Abstract

Feminist theory has evolved over more than two centuries. In the 1960s, a psychological therapy approach based on feminist theory called feminist therapy began and has been evolving since. The principles of feminist theory fit well with the case study which was examined in this paper.
Feminist theory has been more accepted as it has broadened to become more inclusive of all people considered to be in the margins of mainstream, traditional patriarchal societal thinking. However, the feminist therapy approach has been widely accepted but still lacks much empirical support for validation. A case study using principles of feminist therapy was explored and analyzed with respect to sex-role perceptions, ageism, culture differences and power relations within modern health care system encountered by an 80 year old, married, retired, female client. The client had previously had a health decline and came to seek psychiatric help after encountering a medical remedy with resulting in her being severely anxious and moderately depressed. Empowerment and self-esteem were increased after three sessions using feminist therapy as measured by subjective and objective observations of mood, affect and reported increased participation in activities of daily living. The concepts of social context, self-efficacy, empowerment and valuing historically marginalized people were themes discovered in this case consistent with feminist therapy. A psychological well-being measurement tool and the role of the nurse practitioner therapist were explored and further research about these components was recommended.
society as equal members (Enns, 2004). The second wave of feminist theory accelerated from the 1960s until the 1990s and was marked by broadening inclusion to women of color who were not middle class or affluent (Enns, 2004). The third wave of feminist theory began in the 1990s and continues to evolve at present (Enns, 2004). Feminist theory is the underpinning for feminist therapy (Brown, 2006; Mahaney, 2007). This newest wave of theory includes greater conceptualization of multiculturalism, ethnicity, ageism, sex-role flexibility and the inclusion of men (Brown, 2006; Evans, Kincade, Marbley, & Seem, 2005).

Description of Feminist Therapy

Aim and Focus

The aim of feminist therapy is the idea of change not adjustment (Brown, 2006; Mahaney, 2007). The focus is on assertiveness, communication, self-esteem and relationships within the context of an oppressive society blocking growth and development of the client (Mahaney, 2007). Four main approaches to feminist therapy are: (a) consciousness raising; (b) social and gender role analysis; (c) resocialization; and (d) social activism (Mahaney, 2007). Viewing clients within their existing social contexts is also part of feminist therapy (Evans, Kincade, Marbley, & Seem, 2005; Kahn, 2011).

Core Concepts

Core concepts are that the client and therapist relationship is egalitarian rather than the therapist being considered the expert (Evans, Kincade, Marbley, & Seem, 2005). The therapist also assists the client to reclaim personal power and the client’s distress is not just their own personal problem but must be viewed within the context of an oppressive society as well (Brown,
2006; Evans, Kincade, Marbley, & Seem). These concepts are woven into feminist therapy and applied to the case study which follows.

**Case Study Synopsis**

Jane is an 80 year old white, married, retired female who lives with her husband in a house in a large metropolitan city. She was referred to the therapist for work on severe anxiety and moderate depression with DSM IV-TR diagnosis of Mixed Anxiety and Depressed Mood 309.28. Annie had had a moderate progressive health decline six months prior to the therapy visit with diagnosis and surgical treatment of a minor musculoskeletal disability. She had been doing water aerobics 3x/wk, working a part time job, active in church with husband and keeping house and cooking for herself and her husband in the home prior to the onset of the medical problem. The musculoskeletal problem was surgically treated but the client still complained of weakness and some numbness bilaterally which inhibited most activities. She developed total body weakness and emotional worsening. She presented to therapy with flat affect and tearfulness, fidgeting with a facial tissue and with slowed cognition with respect to memory of the timeline of the last six months. She and her husband came to therapy together with the patient using a walker to ambulate. Jane stated that she had delayed coming to therapy for a week in hopes of feeling better but finally came at the urging of her husband and using the walker for the first time that day to steady herself while ambulating.

**Feminist Theory Application**

**Intake History**

The client’s husband asked if he should accompany the client into the session and the therapist got consent from the client. The therapist took a short history of present illness from the context of chronological events preceding the distress noted at present. A social history was taken about
activities and significant relationships prior to the present health decline. Themes of decreased self-esteem, fears of continued health decline, helplessness, as well as physical weakness, and lowered ability to participate in daily living activities were noted.

**Feminist Therapy Tenets**

Therapy proceeded with feminist dogma guiding the theoretical approach as shown in Table 1. These tenets identify the client and therapist roles, the theoretical view of the behavioral problem and guide the therapeutic process. This theoretical orientation has been applied in individual client sessions with both men and women in outpatient counseling. This holistic, outsider empowerment therapy (Brown, 2006) is compatible with the advanced practice nursing standards of client advocacy as stated in the Psychiatric-Mental Health Nursing Standards of Professional Practice (2007), Standard #15. Advocacy is broadened to include access and policy parity, providing direction for decision-making bodies, initiation of guidelines to address emerging problems, and design innovations to effect practice change and improve health outcomes. These goals will be discussed in the case study analysis.

