Chapter 12

Women's Mental Health and Well-Being

From "Mental Disorders" to Feminist Practice

Consider each of the following recognized mental disorders. Fill in each blank with your guess about the gender ratio for each; that is, does each occur more frequently in men (F < M), more frequently in women (F > M), or equally in each (F = M)?

- Trichotillmania (compulsively pulling out one's own hair): F ___ M
- Gambling Disorder: F ___ M
- Alcohol Abuse: F ___ M
- Schizophrenia: F ___ M
- Childhood and Adolescent Conduct Disorder: F ___ M
- Inhibited sexual desire and orgasm: F ___ M

Definitions of what each of these disorders is, as well as a determination about their occurrence in women and men, appear in the *Diagnostic and Statistical Manual of Mental Disorders* published by the American *Psychiatric* Association (DSM–IV, 1994[1]). The gender information provided about each disorder is based on experts' readings of published research about each disorder, but I'd be willing to bet that your guesses fit pretty well with their more informed reports (see the answers in the footnote below[2]). Cynthia Hartung and Thomas Widiger (1998) reviewed 125 disorders and found gender information about 101 (81%) of them in the DSM, with most arguing for gender differences. As we have seen throughout this text, such strong interest in gender differences probably means that there's a lot going on here that deserves a closer look.

I don't mean to suggest that there's intentional malfeasance here, but rather that the picture is likely more complex than what laypeople like us are able to guess and that the concerns we have seen previously about individual differences, stereotyping, status, and power are probably implicated. Hartung and Widiger help us out by drawing our attention to some interesting patterns across the examples above.

First, systematic explorations for gender differences in any disorder are affected by biases in reporting. For example, more women than men might seek treatment for Trichotillmania because appearance is culturally more important to women and because hair loss is more socially acceptable among adult men. Women may be under-represented in treatment programs for gambling because of the social stigma attached to public acknowledgement of this problem for women.

Second, these gender differentials may reflect biases in who is recruited for research studies on a given topic. For example, over 70% of studies on alcohol abuse recruited mostly male participants, and only 6% recruited mostly women. Although the DSM describes schizophrenia as occurring equally in women and men, Hartung and Widiger summed across reviews of participation rates and concluded that 69% of research partici-

[1]DSM–5 is expected in May of 2013. For information, visit the American Psychiatric Association at *www.psych.org*.

[2]Trichotillmania and inhibited sexual desire/orgasm are reported to occur more often in women; gambling disorder (2:1), conduct disorder, and alcohol abuse, more frequently in men; and schizophrenia, equally.

pants were men. Beyond simple counting, women and men vary in the onset of schizophrenia (women later), in their personal histories prior to diagnosis, in the severity of their symptoms (milder in women), in their responsiveness to treatment, and even possibly in relevant brain patterns (also see Taylor & Langdon, 2006).

Third, more boys are diagnosed with childhood disorders, and women dominate more of the adult disorders. Some of this may have to do with who makes the referral (others, like parents and teachers, or one's self) and who is harmed by the person's behaviors. Contrast the aggressiveness and disruption of conduct disorders with the self-injury of Trichotillmania. Overall, childhood disorders tend to be more **externalizing** (affecting others); adult disorders, **internalizing** (affecting one's self). This shift in what is considered disordered behavior by age may itself be gendered, and interestingly, much of what is disordered for boys (e.g., reading disorders) has no parallel in later life.

Finally, the very definitions of some disorders may lean toward stereotyping of one gender. Inhibited sexual desire and orgasm is a good example. It may be more difficult for men to meet the criteria for this diagnosis, and there certainly are differences in cultural acceptance of women's and men's sexual arousal. These last points make us consider issues surrounding the very definition of disorders, a topic to which we'll return.

Our obvious starting point will be the DSM and how clinical diagnoses are done. Notice that I embedded overviews of specific diagnoses with gendered patterns— agoraphobia, alcohol and substance abuse, depression, eating disorders, and three personality disorders (borderline, histrionic, and dependent)—within this disucssion. After critiquing how diagnosis is done within a DSM-based medical model, we'll take a proactive approach and review the theory of feminist practice.

DIAGNOSIS: THE DSM-IV

The DSM defines a "**mental disorder**" as:

> …*a clinically significant behavioral or psychological syndrome or pattern* that occurs in an individual and that is associated with *present distress* (e.g., a painful symptom) or *disability* (i.e., *impairment* in one of more *important* areas of functioning) or with a significantly increased risk of suffering death, pain, disability or an important loss of freedom. In addition, this syndrome or pattern *must not be merely an expectable and culturally sanctioned response* to a particular event, for example, the death of a loved one. Whatever its original cause, it must currently be considered a manifestation of a behavioral, psychological, or biological dysfunction in the individual. Neither deviant behavior (e.g., political, religious, or sexual) nor conflicts that are primarily between the individual and society are mental disorders unless the deviance or conflict is a symptom of a dysfunction in the individual, as described above (DSM–IV, 1994, p. xxi–xxii, italics added by Caplan, 1995).

