importance of an egalitarian therapeutic relationship. For instance, tenets include monitoring balance of power between therapist and client to prevent potential misuses of power, and building an egalitarian and collaborative relationship (Rader & Gilbert, 2005; Worell & Johnson, 1997).

Therapeutic techniques that encourage an egalitarian relationship include: power-sharing behaviors such as communicating values to client, discussing client-therapist fit and emphasizing choice, providing information about the process of therapy, including rights and responsibilities, and engaging in mutual goal-setting (Rader & Gilbert, 2005). Appropriate self-disclosure is another key route toward transparency and reduction of power imbalances in feminist therapy (Brown & Brodsky, 1992; Enns, 2012; Marecek, 2001; Stevens, 2008).

Diversity

Multiculturalism is a fundamental part of modern feminist therapy (Enns & Williams, 2012), and parallels other components through the unifying themes of attention to power and oppression, and the belief that oppression negatively impacts the oppressed (Enns, 2012). Intersectionality, or acknowledgement of multiple, overlapping forms of discrimination or power imbalances, is a key theme for feminist therapists when considering diversity (see Collins, 1990; Crenshaw, 1991). Feminist therapy theorists also view identity categories as socially-constructed (Enns & Williams, 2012). To illustrate, feminist theorists have argued that gender is an active process requiring maintenance, rather than a static category with one essential definition, echoing early sociological theorists (Enns & Williams, 2012; West & Zimmerman, 1987).

In the feminist view, therapy is a "struggle against oppression" (Brown, 2004, p. 29), and therefore aims to empower clients through affirming diverse identities and attending to social inequalities and stigmatization. Consciousness-raising may also be used to normalize client's concerns and, again, externalize blame (Israeli & Santor, 2000). Moreover, therapists make an effort not to operate on the basis of stereotypes or assumptions of universality of experience when working with clients (Brown & Brodsky, 1992; Enns, 2012). Finally, modern feminist therapy can be applied to all types of clients and, as recent theorists have argued, all therapists can be feminist therapists, including men (Brown, 2006; Kahn, 2010).

Uncovering empirical support

Research, both within the field of feminist scholarship and beyond it, has supported key aspects of feminist therapy theory. Specifically, empirical studies have demonstrated the negative impact of oppression on mental health outcomes, feminist therapists' attention to power and oppression, the importance of egalitarian therapeutic relationships, and benefits of consciousness-raising and empowerment.

The link between oppression and mental health

One prominent example of empirical research supporting the notion that oppression (unhealthy environment) negatively impacts individual health outcomes is Meyer's (2003) minority stress model. The model focuses on sexual minority individuals and holds that they are exposed to unique minority stressors (e.g., discrimination), which increase risk for development of mental health concerns (Meyer, 2003). A wide body of quantitative literature and meta-analytic reviews have supported the tenets of this model, across age groups and contexts (e.g., adults and youth; workplace context), and using both cross-sectional and longitudinal methods (e.g., Almeida, Johnson, Corliss, Molnar, & Azrael, 2009; Hatzenbuehler, Nolen-Hoeksema, & Erickson, 2008; King et al., 2008;