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<td>Adapted from Walker’s Six Tenets of Feminist Theory for Use in Client Individual Therapy modified by Brown 2006.</td>
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(1) Egalitarian Relationship- Client and therapist emphasize personal responsibility and assertiveness in other relationships.

(2) Power in relationships- Teach client to gain and use power in relationships and identify consequences of these actions.

(3) Enhance women’s strengths- Optimistic assessment of client’s positive attributes not of their shortcomings and weaknesses.
(4) Non-pathology oriented and non-victim-blaming- Medical model is only a potential consideration for therapy. Women’s problems are seen as coping mechanisms and viewed in their social context and as a larger microcosm of a patriarchal society.

(5) Client Education- Recognize cognitions which are detrimental and educate client for the benefit of all women.

(6) Acceptance and validation of feelings- Therapists value self-disclosure and attempt to remove *we-they* barrier of traditional therapeutic relationships.

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**Case Study Examples**

The client stated, that she had been told by her health care provider that there was nothing else he could do for her. A goal was the client reclaiming personal power (Mahaney, 2007). An example of this guidance was challenging the concept of terminality implied above by discussing with the client that there are things that she can do to improve her weak physical state and thereby work to alleviate her mental distress. The therapist stated, “Yes there are things that you can do to improve even when feeling as bad as you do”.

Power in relationships was addressed by suggesting that the client enter into a walking regimen with her neighbor who also needed continued physical rehabilitation after having exhausted all of her allotted physical therapy sessions past total joint replacement surgery. (Brown, 2006).

The aim of change rather than adjustment (Mahaney, 2007) was accomplished by empowering the client to change the medical status quo implication that, because the specialist has no further recommendations, then there is nothing more that can be done to the positive stance of doing rehabilitation on her own and assisting a neighbor with a similar endeavor.
A core concept of egalitarianism with the therapist and the client (Mahaney, 2007) was honored by use of Socratic language to allow the client self-determination. This was accomplished by referring to her as Mrs. ___[last name] and honoring her husband as a significant other with the client’s permission.

Acknowledgement of sex-role as long time homemaker, as well as business woman, wife and great grandparent were accepted as worthy and valued aspects of the client’s identity. Empowerment was based on this client’s identity strengths. The client was viewed as worthwhile and important. She was more than society’s view of an elderly, female in declining health just having interacted with a complex, patriarchal medical system. This hypothesized culture difference was viewed as blocking the client’s growth and development (Camillo, 2004). The therapist also used the example of another elderly female who had gotten weak from not exercising and had had to do her own exercise plan to feel better.

**Case Study Analysis**

The advanced practice nurse therapist’s role remains that of being a patient advocate and understanding societal and policy ramifications upon the client and his/her self perception. Empowerment of an ill elderly woman because she relevant and has her own cultural needs required a therapist mindset of feminism. The case study client was honored in her social context and her distress was viewed as a culture difference between the medical system and her generational perceptions and expectations. She was empowered to take on her own physical therapy, to change not adjust to her physical weakness and distress. The therapist is also called to examine the issues of this case and attempt to enlighten society about the millions of elderly women who are just as important as anyone else.

**Literature of Similar Treatment Issues**
Health Care Culture vs. Elderly Women

The distress the case study client experienced is similar to what was discovered in the following study. Camillo (2004, p. 14) did an ethnographic study to assess whether older women experienced barriers to health care related to gender and power relations within biomedical culture of primary care in a Midwestern town. The average age of the participants was 82 years. Themes which emerged from this study were very similar to the case study examples of uncertainty and communication needs not being met for the elderly clients. These involved what would happen after a hospital discharge, who their inpatient physicians would be and how their needs for care would be met in activities of daily living outside of the medical model of care (Camillo, p. 17). These were themes noted by the case study therapist as well for Annie.

Gender and age bias created barriers to care because the culture of the medical model and that of the elderly women was so different (Camillo). A theoretical model explaining this primary care experience fits well with what Annie, in this paper’s case study, related to the therapist. Her distress can be correlated to the model within the feminist theoretical framework which guided the study. Her described experiences and feelings were very similar to the themes discovered by Camillo.

Wellbeing in Health Challenged Older Females

The following study documents the strength and adaptation of older women to improved wellbeing after facing health challenges over time. It challenges the mainstream societal views of aging women as others (Brown, 2006). Helson, George and John (2008) did a 20 year prospective longitudinal study of aging women who encountered health challenges either at age 52 or at age 62 and measured their subjective wellbeing over time. The results documented that both groups of women were able to increase their subjective wellbeing over time. The
researchers discussed that aging and development over time led both groups to regain involvement in life through emphasis on generativity. These women actually may have benefitted from aging and its hypothesized emphasis on positive affect over negative affect (Helson, George, & John). The health challenges undergone by the aging women in the Helson, George and John study and resulting increases in subjective wellbeing over time are consistent with the feminist concept of emphasizing client strengths, and meeting clients in the framework of their lived experiences with health challenges.