Although this definition may sound reasonable and definitive on the face of it, a closer look reveals that all the italicized portions are compromised by subjectivity, and therefore vulnerable to biases (Caplan, 1995). For this reason, some therapists have questioned

whether we should even think in terms of diagnostic labels.[3] A key question to ask may focus on how labels, once applied, will be used. Despite these very serious objections, labeling is at the heart of the DSM; is widely used (over 1 million copies of DSM–III–R were sold in less than 6 years [Caplan, 1995]); and assumes that a line can be established such that crossing it moves an individual from normality to abnormality.

The DSM claims that it classifies symptoms, not people, but in reality, a DSM diagnosis labels a person. Each disorder is assigned a number with decimal (e.g., 302.73 for "Female Orgasmic Disorder") that becomes a handy referent for insurance companies and lends a scientific aura to the diagnosis. A list of diagnostic criteria outlines the symptoms for each disorder, usually specifying cut-off points: how many symptoms must be present to merit each classification and its duration. There even are decision trees at the back of the volume to walk one through the choices possible within a general diagnostic category.

As early as 1977, a task force of the American *Psychological* Association questioned the conceptual basis of the DSM by highlighting its limitations. The DSM reflects a disease-based model extrapolated from medicine; the specific categories are unreliable (and continue to be so with low agreement rates even among trained therapists; Garfield, 1986); categories are deleted and added based on committee vote with little research backing; the labels can lead to biased treatment; and there is little evidence that such categorization facilitates treatments or predicts outcomes (Task Force, 1977, cited in Lerman, 1996; also see Hyman, 2010). Furthermore, the DSM imposes sharp boundaries between normal and abnormal as well as between disorders (Marecek, 2001). One estimate concluded that 60% of clients who seek help from a professional describe problems that fit none of the DSM categories (Wylie, 1995, cited in Marecek, 2001).

GENDERED PATTERNS IN DSM DIAGNOSES

Data collected from 2001 to 2003 in the United States demonstrate that fewer women than men (a ratio of 0.7:1.0) were *un*affected by DSM-defined mental disorders (Kessler et al., 2005). Women were consistently more likely to report internalizing disorders (both alone and in combination with other disorders; that is, co-morbid) as well as highly co-morbid major depressive episodes than men; men, more externalizing disorders (including social phobia and attention-deficit/hyperactivity disorder). The one area where no gender difference was found, bipolar disorder, also shows few gender differences in its expression, severity, and treatment (Diflorio & Jones, 2010). These general patterns for the lifetime **prevalence** of mental disorders extend to 15 countries surveyed by the World Health Organization (Seedat et al., 2009).

Table 12.1 catalogues some specific disorders identified in DSM-IV as occurring more frequently in one gender than the other (**intergroup differences**). American boys are more vulnerable than girls; adult women are more susceptible to major mood, anxiety, and eating disorders; men dominate in substance-abuse disorders; and women and men are diagnosed with some different personality disorders.

[3]Labeling opponents argue that labels are stigmatizing; labeling proponents argue that labels result in the provision of needed services. For a good overview of this debate, as well as data linking both lower stigma and high quality services to quality of life and enhanced self-concept, see Rosenfield (1997).

TABLE 12.1
Differential Diagnosis by Gender

More Common in Women	*More Common in Men*
CHILDHOOD	
Selective Mutism	Mental Retardation (1.5:1) Reading Disorder Language Disorders Autistic Disorders Attention Deficit/Hyperactivity Conduct Disorder Oppositional Defiant Disorder Feeding Disorder Tourette's Disorder (motor/vocal tics) Stereotypic Movement Disorder Elimination Disorders
ADOLESCENCE AND ADULTHOOD	
Substance-Related Disorders	
	Alcohol Abuse and Dependence (5:1) Drug Abuse and Dependence
Mood Disorders	
Major Depression (2:1) Dysthymic Disorder (2:1) (long-term depression	
Anxiety Disorders	
Agoraphobia (3:1) Specific Phobia Social Phobia	
Somatoform Disorders	
Somatization Disorder Conversion Disorder	
Dissociaative Disorders	
Dissociative Identity Disorder (3-9:1)	
Eating Disorders	
Anorexia Nervosa (9:1) Bulimia Nervosa (9:1)	
Impulse-Control Disorders	
Kleptomania Trichotillomania	Explosive Disorder Pyromania Pathological Gambling (3:1)

(continued)

TABLE 12.1
Differential Diagnosis by Gender (cont.)

