

# CHAPTER 1

## FEMINIST THERAPY: ROOTS AND BRANCHES

*Feminist therapy, like many movements and concerns focused on a revisioning of society, is grounded in history and theory. In the current therapeutic climate of empirically validated treatments and evidence-based practice, we believe it is necessary to understand the roots of feminist therapy theory and practice, the context in which these developed, and the manner in which they continue to flourish.*

Contemporary feminist therapy grew out of the Women's Movement of the 1960s. This began as a grassroots movement—a social and political movement that grew out of the dissatisfaction of common women in everyday life. To this day, feminist therapy seeks to remain true to these roots and to be relevant to a wide spectrum of concerns and clients. It is also important to understand that the modern women's movement is well grounded in feminist theory, the philosophical belief system that underlies feminism. Feminist theory is a philosophical point of view with a history reaching back more than 150 years. Feminism as a political-activist movement developed from the experiences of women, in their daily lived experiences in love and work. We acknowledge that because of social, political, and economic factors, the feminist movement was initially based on the experiences of middle-class, majority-culture (e.g., White) women. This is an artifact of the dominant cultural paradigm. Women from lower socioeconomic backgrounds and from oppressed ethnic cultural backgrounds did not have the

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time or resources to ponder and seek to change their sociopolitical status. They focused on daily survival for themselves and their families. In an ironic twist, it was the male, middle-class domination of the sociopolitical sphere that allowed middle-class, majority-culture women the “privilege” to develop feminist consciousness. Unfortunately, middle-class, majority women did not immediately apply their feminist consciousness of oppression to their sisters who experienced multiple oppressions. We will discuss this in more detail as we examine the history or rather *her-story* of feminist therapy.

The authors view feminist therapy as a therapy focused on eliminating oppressions, both internal and external, for all people—not just for women. Throughout this book we make the case for feminist therapy as transformation on both individual and cultural levels. However, feminist therapy *did* begin as a therapeutic stance for women that privileged women’s experience. This stands in direct contrast to previous therapeutic frameworks that privileged men’s experience and then attempted to fit women’s experience into those frameworks. In understanding the history and context of feminist therapy, it is important to understand feminist philosophy and feminism as privileging women’s experience.

### ● FEMINISM AND FEMINIST PHILOSOPHY

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First, it is important to understand the concept of feminism and feminist philosophy because misconceptions about feminism abound. Quite simply, feminism is a social movement to end sexism and sexist oppression (hooks, 1984). Dictionaries agree on a fairly simple definition: “a belief in the social, political, and economic equality of the sexes” (*American Heritage Dictionary*, 2006). An early but still important work on feminism, psychology, and therapy (Mander & Rush, 1974) stated that feminism is about making connections—between feelings and experiences and political context, between personal and economic power, between feelings and theories, between domestic oppression and labor exploitation, and between inner psychological worlds and outside worlds. Feminism provides a lens through which a woman can understand her experience. It allows her to make a connection between what she believes is her individual situation and pain to the larger world in which she lives and which expects her to behave in certain ways regardless of her needs and wants, skills, and abilities.

Feminist philosophy and theory looks closely at power structures in society. For example, all inequities are assumed to be based on institutionalized power. Those who have this power in the United States are generally White, middle-to-upper-class, heterosexual, Christian, able-bodied males.

Discrimination and oppression occur against those without such power, for example, women, racial/ethnic minorities, lower and poor classes, sexual minorities, non-Christian, and non-abled people. The common theme that runs through feminism is the need for social change and the use of power analysis of the dominant culture in order to understand what needs to be done to achieve this change.

## WOMEN'S LIBERATION AND ● THE FEMINIST MOVEMENT

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The Women's Liberation Movement emerged during the politically charged 1960s and certainly challenged the gender status quo of that era. However, the seed for what is commonly called the Second Wave of United States Feminism began in the 1940s and 1950s (Sturdivant, 1980). First, World War II led to a shortage of male workers in all fields. Women filled these positions, from factory workers to baseball players to bank administrators. Second, by the end of the 1950s, middle-class White women—many of whom had been professionally employed 15 years earlier or had role models from that era—became disenchanted with the cultural myth of that period that endorsed marriage and children as the only fulfillment of a women's role in life. This was exemplified in the book *The Feminine Mystique* (Friedan, 1963). Finally, the Civil Rights Movement of the 1960s led many to question the United States's value system. Social protest against social inequality began to cut across race and class lines. The Civil Rights Movement called into question the United States's support of a single set of values based on White, middle-class people (Boyd, 1990). This set of values did not acknowledge or support ethnic diversity. Thus, the Civil Rights Movement raised the dominant society's consciousness. Women were strong supporters of, and participants in, the Civil Rights Movement. This participation led women to become aware of their own oppression and to question the gender status quo. In 1966, the National Organization for Women (NOW) was formed to address the legal and economic equality of women. As a result of these social factors, the second wave of feminism began. This second wave of feminism is what most of us are familiar with as the Women's Liberation Movement.

