# The Female Body in Mind

## The Interface between the Female Body and Mental Health

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Chapter 15

# Feminist therapies

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## INTRODUCTION

Feminism. Just the mention of this word evokes emotional responses from even the most dispassionate researchers and clinicians. Is there only one definition of a feminist perspective? Can a feminist perspective offer an alternative orientation to therapies to improve body image? Can a feminist approach augment or exist along with cognitive therapy? In the pages that follow we will first address the issue of definition. Then we will discuss the ways in which a feminist lens can be compatibly employed with existing cognitive and body-orientated strategies to improve body image.

Feminism, as defined by the *Webster's New Word Dictionary* (1978) is "the principle that women should have political, economic and social rights equal to those of men, as well as the movement by which women could win those rights".

The women's movement in the late 1960s prompted a reconsideration of roles for women and men in Western society. Consciousness-raising groups provided a forum for women to make the link between their personal experience and the political context in which these experiences were constructed, with its depiction of male traits as the norm and the omission of women from the knowledge base of psychology. There was increasing recognition that psychopathology may reflect "power imbalance" rather than "intrapersonal difficulty". There was also a re-evaluation by many health professionals of women's self-reported experience and a rejection of the historic tendency to attribute blame and responsibility to women for past sexual and physical violence (Worell and Remer, 1992).

These emergent views challenged the traditional structure and had an impact on the field of psychology, which began to expand in new directions. This led to the development of feminist therapists, women's therapy groups, feminist supervision and the evolution of services run by women for women. Feminist therapy embraced a multitude of perspectives that operated within the framework of evolving psychological therapies – interpersonal, psychoanalytic or cognitive-behavioural.

There was also an increasing recognition that the choice to seek care, the dialogue between the professional and the "help seeker" and the "cure" offered are all socially constructed transactions. This constituted the main tenets of feminist therapy, and although the therapy may vary in its application, at the core of it all lies the following assumptions (Worell and Remer, 1992):

1 Women's problems cannot be solved in isolation from gender politics, which often result in women's lower social status and oppression in most societies.
2 Equal status and empowerment are vital not only for women but for all oppressed groups.
3 Values enter all human enterprises: neither science nor clinical cases can be value free.
4 Women's experience and knowledge should be appreciated and studied.
5 Few individual women can achieve parity alone; individual and collective action is necessary to achieve the social and political change that underpins mental health problems.

Feminist therapy thus recognises that many of the problems women bring into therapy stem from feelings of powerlessness and low self-esteem, partly due to idealisation of masculine qualities and the general devaluation of feminine qualities. Feminist therapy helps women explore the inherent contradictions in prescribed social roles, and encourages change rather than adaptation to these roles (Sesan, 1994).

In this chapter, the various approaches to feminist therapy will be discussed under the following subheadings:

1 feminist therapy as empowerment;
2 feminist therapy as a tool for emotional/social connection;
3 feminst therapy as cognitive reconstruction of the body;
4 feminist therapy as body-orientated therapy.

## FEMINIST THERAPY AS EMPOWERMENT

### Definition

Empowerment – defined as authorising, delegating authority to, enabling or permitting – is often a central goal in feminist treatment. Inherent in this definition is a belief that one has the power or the free will to act on one's own behalf and to make choices. Although it is important to relinquish the idea of a unitary, modernist subject in order to explore women's differences (Hare-Mustin and Marecek, 1988), modernist concepts such as progress, self-improvement and self-determination remain essential to the theory and practice of feminist therapy. Women in therapy are helped to differentiate

between cultural causes of their distress and internally imposed restrictions (Worrell and Remer, 1992). Such an analysis minimises feelings of being sick, dysfunctional or wrong, and reduces women's feelings of powerlessness and hopelessness. An empowerment model assumes that power can be reclaimed once lost and that power can be given or taught to someone. It also assumes that power to make choices, to speak for oneself and to determine one's course or direction is a positive attribute.

Empowerment models of therapy draw from several different feminist therapy perspectives (Brown, 1994; Butler, 1985; Gilbert, 1980; Travis, 1988), resulting in approximately four key principles of feminist therapy that tend to unite feminist therapists:

1 consciousness raising: clients are encouraged to explore the role of sexism and oppression and examine contradictions in prescribed sex roles;
2 egalitarian therapy: minimising the power differentials between client and therapist, which are openly examined and explored;
3 recognising women's strengths and minimising demeaning language towards women;
4 engagment with and awareness of social action to change systems which are harmful to women and others.