More Common in Women	*More Common in Men*
Personality Disorders	
Borderline Personality Disorder (7.5:1)	Paranoid Personality Disorder
Histrionic Personality Disorder	Schizoid/Schizotypal Personality Disorder
Dependent Personality Disorder	Antisocial Personality Disorder
	Narcissistic Personality Disorder
	Obsessive-Compulsive Personality Disorder

Note. Compiled from the *Diagnostic and Statistical Manual of Mental Disorders*, 4th ed. (1994). Other categories of disorders include: cognitive disorders, mental disorders due to a medical condition, psychotic disorders (e.g., schizophrenia), factitious disorders (feigned ailments), sexual and gender identity disorders, sleep disorders, and adjustment disorders.

Although non-Hispanic Blacks and Hispanics overall were less likely to be affected by a mental disorder than Whites (Kessler et al., 2005), some patterns differ along racial and ethnic lines for specific disorders (**intragroup differences**). Major depression appears most commonly in White Americans and least in African Americans. Among women, alcohol abuse and dependence is highest for African Americans and lowest for Latinas. Panic disorders are most pronounced for White women and least common among Latinas, and **somatization disorders** occur more frequently in the lifetimes of non-Black women (.78%) than African American women (.17%).

Summing up, gender differences emerge in a variety of areas. Five of these have attracted the attention of clinical researchers and will be described in this chapter: agoraphobia, alcohol and substance abuse, depression, eating disorders, and a set of three personality disorders (borderline, histrionic, and dependent). Rather than focus on each of these "mental disorders" separately, as a DSM-based approach might dictate, our discussion will proceed as a critique of the DSM, using each of these five gendered areas as examples to illustrate points made in this argument. My argument will focus on three areas: (1) on definitions of what is pathological and what is normal; (2) on biological explanations for gender differences in diagnosis; and (3) on problems with exclusively intrapsychic explanations.

DSM DEFINITIONS

We saw at the start of this chapter that determining the gender ratio within any diagnosis is complicated by sampling and definitional biases. Fundamentally, there's a logical tautology here that draws on circular reasoning: Because research on DSM classifications starts with these classifications, it confirms itself. If the DSMs recorded psychopathologies that existed independent of it, we might expect revisions to be relatively minor. However, the DSMs have grown remarkably over time. The first edition appeared in 1952, was 129 pages long, and described about 79 different diagnostic categories. The most recent version, published in 1994, extends to 886 pages and defines 374 categories (Lerman, 1996). Disorders come and go, take on different names and defining criteria, and move from presumably legitimate status in the text back into the appendices, where they hang in limbo until further research either re-establishes them in the text or removes them. These flip-flops seem most

common for controversial disorders involving sexual orientation and gender. In sum, we need to explore what *legitimates* a disorder so that it is included in the DSM, as well as what remains excluded, and thus "normal."

What's Pathological?

Picture the following client who is being assessed by a therapist:

> Within less than 10 minutes of talking with a therapist, *Terry* is sweating profusely, trembling, having trouble breathing, and feeling lightheaded and out of control. When things settle down, Terry says that fears of these sorts of attacks make leaving the house difficult. Terry goes to great lengths to avoid being in a crowd, crossing a bridge, or traveling, preferring to stay home or venture out only occasionally with a companion. Terry always needs to know that escape is possible.

Is Terry a woman or a man? If you slipped a pronoun into the description as you read it, was it "she" or "he"?

The description of Terry illustrates the two defining criteria for diagnosing **agoraphobia** (with or without a history of panic disorder). In all likelihood, you pictured Terry as a woman. Fully 85 to 95% of diagnosed agoraphobics are women, the typical age of onset is the mid-twenties to early thirties, the majority are married (Gelfond, 1991), and symptoms are more severe in women than men (Turgeon et al., 1998). Prevalence rates for panic disorder are comparable across Latina, African American, and White women (Katerndahl & Realini, 1993). It is estimated that only about one-quarter of phobics seek treatment (Fodor, 1992), and fully 26% of normal college students report experiencing panic attacks in the past year (Brown & Cash, 1990). In a study of average women, 55% scored at or near the clinical range for agoraphobia (Gelfond, 1988, cited in Gelfond, 1991). These findings suggest that there's a lot more agoraphobia in the general population of women than has been diagnosed as a mental disorder, raising red flags about how "abnormal" some agoraphobia really is.

Agoraphobic women differ from agoraphobic men in that women are more sensitive to others, fear being alone more, and avoid going out alone (Bekker, 1996). Married women's agoraphobia may be sustained by a symptom-supportive spouse (Hafner & Minge, 1989) who generally is more critical of his wife than control husbands (Chambless et al., 2002). Thus agoraphobia is expressed by women as fears of solitary and anonymous situations. Agoraphobia also may be easier for women than men to admit—it may be compromising for a guy to admit fears of being away from home (Bekker, 1996). When an antipanic pill was introduced in Holland, signaling that panic was biologically based and hence chemically correctable, significantly more phobic men called a hot line for help and advice than before.