Feminism asks that individuals carefully examine their adherence to dominant cultural assumptions that might be harmful to others. Since the early 1980s, contemporary feminists have examined feminism itself and have asked the following question: What dominant cultural assumptions may be entrenched in feminist theory and practice? Out of this self-reflection grew the awareness that feminism is not a unitary movement, nor does it have to

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be. To be effective as both a social and an individual change mechanism, feminism must be inclusive. It must recognize that diversity is strength rather than weakness. Current feminist theoreticians embrace multiple points of view under the “feminist” umbrella and talk about feminisms rather than feminism. These feminisms look at a multiplicity of paths leading to a more egalitarian society for all genders. They acknowledge that women are not a monolithic grouping and that power and status inequities exist across women of differing social positions (Brown, 1994; Enns, 1992; Worell & Remer, 2003). Contemporary feminism considers not only the diversity of women’s experiences but also the diversity of human experience. This diversity can best be understood by examining the different ways in which feminisms view the cause and cure of oppression.

### ● FEMINISMS: A DIVERSITY OF POSITIONS

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Commonly accepted positions within feminism are as follows: (a) liberal or reformist, (b) radical, (c) socialist, (d) women of color or womanism, and (e) cultural. Each one will be outlined briefly in the following discussion. The annotated bibliography provides more information about the theorists and writers in these areas.

*Liberal or reformist feminism* (Brown, 1994; Crawford & Unger, 2000; Enns, 1992, 1993; Evans, Kincade, & Seem, 2005; Sturdivant, 1980; Worell & Remer, 2003) views women’s oppression as a result of sexism. Sexism involves constraints on individuals with regard to gender-role socialization, culture, laws, and economics. These constraints are primarily focused on women and limit women’s opportunities and roles. In liberal feminism, gender is the only important category of political analysis. This perspective tends to exclude other variables, such as class, ability, sexual orientation, and race/ethnicity, all of which could be more important than gender regarding human experiences of power and oppression (Brown, 1994). In liberal or reformist feminism, the solution to women’s oppression is to reform the system by changing laws, politics, and educational and employment arrangements to guarantee equal rights for women. This perspective informed the move for an Equal Rights Amendment in the United States. It is the philosophy behind gender equality in sports (Title IX legislation) and nonsexist hiring practices in the workplace.

*Radical feminism* (Brown, 1994; Crawford & Unger, 2000; Enns, 1992, 1993; Evans, Kincade, & Seem, 2005; Worell & Remer, 2003) views women’s oppression as embedded in the patriarchy or the unequal allocation of power to men in our society. Gender-based oppression is perceived as the most basic and pervasive form of oppression and, as such, is common to all women.

Radical feminists believe that the unequal allocation of power leads to institutionalized male domination, heterosexism, and violence. Instead of working within the system to change laws as liberal feminists would do, radical feminists believe that the liberation of women requires the total transformation of patriarchy (male-privileged culture) and advocate altering social institutions and relationships. This perspective has led to women-only movements in therapy (Chesler, 1972/2005) as well as to feminist separatist movements.

In contrast with liberal and radical feminists, *socialist feminists* (Crawford & Unger, 2000; Enns, 1992, 1993; Evans, Kincade, & Seem, 2005; Sturdivant, 1980) believe that oppression is a product of both gender and socioeconomic class. Other categories of inequity, such as race/ethnicity, sexual orientation, ability, and other minority statuses, are also considered important as they are often interwoven into class structures. In fact, multiple oppressions are viewed as inseparable and caused by the impact of gender-role socialization, institutionalized control of reproduction and sexuality (the refusal of insurance to reimburse for birth control prescriptions), the structure of production (gender roles in paid and unpaid employment), and the capitalistic socioeconomic paradigm. Socialist feminists believe that capitalism, the dominant socioeconomic paradigm, upholds a patriarchal system and precludes any lasting change. Restructuring life, both publicly and privately, is the source of liberation. Thus, socialist feminists call for dramatic changes to the dominant socioeconomic paradigm (capitalism) in order to end multiple oppressions and the patriarchal system that benefits from them.