**Aging as a social construct.**

Societal marginalization of older women can be rejected with social narratives rewritten which challenge assumptions (Mitchell, & Bruns, 2011). Feminist therapists can empower clients by having them question the *all or nothing* idea of successful aging in terms of equating power with youth, agency, or activity (Mitchell, & Bruns, p. 122). The feminist therapist can help clients to choose their own definitions of meaningful activity independent of social expectations externally articulated (Mitchell, & Bruns). Hill, & Ballou as cited in Kannan, & Levitt, (2009) identified therapist techniques of challenging destructive beliefs, setting goals for change, and focusing on self-care to combat oppression as themes which emerged from their grounded theory study of feminist therapist practice. Kannan and Levitt also did a grounded theory study in which they found themes of feminist therapist work with clients was based on gender equality, female autonomy, and the intersection of external social influences such as power and it’s confluence with prejudice and oppression in their clients’ lives (2009, p.418).

These qualitative and quantitative studies serve to strengthen the feminist premise that bias exists, is detrimental to those labeled as at the margins of paternalistic society, it is correctable on an individual basis and at higher levels of societal context, and is complementary to aging
women’s natural course of increased wellbeing over time. It is also consistent with empowerment of those who are oppressed to write their own definitions of wellbeing.

Measurement of Outcomes

The literature is lacking in empirical validation of feminist therapy to individual client populations for two reasons. The therapy is still rapidly evolving and broadening in response to criticism of the second wave of feminism being mainly introduced by white, middle-class, females and it’s perception of non-inclusiveness of minorities (Brown, 2006; Mahaney, 2007; Mitchell, & Bruns, 2010). Secondly, measurement of success should be in individual cases as well as in societal trends over time (Singh, & Burnes, 2011). Instruments need to be developed and tested to accomplish this. Evidence-based practice requires constant revision of guidelines as new, high level empirical evidence becomes available (Polit, & Beck, 2008). However, the role of qualitative research must not be minimized as it can enlighten researchers about which practices are individually effective (Polit, & Beck).

Measurement Tools

Symptom measurement surveys are advocated for use in psychiatric-mental health advance practice nursing practice which may include psychotherapy. The theoretical reliability of a tool for a holistic therapy such as feminist therapy requires that it measure outcomes in a manner consistent with treatment goals. In keeping with the feminist therapy strategy of emphasizing client strengths, a survey of wellbeing which may also be compatible with measures of life adjustment may be useful. The following scale has been reported as being used in national surveys and also in individual therapy cases (McDowell, 2010).

Ryff’s scales.
McDowell (2010) reviewed several measures of self-perceived well-being in the literature which reflect expanded holistic goals of health care delivery as viewed by the patient. The Ryff’s Scales of Psychological Well-Being (Ryff as cited in McDowell, 2010) have been extensively tested for reliability, stability, and concurrent validity with two other scales of well-being (McDowell) and is an option for outcome of therapy documentation. The 18-item version is in wide use (McDowell). Measurement of multiple forms of well-being seems consistent with feminist theory tenet application (Brown, 2006; McDowell, 2010; Mahaney, 2007).

Current Applications of Feminist Theory

There are several instances of note about how feminist theory has helped shape psychology practice in the last several years. The American Psychological Association (2007) has guidelines for therapy for women and girls as well as a task force on the subject (Kannan, & Levitt, 2009). Diversity and multiculturalism are part of the feminist construct which has become important in psychological assessment of minority groups (Kannan, & Levitt, 2009). Enns (2004) discussed using diverse methodologies using the tenets of feminist theory to assist clients with: (a) overall empowerment, (b) problem solving, (c) behavior change and (d) their awareness of themselves. Therapy can also be useful to men (Kahn).

Discussion

Feminist theory has informed the practice of feminist therapy by broadening the perspective of individual clients as well as resisting a narrow lens of acceptability in society as defined by external oppressive societal views which may become internalized in clients and cause distress, anxiety and depression. It is a framework for valuing diversity and multiculturalism. It is applicable to several therapeutic approaches as a set of tenets which are applied by a politically and culturally well informed therapist. These goals are consistent with those of the advanced
practice nurse therapist. The therapy also insists that the oppressive societal constructs which marginalize clients must be challenged at the societal level in order for the therapy to remain effective for clients. It is based on personal narrative construction and empowerment for distressed and marginalized clients. It is based on an egalitarian and positive therapeutic relationship and challenges whether there is really something wrong within the client or something which is disempowering the client, unfairly so. Strong consideration is given to client internalized a narrow external view of the client’s relevance. The client is honored in her lived context and strengths are nurtured. It seems like the key to unlocking the door barring freedom.

References