Majorie Gelfond (1991) interviewed, tested, and observed 21 women diagnosed as agoraphobic, 20 average women, and 21 independent women (who scored highest on a measure of autonomy reflecting how often in the past year they traveled more than 50 miles alone, traveled at night, and ate alone in a restaurant). Overall, independent women differed from the other two groups who had many qualities in common. Agoraphobic and

average women shared less **agentic** gender-role orientations, were less confident in their way-finding abilities, used less detail in the neighborhood maps they drew, and had restrictive parents (although the agoraphobics' parents were even more anxious). All women considered home a safe haven, although the agoraphobic women lived in the most highly personalized, carefully decorated houses. All shared similar experiences with crime, but only the independent women were confident in their abilities to respond to criminal occurrences. The overriding finding is that agoraphobic women, although quite different from independent women, weren't that different from women in general.

All this suggests that agoraphobia represents the extreme end of a continuum reflecting many women's concerns about a not-so-women-friendly world. If a continuum of such fears does exist, where do we draw the line between reasonable fears and psychopathology? Also, how much does it help Terry to classify her/him as an agoraphobic? There is no doubt but that Terry is experiencing hardship, but is this lessened by labeling this pain as an abnormality? We might ask similar questions of other presumably pathological disorders, calling into question the whole basis of the DSM by asking, What's abnormal? There are no definitive answers, but our discussion certainly suggests that these concerns cannot be dismissed lightly.

What's "Normal"?

Maybe we can get a better sense of what's pathological by defining what is normal. Again, consider the following profile of a client coming for therapy:

> *Lee* can't stay in a relationship—friends, relatives, and lovers fence Lee in. Lee doesn't like talking about feelings, stays withdrawn from others, and doesn't want to know what others are feeling. Lee thinks there's a place for men and women; feels confident to do anything, especially perform sexually; and thinks others should respect and praise this sexual prowess and omnipotence. Lee is threatened by women who seem more intelligent and derives little, if any, pleasure from helping others.

Did you picture Lee as a woman or a man?

Lee doesn't fit neatly into any of the 374 DSM classifications, so by default, Lee is normal. In contrast, Lee might be labeled as exhibiting "Delusional Dominating Personality Disorder," according to DSM critic Paula Caplan (1995). If Lee sounds like a man, he's meant to. He represents an exaggeration of masculine stereotyping. Caplan finds that audiences respond knowingly to this caricature, granting it some legitimacy if we define abnormality by popular acclaim. Expecting to be rebuffed, she submitted it to the DSM committee for consideration where their initial reaction questioned her sincerity.

However, evidence is growing which suggests that the kind of **hypermasculinity** attributed to our hypothetical "Lee" negatively impacts men's mental health and well being. Popular media descriptions of threats to men's mental health focus on the suppression of emotion, gender role changes in employment and sexual expression, and the advancement of women (Coyle & Morgan-Sykes, 1998). Some of these may indeed prove problematic. A study with 98 men seeking counseling found connections between unfavorable well-being and intense competitive strivings, restricted affection, and work-family conflict (Hayes &

Mahalik, 2000). Emotional restriction was related to relationship problems among college men (Blazina & Watkins, 2000). Similarly, mildly depressed men differed from nondepressed men on gender-role conflict (Mahalik & Cournoyer, 2000). Among Mexican American men, high levels of machismo, gender-role conflict, and restrictive emotionality went together and predicted depression and stress (Fragoso & Kashubeck, 2000). Hypermasculinity may belong in the DSM!

Contrast Caplan's proposal with **self-defeating personality disorder**. This "mental disorder" appeared in DSM-III, was intended for inclusion in DSM-IV despite serious empirical shortcomings (Caplan & Gans, 1991), but it was withdrawn at the last minute in response to a public outcry (Caplan, 1995). In essence, this "disorder" blamed women for being abused: "chooses people and situations that lead to disappointment, failure, or mistreatment…"; "rejects or renders ineffective the attempts of others to help him or her"; "incites angry or rejecting responses from others…"; "rejects opportunities for pleasure…" ; "engages in excessive self-sacrifice"; and so on. The inclusion of this category would have provided a sanctioned way to blame people (in most instances, women) for their own victimization.

What I am asking you to think about here is what may be missing from the DSM. Might the columns of Table 12.1 tip in the direction of more disorders ascribed to women because more disorders in the DSM fit women, whereas those that might describe men are missing? This is the question Paula Caplan is raising with her proposal for a Delusional Dominating Personality Disorder. Although Caplan surely does not want to expand the DSM by adding more "disorders," her proposal does raise questions about what makes the grade and what doesn't.