Put another way, a feminist analysis could be considered a power analysis. It is often too simple to confuse issues of gender with those of power (Katzman and Lee, 1997). Often, what is attributed to a female way of being could also be understood as behaviours resulting from a subordinate social position. In taking a feminist approach, issues of power are made explicit and there is an effort to respect the expertise of all involved in both treatment and training As a result a non-hierarchical approach to therapy assumes that the patient will ultimately be the expert on her own recovery.

For example, under the feminist banner clinicians began to talk about the co-existence of physical and sexual abuse in women presenting with eating problems (for a detailed discussion refer to Fallon et al., 1994). As patients and clinicians found a vocabulary and a space to discuss issues, secrets about abuse in the family as well as the treatment setting were revealed. This has prompted a more critical examination of the potential abuses of power both at home and in therapy. Although the ultimate answer is certainly not to avoid male caregivers, the questions heightened our awareness and nudged us to challenge the safety of our delivery systems.

## The issue of culture

Feminist analyses in the area of eating disorders also recognise the importance of culture and cultural variables. By assessing the impact of societal

expectations on behaviour, feminist approaches recognise not only the contribution of individual variables to one's social functioning but the influence of culture and society on one's individual psyche (Dolan and Gitzinger, 1994; Nasser, 1997). This is not unique to feminists and, in fact, is where feminists and trans-cultural scholars cross paths in very interesting ways (Katzman and Lee, 1997). Acknowledging social and interpersonal influences enables women to identify the impact both forces have on their choices and their sense of self. It also highlights the importance of a self-reflective stance to our culture of care and cautions against ethnocentric and andocentric views of mental health and health care delivery. Often by questioning the patriarchy we question unnamed assumptions – a level of self-consciousness that can result in growth (Katzman et al., 1994).

A feminist understanding casts eating disorders as the solution and asks, "What is the problem?" (Fallon et al., 1994). In so doing feminist approaches pave the way for theorising that recognises that food disturbances, rather than being a pathological response to sane circumstances, may in fact reflect a reasonable answer to insane conditions. The woman is not viewed in isolation but as a part of a larger system that defines illness and health.

### Impact on care

The challenge for the therapist is to share the power the institution of therapy so readily confers. In training there is an effort to value personal experience and to "know what we know" – that is, to respect the textures of personal experience as well as the data that might impact on our provision of care and our attempts at prevention.

In a feminist approach, issues of power are made explicit and there is an effort to respect the expertise of all involved in both treatment and training. Hence, this approach to therapy assumes that the patient will ultimately be the expert on her recovery.

## FEMINIST THERAPY AS A TOOL FOR SOCIAL/EMOTIONAL CONNECTION

### Definition

Therapists/clinicians such as Steiner-Adair (1991), Fallon et al. (1994) and Kearney-Cooke (1991) have presented an alternative model which recognises women's need for social and emotional interdependence, rather than the heretofore preferred value of "independence" in which psychological maturity is defined as separation and independence. Feminist treatment environments thus enhance opportunities for connection, explore the successful

navigation of competition in relationships and develop a sense of self in relation to others (Miller, 1986; Noordenbos, 1991; Sesan 1994).

### Impact on care

Within the "connection model" the relationship between therapist and client is actively explored and experimented with. A feminist therapist does not use a hierarchical expert model: instead, a feminist therapist strives to reduce the power differential through psycho-education, narrowing the knowledge gap between client and therapist. This promotes an atmosphere of trust, equality and transparency.

Feminist therapy rejects the notion that the source of psychological distress is solely internal. Psychological problems are viewed within a socio-cultural and political context. Therapy challenges the notion of remaining distanced and detached in therapeutic relationships, questioning the concept of therapeutic neutrality. Interdependence, as opposed to autonomy, is set as a goal, and demands that both the therapist and client engage in a relationship in which there is mutuality and acknowledgment of the individual's sense of self and self-need for nurture, connection and care for others. Therapy thus becomes a collaborative process which includes a two-way dialogue between client and therapist, helping to demystify therapy and the therapy relationship. Such a model allows a client to rely less on the authority of others and more on her own inner authority (Steiner-Adair, 1991).

Many women we treat inhabit two worlds – the personal and the public. In their efforts to be attractive physically and relationally, many basic needs and potentially "ugly" feelings go underground, especially those that might reflect differences with a group they are trying to join. The feminist treatment, as a result, is an attempt to make explicit the unsaid and open it up for review and discussion. The ability to dialogue and connect is valued highly, as is the need to bring out from behind closed doors what we learn behind them (i.e. sexual and physical abuse). In essence, recovery becomes a movement from isolation to connection (Fallon et al., 1994) as women are encouraged to discover the value of emotional nourishment.