*Women of color feminism or womanism* (Brown, 1994; Crawford & Unger, 2000; Evans, Kincade, Marbley, & Seem, 2005; Worell & Remer, 2003) challenges other feminists' belief that gender is the only salient category of oppression and insists that the experiences of White women cannot be generalized to the lives of women of color. Womanism identifies institutional racism as a major source of women's oppression and, in general, does not view men of color as sexist oppressors but as co-victims of racism. Womanism focuses its attention on the impact of the combined forces of race/ethnicity and gender not only on women's and men's experiences but also on the entire culture. Liberation occurs through the elimination of White privilege, respect for the values and cultures of people of color, and the elimination of both institutionalized racism and sexism.

*Cultural feminism* (Enns, 1992, 1993; Evans, Kincade, & Seem, 2005; Sturdivant, 1980; Worell & Remer, 2003) acknowledges differences between women and men and attends to women's unique strengths. Because women's oppression is rooted in the devaluation of women's relational strengths, this perspective seeks to honor women's abilities to be emotionally intuitive, cooperative, altruistic, and communal. The solution to women's oppression

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lies in the feminization of the culture so that both men and women's ways of being are valued.

Despite the diversity of feminisms, two common themes unite all the feminisms (Crawford & Unger, 2000). All feminisms highly value women's experience and women. All also recognize the need for social change. Because feminisms focus on the social contexts of women's lives, changing social systems and equalizing power are considered necessary to ending all forms of domination, subjugation, and oppression in a patriarchal society. In sum, feminist philosophies focus on the social and political context of women's lives and promote social change, rather than individual adjustment to the status quo, as a way to improve lives and mental health (Rawlings, 1993).

The various forms of feminism as articulated earlier are closely connected to the practice of feminist therapy. Feminist therapy is grounded in two beliefs. First, women's lived experiences and the context of those experiences are important to both women and their therapists and are prioritized in therapy. Second, societal change is necessary for lasting individual change and growth. Contemporary feminist therapists recognize that gender and gender roles are important aspects of the lives of all individuals and underlie the foundations of many contemporary institutions. It is not only women who are impacted. As contemporary feminist therapists, we speak about the focus on the lived experiences of human beings in a society within inflexible and often unconscious gender roles and the need for social change to impact emotional health for both individuals and cultures. Next we turn to the *development of contemporary feminist therapy*.

## ● PRECURSORS OF FEMINIST THERAPY

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Perhaps, the most long-lasting statement from the second wave of feminism of the 1960s and 1970s was the adage that *the personal is the political*. This statement challenged women and men to consider that their personal lives reflected the values and politics of the culture and that the values and politics of the culture also impacted their personal lives. Breaking from traditional ways of thinking about women and men in one's personal life was a political act as well as a personal act. From this mode of thinking arose consciousness-raising (CR) groups.

The Women's Liberation Movement had two major aims (Rosenthal, 1984): (a) to change the social and economic conditions of women and (b) to change individuals. CR groups linked these two goals. Women met in small, leaderless groups to discuss their personal experiences, that is, to bring into their consciousness awareness of problems and issues that had a political as well as a personal context. As women in these groups discovered

the similarity of their experiences and concerns, they began to understand that their individual experiences were a result of the condition of women in society and not of their individual failure. Personal experiences were analyzed in political terms (Sturdivant, 1980). The objective of CR groups was to empower women to take social action. Psychological healing was an unintended by-product brought about as members' social isolation decreased and they became aware of their oppression and own internalized sexist beliefs about women's inferiority. This empowered women to think differently about their abilities and their self-worth (Sturdivant, 1980).

On the political level, CR groups developed an analysis of society based on female experience, thus connecting the personal to the political through the sharing of women's stories (Sturdivant, 1980). As a grassroots organization, the Women's Liberation Movement believed that CR groups would create the revolutionary politics necessary for mass, social action (Rosenthal, 1984; Sturdivant, 1980). Women would work together to find solutions to their common problem, oppression.