In conclusion, we raised questions in the preceding section about what is included and excluded from classification in the DSM-IV. In the next two sections, we examine specific diagnoses within the DSM with an eye to understanding why gendered patterns exist within them. Why is it that more women than men are diagnosed as depressed, eating disordered, and characterologically different with borderline, histrionic, and dependent personality disorders? Why are more men diagnosed for alcohol and substance abuse? One explanation relies on biological differences; another, on intrapsychic differences which can ignore broader contextual influences in women's lives.

NOT ALL BIOLOGY

The DSM system best fits with the assumptions of a medical model. Adherents of this model envision mental disorders as similar to physical ones—the role of therapists, paralleling that of physicians, is to catalog symptoms, diagnose, and subsequently treat as the diagnosis dictates. The strongest evidence in support of a medical model comes from explorations of the etiology (origins) of disorders in biology. There is evidence that biology plays a role in some disorders, although never an exclusive or even dominant role. Also, as we saw in Chapter 3, it is important to remember that causal relationships between biology and behavior run both ways: Biology not only influences behavior but is influenced by it as well.

For example, in a series of studies with female twins, Kenneth Kendler and his associates found greater **concordance rates** in **monozygotic twins** than in **dizygotic twins** for major depression (Kendler et al., 1992a), generalized anxiety disorder (Kendler et al., 1992b), phobias (Kendler et al., 1992c), and alcoholism (Kendler, Health et al., 1992b).

Estimating the proportional contribution of genetics to the presence of each disorder (**heritability**) for women and men, these researchers reported heritability estimates of 60% for agoraphobia, 52% for alcohol abuse and dependence, 43% for depression, 42% for eating disorders, and 49% for borderline, 32% for histrionic, and 37% for dependent personality disorders (Kendler et al., 2011). Be sure to note that none of these percentages is close to 100%, and understand that a specific genetic marker has not been identified for any. Genetics, like other biological explanations such as hormonal changes, may trigger depression in women but always as part of a complex confluence of social, psychological, and biological factors (Nolen-Hoeksema & Hilt, 2009).

Differing intragroup patterns across the life course, across race and ethnicity, and across cultures suggest that more than biology is at work. In pre-adolescents, rates of depression are low and likely equal for girls and boys, but then a gap emerges and peaks from ages 15 through 30 years old (Parker & Brotchie, 2010). From the late thirties onward, rates of depression decline for both women and men but the numbers never equalize. This gender difference is even more pronounced among Black and Latino/a adults than among White, and this gender difference holds up across many cultures and countries (Nolen-Hoeksema & Hilt, 2009).

Focusing on biological causes leads to the treatment of disorders with medical treatments (drugs), the domains of psychiatrists and physicians (not psychologists and other mental health professionals), although these exclusive rights are being challenged. Over half of physician visits where patients are diagnosed with a mental disorder result in a prescription for mood-altering **psychotropic drugs**: tranquilizers, sedatives/hypnotics, antidepressants, and stimulants (Travis, 1988b). In the United States, adult use of antidepressants almost tripled between 1988 to 1994 and 1999 to 2000 so that 10% of women and 4% of men were taking antidepressants in 2000 (CDC, 2004).

It has been argued that women receive more drug prescriptions because they suffer from more psychiatric distress and are more willing to report psychological symptoms to physicians. There is evidence that doctors are more likely to believe that women's physical illnesses encompass a psychological component and dismiss women's complaints of undesirable side effects of medication (Shapiro, 1995). Furthermore, advertisements for drugs in professional magazines more commonly feature women (Hansen & Osborne, 1995), and drug ads appeal directly to women consumers through women's magazines (Sokol, 2010).

Although biology does appear to play some role in the etiology of certain mental disorders, these studies urge us to look beyond biology for a fuller picture. The medical model that underlies the DSM may not foster such expansive exploration. Furthermore, the possible over-reliance of medical practitioners on psychotropic drugs to treat women's complaints, both physical and psychological, suggests needs for further research and cautious vigilance on the part of consumers. It also raises questions about the potential psychological treatment of truly physiological maladies—problems that if left untreated could jeopardize women's lives (Brozovic, 1989). All this underscores the need for a feminist approach to psychopharmacology (Marsh, 1995) that considers biochemical treatment as an adjunct to, not a replacement for, psychotherapy (Rosewater, 1988).

NOT ALL INTRAPSYCHIC

Jeanne Marecek (2001) argues that the conventional DSM system identifies the individual as the locus of pathology without taking into consideration the **social contexts** of women's and

men's lives. This assumption removes the family, the community, and other social factors from consideration in both diagnosis and treatment. Feminist critiques have challenged this exclusive focus on intrapsychic factors presumably internal to, and controlled by, the client. Apparent gender differences in specific diagnoses might be influenced by gender stereotyping, involving both the definition of disorders and therapists' judgments in assigning diagnostic labels, as well as from contextual factors differentially affecting the lives of women and men.