## FEMINIST THERAPY AS COGNITIVE RECONSTRUCTION OF THE BODY

### Cognitive approaches

The aim of cognitive therapy is to change maladaptive cognitions concerning body, weight and self, and to assist in the development of more positive alternative beliefs. There have been a number of extensive reviews on these techniques; the basic tenets are listed here. The first step is to

explore thoughts women have about their bodies. Diaries are often employed to track the environments and emotions that may trigger negative thinking and serve as a means of capturing an alternative, healthier self-dialogue, which is the goal of cognitive interventions. The client learns to assess how realistic her thoughts and cognitions are, and then to restructure irrational thoughts and beliefs that will ultimately lead to a change in behaviour. Finally the results of this changed behaviour are evaluated, working towards the goal of developing a less critical and more realistic body image and the attainment of a more positive attitude towards one's physical being.

Based on cognitive behavioural therapy, Cash (1997) developed a self-help book for women with negative body experience with the following eight steps:

1. to understand the psychology of the physical appearance;
2. to become aware of the own personal body experience;
3. to learn to comfort the body;
4. to discuss the suppositions about the body appearance;
5. to change false and irrational thoughts about body experiences;
6. to eliminate dysfunctional thoughts and behaviours;
7. to handle the body in a correct way;
8. to keep a positive body experience and to prevent relapse.

Cognitive approaches might also challenge some of the assumptions regarding perfection and the unreal standards women set for themselves, particularly in the area of eating disorders. Programmes such as those described by Weiss and colleagues (1985, 1986) employ cognitive techniques in a feminist-orientated way for eating disorders in that women are asked to challenge assumptions they have about basic human rights, assertiveness and the ways in which one can be attractive (e.g. through behaviours) other than altering appearance (see also Chapter 6 in this volume).

## FEMINIST THERAPY AS BODY-ORIENTATED THERAPY

Body-orientated therapy focuses on the use of body activities to change the body attitude in a positive way and subsequently develop positive experience of the self (Probst, 2002). It revolves around connection between women's bodily sensations and inner emotional experience across all stages of the life cycle (Kearney-Cooke and Isaacs, 2004).

A body validation exercise was developed by Weiss et al. (1985) – a technique in which first the therapist and then each woman (in a group) stands and lists the parts of her body, citing what she likes about it. In this

context, a body can be celebrated because it is healthy or one could like her stomach because it feels good when tickled. No one is allowed to recite a negative quality and everyone helps anyone who has difficulty finding something positive. This affirmation of how one's body feels and what it can do is very powerful and the need to have it modelled first by the therapist is critical.

Other body-focused techniques include relaxation, sensory awareness, moving and dance therapy, bio energetic therapy, fantasy guided experiences, role playing, mirroring and video confrontation techniques. In the case of mirroring and video confrontation, the aim is to reduce avoidance and develop a more realistic perception of the body (Rekkers and Schoemaker, 2002). Through the non-verbal experience of the body, the client learns to translate bodily feelings into the verbal language of emotions and sensations (Probst, 2002). These activities have to be used with care and explained properly to the client. Women in therapy need to feel that they are in control of their body and are allowed to stop when emotions become overwhelming.

## FEMINIST THERAPY: CRITIQUE AND CONCLUSION

Feminist perspectives on therapy have been criticised on the basis of being mainly "ideological" and not easily translated into clear therapeutic methodologies. In addition, it can be argued that not all psychological issues are caused by power imbalance, male dominance or oppression. Rodin et al. (1984) described women's dislike of their bodies as a "normative discontent" since it is rare for a woman to accept her physical shape unequivocally. Perhaps this is not surprising, given the historical constructions of women as the second gender and the very profitable industry created to reshape women's bodies (inside and out). Feminist approaches to women and their bodies don't stop at an analysis of dietary compliance or desires to reshape one's form, but instead encourage us to help women reclaim and reinhabit their physical being. Cognitive approaches to improved body image may take a feminist orientation or simply focus on irrational beliefs about a woman's self. Often many different therapeutic tools can be combined creatively to assist women in making the necessary changes and, as reviewed in this chapter, these include verbal as well as non-verbal techniques.

In all instances it is critical to maintain a safe and supportive environment in which the woman is in control of modulating her experiences and experimenting with new techniques. What we do as therapists as we deploy our tools says as much to our patients as any words we use. In an age in which it is common to critique one's self and one's body, therapists can serve as powerful models of comfort and as architects of a therapeutic culture that honours the women we treat. To the extent that a feminist approach prompts the exploration of new questions in our field it offers a

valuable additional lens through which we can explore the impact of other theories, be they social, biological or genetic.

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