The norms of CR groups were feminist: a collective structure; the equal sharing of power, responsibility, and resources; the focus on social conditioning and social problems as the roots of women's distress; and women's commonalities (Enns, 1993). Groups were leaderless; each woman was considered an expert about herself and able to help others as much as others aided her. Women's experiences and truths were valued and respected. Although feminists acknowledged that participation in CR groups could be therapeutic, they did not regard CR groups as therapy (Sturdivant, 1980). Therapy meant that the individual was the patient and was sick. Rather, feminists believed that society was the sick patient and that social change was the cure. In sum, feminism and CR groups challenged the traditional assumptions of counseling and psychology and therapy practice and were the precursors of feminist therapy. Both CR groups and feminist therapy were predicated on the belief that women's problems were contextual, not individual, and political, not personal, pathology (Brown, 1994; Collins, 2002; Sturdivant, 1980; Enns, 1992, 1993, 1997; Evans, Kincade, et al., 2005; Worell & Remer, 2003).

## FEMINIST CHALLENGES TO ● TRADITIONAL COUNSELING AND PSYCHOTHERAPY

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Freudian theory strongly influenced psychotherapeutic practice during the first 70 years of the last century. Feminists criticized Freudian theory in three major areas (Sturdivant, 1980): (a) its belief in intrapsychic causation of problems, (b) its failure to recognize the impact of sociocultural factors on

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development, and (c) its sex bias in using male standards as the norm for mental health. Feminist critics of psychotherapeutic practice argued that differing social and gender roles were a result of socialization and institutionalized gender bias, not biology, and that intrapsychic conflict and pain were a result of sexism or the mismatch with socially prescribed gender roles and role conflict, not individual pathology. The feminist critique of Freudian theory focused on its intrapsychic focus, failure to recognize sociopolitical context, and andocentric norms of health.

When the early feminist critics of counseling and psychotherapy looked carefully at the techniques and theories of the time, they focused on the following three areas: (a) the mechanism of control, (b) the failure to acknowledge the impact of context on individual lives, and (c) the androcentrism of psychological theories that underlie psychotherapy. Much research indicates that these failures resulted in a double standard of mental health for women. See Sturdivant (1980) for an excellent review of this research. For our purposes, two critical pieces of research will be discussed.

The Broverman, Broverman, Clarkson, Rosenkrantz, and Vogel study in 1970 was a groundbreaking piece of research. Prior to this time, differential standards of mental health for men and women had not been investigated. These researchers asked mental health workers (i.e., psychologists, psychiatrists, and social workers) to evaluate mental health for men and women on a 122-item questionnaire. They hypothesized that (a) clinical judgments of the characteristics of a healthy, mature individual would differ based on the sex of the person judged and that (b) behavioral characteristics that were regarded as healthy for an adult, sex unspecified, would be more often regarded as healthy for men than for women (i.e., following societal, stereotypic gender-role differences). A high degree of consensus among participants about the qualities characterizing mature, healthy adults (sex unspecified), healthy men, and healthy women was found and did differ as a function of the sex of the person judged. Clinicians' judgments of male mental health did not differ significantly from those held for adults (sex unspecified), whereas judgments of health for women differed significantly from those viewed for healthy males and healthy adults. These differences corresponded with societal gender-role stereotypes for men and women held during that time. For example, mentally healthy women were described as differing from both healthy men and healthy adults in that they were characterized as more emotional, submissive, less independent, and less objective. The authors concluded that a double standard of mental health existed. Men could be perceived as mentally healthy adults, whereas women could not. For a woman to be viewed as mentally healthy by mental health professionals, she needed to be perceived as feminine and not adult-like (i.e., not male-like).



In the mid-1970s, the American Psychological Association (APA), based on input from women psychologists, as well as on concerns for consumers of psychological services, formed the Task Force on Sex Bias and Sex Role Stereotyping in Psychotherapeutic Practice. In 1975 they published their report and recommendations. Three primary areas of sex bias were found: (a) fostering of traditional sex roles, (b) bias in expectations and devaluations of women, and (c) responding to women as sex objects, including seduction of female clients. This task force clearly found that when traditional sex roles were fostered within a psychotherapeutic environment, sociocultural factors in women's problems were not acknowledged and therapy operated as a means of social control. For example, women wishing to explore career options in a traditional male field might be influenced by the counselor's belief system about male and female career roles. Furthermore, psychological interpretations were used to divert attention from the possibilities of social causation. This document marked a significant change in the field of psychology. Prior to this report, feminist critique had not been an accepted part of the mainstream of psychological culture. Guidelines for working with nonsexist psychotherapeutic practice were developed and are still in use (APA, 2007; Fitzgerald & Nutt, 1986).