Stereotyping and DSM Definitions

Try picturing two more clients seeking therapy:

> Over the past two weeks, *Chris* has been depressed most of nearly every day, feeling sad and empty and appearing tearful to others. Chris, who usually isn't like this and who is not experiencing bereavement, doesn't get pleasure from or feel interested in what had been pleasurable activities. Chris doesn't feel like eating, resulting in weight loss across the past month, and wakes up in the middle of the night and can't get back to sleep. Thus Chris is fatigued so that even the smallest tasks, like washing and getting dressed, seem exhausting. Chris appears agitated during the interview, having trouble sitting still, speaks in low, labored tones, and has trouble concentrating. Chris reports feeling worthless and keeps thinking morbid thoughts. What's wrong with Chris?
>
> *Pat* shows up reeking of alcohol. Pat has been referred for counseling because of repeated driving violations and for picking fights with coworkers. Pat knows that drinking creates problems but feels terrible if a day goes by without a drink—nauseous, agitated, sweating, and just plain nervous. At these times, it seems easier to take a drink (or two, or more—it seems to take more and more to help), even though obtaining and consuming alcohol takes up lots of Pat's time. What's wrong with Pat?

The argument proposed here is that the DSM system, as conceived, draws on gendered stereotyping to define syndromes. For example, is the list of symptoms that defines major depression gender-neutral, or does it, at its core, rely on images of women as depressive and thus describes gender-biased versions of this disorder? Chris fits the DSM definition of major depression. Did you imagine her as a woman (specifically a White, middle class woman)? Similarly, does the image of an alcoholic as a man shape how alcohol dependence and abuse are presented in the DSM? Pat presents the symptoms of alcohol abuse and dependence—do you picture "him"? Parallel logic applies to the scenario for Terry, our agoraphobic earlier in the chapter. Hope Landrine (1988; 1989) found these patterns in the responses of students who made consistent determinations regarding the gender of targets diagnosed with depression, dependent personality disorders (White, middle class, married women), and antisocial personality disorders (poor, young men). Notice how *stereotyping of these disorders is consistent with gender stereotyping.*

Throughout this book, we have seen that gender stereotyping goes not only with the sex category of participants (women are expected to be depressed), but also with gender-typing (femininity is associated with depression). Melissa Hoffman and her colleagues (2004) tested both these linkages by looking at how sex categories (being female or male)

as well as femininity (expressiveness or **communion**) and masculinity (instrumentality or **agency**) affected the mental health symptoms reported by high school students. They classified these symptoms broadly as **internalizing** (causing problems for the student her/himself; e.g., feeling depressed) or **externalizing** (causing difficulties for others; e.g., lying and cheating). As sex category would predict, girls reported higher femininity and internalizing; boys, more masculinity and externalizing; but this is just the start.

Differences between girls and boys in externalizing closed when gender-typing was considered. Rather, both girls and boys high in masculine agency or low in feminine communion were more likely to report externalizing symptoms. Thus, gender-typing, not being female or male per se, predicted externalizing. In contrast, being female was associated with high internalizing, but so was low agency combined with low social attractiveness and self-worth (for both girls and boys). In other words, girls did report more internalizing symptoms than boys, but so did girls *and boys* with low agency, social attractiveness, and self-worth.[4]

Stereotyping and Therapists' Judgments

We have asked many questions about the validity of the DSM itself. Here we will focus on how the DSM is *used*. Might therapists themselves bring biases to the DSM that are justified, reinforced, and further entrenched by biases within the DSM system so that their combination further compounds the effects of gender stereotyping? In a classic study, Inge Broverman and her colleagues (1970) asked clinically trained psychologists to rate one of three clients described as a "healthy, mature, socially competent adult" (1) "man," (2) "woman," or (3) "person."

There was remarkable consensus among the therapists about what constitutes psychological health for women, for men, and for adults in general, when each was considered separately. Healthy "men" and "persons" were described similarly to each other and differently from the "woman." Healthy women, relative to men, were portrayed as being more submissive, less independent, less adventurous, more easily influenced, less aggressive, less competitive, more excitable in minor crises, more emotional, more conceited about their appearance, less objective, having their feelings more easily hurt, and disliking math and science—not a very flattering picture of women's mental health.

Given what we have learned about contemporary stereotyping, we might expect such explicit linkages of mental health to being male/adult and not to being female to have ceased. They haven't. Susan Seem and Diane Clark (2006) updated their list of stereotypic traits and repeated the above research design with Masters'-level counseling students. They found that the healthy man was still generally masculine stereotyped, that the healthy man and adult overlapped more than each did with the healthy woman and that the healthy woman continued to be generally feminine, but with three new, masculine-typed expectations: to be "strong" and "independent" and to "enjoy a challenge."

There also is some evidence of the more subtle bias we might expect in contemporary stereotyping studies. For example, a study of gender-typing by 554 psychotherapists found that they typically stereotyped women as more communal and less agentic than male

[4]Similarly, other studies link gender-typing with specific mental disorders—depression: Broderick & Korteland, 2002; eating disorders: Klingenspor, 2002; self-sacrificing: Dear & Roberts, 2002; and general psychological health and well-being: Woodhill & Samuels, 2003.

targets (Turner & Turner, 1991). Another study of 229 therapists reported that they were more likely to view men's problems with a utilitarian, let's-fix-it approach (Fowers et al., 1996). Both studies suggest that therapists approach male clients expecting a more favorable prognosis.

We saw in Chapter 11 that physicians' expectations about who has heart disease may affect how women are diagnosed. A similar pattern regarding therapists' biases appears here. In a clever analogue study by John Robertson and Louise Fitzgerald (1990), 47 practicing counselors-therapists were shown one of two videos in which the same male actor described symptoms of depression (poor appetite, boredom, and sleeplessness). In half the tapes, the actor described his marriage as a traditional one in which he was employed as an engineer and his wife was a homemaker and primary caretaker of their children. In the other version, only these segments were altered to describe a nontraditional arrangement in which domestic and employment roles were reversed.

Not surprisingly, practitioners rated the nontraditional client as less masculine (**agentic**) on 14 of 20 items of the Bem Sex Role Inventory. Most notably for us, the nontraditional client was diagnosed significantly more frequently with severe mood disorder, and more therapists planned to probe for marital problems as the source of his depression—despite the client's expressed belief that his marital arrangement was satisfactory. This speaks volumes about the mental health implications of breaking gendered occupational and domestic norms. More to the point here, depression, with its feminine connotations, was a more likely diagnosis for a less "masculinized" client.

Other analog studies present the same written description of a case to practitioners and then ask for their diagnosis. For example, Douglas Samuel and Thomas Widiger (2009) shared the case of "Madeline G" with practicing therapists—a case widely regarded as a prototypical example of narcissistic and histrionic personality disorder. Their participants largely agreed with this assessment, but not when "Madeline" was framed as "Matthew." Their diagnosis of Matthew veered away from histrionic toward antisocial personality disorder. This shift reflects the general framing of histrionic as more common in women; antisocial, as more typical of men (Lynam & Widiger, 2007), suggesting that therapists' expectations about the gendering of each personality disorder influenced their judgments.

What happens when we look at the opposite scenario, such as when a woman presents the symptoms of a male-dominated disorder such as **alcohol abuse and dependence**? Alcoholism may not be suspected when it indeed exists (Vogeltanz & Wilsnack, 1997). A review of 90 studies on substance abuse found that fully 65 of the researchers (72%) failed to probe their data for potential gender differences, even though these analyses were feasible (Toneatto et al., 1992). This oversight results in a gap in our understanding of alcoholism (Wilsnack et al., 1994) and reinforces **androcentric bias** (Wilke, 1994).

Reflecting stronger societal linkages of drinking with men (LaBrie et al., 2008) and complementary disapproval of drinking by women (Gomberg, 1993), except when the context permits (bachelorette parties; Montemurro & McClure, 2005), women alcoholics are thought to require more therapy sessions (Hardy & Johnson, 1992). Given this, alcoholic women are more likely to be considered co-morbid, combining alcohol abuse with additional diagnoses of mental disorders, most often depression and anxiety (Haver & Dahlgren, 1995) and eating disorders (Harrop & Marlatt, 2010). In keeping with these co-diagnoses, women report that they drink to reduce anxiety (Dunne, et al., 1993) and alter their moods (Olenick & Chalmers, 1991). This perspective then tends to view women's, but not men's, alcoholism as symptomatic of another underlying disorder.

Many adult American women (43%) and men (61%) drink alcohol (at least 12 drinks in the past year), with more White (51%) than both Black (31%) and Hispanic (28%) women drinkers (CDC, 2010b, Tables 26 & 27). Cross-culturally and across age groups, men drink larger quantities, drink more frequently, and report more drinking-related problems (Wilsnack et al., 1994). Young women generally have higher rates of intoxication, drinking problems, heavy episodic drinking, and alcohol dependence than older women, who are often characterized by moderate but more frequent drinking. Binge drinking by women is more common in coeducational colleges than women's colleges (Dowdall et al., 1998). Alcohol abuse is sanctioned more in African American than White women (Rhodes & Johnson, 1997), and their patterns of drinking differ. Among Black women, alcoholism rates rise from 18 to 44 years of age and remain high until after 65. In contrast, incidence among White women peaks early (18 to 29 years) and then declines steadily (Caetano, 1994). Patterns of alcohol problems among lesbians, like those of African American women, do not decline with age and are at rates two times higher than those for the general population (Hughes & Wilsnack, 1994).