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## CHALLENGES TO FEMINIST THERAPY ●

Although feminist theory and philosophy as well as feminist therapy have always prized nondominant realities and values in its vision, early on it was largely a White, middle-class, women's endeavor (Boyd, 1990; Brown, 1991, 1994; Brown & Brodsky, 1992; Worell & Remer, 2003). The consideration of cultural diversity in prevalence, etiology, diagnosis, and treatment was noticeably missing in the early years of feminist therapy (Brown & Brodsky, 1992; Brown & Root, 1990; Evans, Kincade, et al., 2005; Greene, 1994; Sturdivant, 1980; Worell & Remer, 2003). During the 1970s, when feminist therapy was first articulated, gender was viewed as the most salient feature of oppression. Societal privileges enjoyed by White women made it difficult, if not impossible, for them to see how they benefited from the White power structure and thus made them largely insensitive to multiple oppressions (Brown, 1994; Enns, 1993; Espin & Gawelek, 1992; Greene, 1994). Ironically, what feminists charged men with doing—ignoring male privilege—was what White feminists did with women of color—denying White privilege. As a result, most of the first 20 years of feminist therapy ignored the contributions of therapists and theorists of color, the working class, and other oppressed groups (Brown, 1994). In fact, White lesbians have been the only marginalized group that has been consistently included in feminist therapy and theory from the beginning (Brown & Brodsky, 1992).

Marginalized groups challenged feminist therapy in the same manner that White feminist therapists challenged traditional therapy and theory. African American women confronted White feminists who viewed White women's problems as analogous to the African American experience. White feminists were also challenged when they assumed that Black women identified more with White women than with Black men (Boyd, 1990; Evans, Kincade, et al., 2005; Greene, 1992). Historically feminism had ignored the history and contributions of women of color and therefore was not perceived as relevant to their lives (Evans, Kincade, et al., 2005). "Women of color view feminism as yet another system in which they have to define and justify their reality, which makes it (feminism) just as oppressive as the traditional sexist patriarchal system" (Boyd, 1990, p. 162). Thus, feminism and feminist therapy are oppressive if presented as another system that defines reality for all women. To be truly representative, feminist theory must be built on the experiences of all women (Barrett, 1990; Brown, 1994; Worell & Remer, 2003). This means understanding that for many women, gender may not be the most salient feature in their lives. "Although sexism affects all women, the way it affects them varies or can be 'colored' by the lens of race and other parameters" (Greene, 1994, p. 337). The salience of gender may be modified, intensified, or transcended by other variables of a woman's life, such as race/ethnicity, class, and sexual orientation (Espin & Gawelek, 1990; Greene, 1992, 1994).

It has been a struggle for White and/or middle-class feminist therapists to acknowledge that issues of culture (broadly defined here as those of race, class, ethnicity, linguistic affiliation, age, disability, sexual orientation, spiritual affiliation, and appearance) cannot be of less importance in a feminist analysis than gender and that if our theories are to advance social change and undermine the patriarchy we must include all categories in our analysis. (Brown, 1994, p. 70)

The challenge for feminist therapy in the 1990s was to prize all non-dominant realities in its vision (Evans, Kincade, et al., 2005)). In the last 10 to 15 years, much has been written about the inclusion of diversity in feminist therapy (see, e.g., Boyd, 1990; Brown, 1991, 1994; Brown & Brodsky, 1992; Brown & Root, 1990; Chrisler & Howard, 1992; Espin, 1993; Greene, 1994; Landrine, 1995; Worell & Remer, 2003). The challenge in the early 21st century was to put this new theorizing into action in therapeutic practice—to create a more inclusive form of feminism and feminist therapy (Enns, 1997). The current challenge for feminism is to establish itself as an integral part of the therapeutic landscape without losing its emphasis on egalitarianism, the sociopolitical context, and the use of power.

## SUMMARY

This chapter presented an overview of feminist therapy's challenges in its movement toward recognition as an established theoretical orientation. From the early years when there was little distinction between political action and therapy to the more recent emphasis on therapeutic techniques, feminist therapy has embraced the importance of women's reality as situated in the sociocultural context.

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