Factors putting women at risk for drinking-related problems include a family history of problem drinking, depression, trauma, employment in male-dominated occupations, unwanted statuses (e.g., being involuntarily unemployed), stress, and peer and spousal pressure (Gomberg, 1994; Wilsnack et al., 1994). Although linked to marital dissolution for some women with no prior history of alcohol abuse, drinking problems may abate for women who leave reinforcing relationships in which the partner is a heavy drinker (Sandoz, 1995; Wilsnack et al., 1991). Women with alcoholic parents will offer more help to an exploitative man, suggesting that high-risk women are prone toward developing nonsupportive relationships (Lyon & Greenberg, 1991). In sum, just as there are male depressives, there are female alcoholics, regardless of gendered stereotyping of these two (and presumably other) disorders.

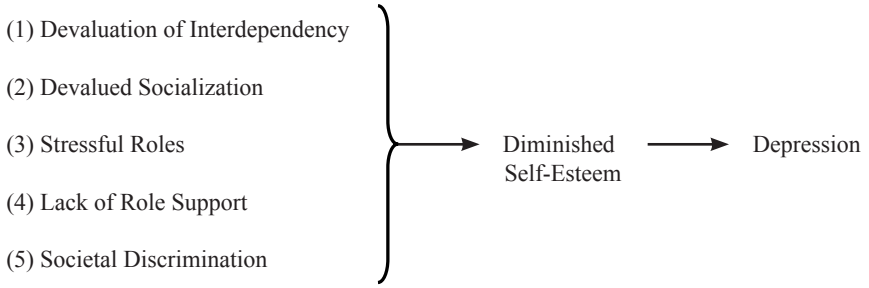
Neglected Contextual Factors

The DSM and its use have been criticized for focusing solely on individual causes and expressions of disorders, to the exclusion of contextual influences (Brown & Ballou, 1992; Kaschak, 1992; Lerman, 1996; Marecek & Hare-Mustin, 1991). For example, in the American Psychological Association's "Task Force Report on Women and Depression" (McGrath et al., 1990), a variety of moderating variables is identified (such as family and employment roles, victimization, and poverty) that may combine with an individual's personality to predict depression. To focus on individual personality factors alone implies a personal deficit model that ignores history, human spirit, and a life span perspective (Root, 1992).

Such an individualistic focus is most pronounced in the DSM for personality disorders which are stable over time and hence presumed to be characterological; that is, coming from within the person regardless of external stressors (Brown, 1992). These disorders are afforded heightened attention by "multiaxial assessment" in the DSM-IV whereby clients are assessed over five axes, including Axis II specifically for personality disorders and mental retardation.[5] Looking at Table 12.1, women dominate in the diagnoses of borderline, histrionic, and dependent personality disorders. The most extensively studied dif-

[5]The other axes are: Axis I: Clinical Disorders; Axis III: General Medical Conditions; Axis IV: Psychosocial and Environmental Problems; and Axis V: Global Assessment and Functioning.

Figure 12.2
Five models expand the known association between lower self-esteem and higher rates of depression.



ferential diagnosis on Axis I (Clinical Disorders) is major depression, estimated as two times more common in women. Each of these disorders will help paint a picture about the importance of **social context**.

To be classified as exhibiting **major depression**, a client must experience at least two depressive episodes, each of which entails at least five symptoms from a list of nine, present over at least a 2-week period, and at least one of which must be either depressed mood or loss of interest or pleasure. (If depression is chronic over the course of at least 2 years, the diagnosis changes to **dysthymic disorder**, which also tips toward higher prevalence in women.) The only mentions of causes external to the person in this presentation are the disqualifying exceptions of depression due to physiological effects of a substance (street drugs or a medication), a general medical condition, or bereavement. Beyond these exceptions, external threats to self-esteem, interpersonal stress, body dissatisfaction, physical illness, finances and employment, acculturation, and trauma are ignored.

Self-esteem and depression. A link between low self-esteem and depression has been well established (Katz et al., 2002) and has been accounted for by at least five interrelated models (Woods et al., 1994). Each of these models explores what causes the client's self-esteem to be low, considering factors outside the woman herself for the root cause of diminished self-esteem. Self-esteem then becomes a **mediator** in these models, holding for Asian, African American, and White women (Woods et al., 1994).

First, *self-in-relation* theorists posit that lowered self-esteem results from the devaluation of women's learned desires for interdependency and intimacy. Indeed, undergraduate women who reported lack of mutuality in their relationships were more prone to depression (Sperberg & Stabb, 1998), as were eighth-grade girls who reported low authenticity in their relationships (Tolman et al., 2006). Both self-esteem and relationship harmony are tied to women's well-being (Reid, 2004) and to rumination and depression (Cambron et al., 2009), especially when women feel responsible for the emotional tone of their relationships (Nolen-Hoeksema & Jackson, 2001). Whereas women seek validation through relationships, our individualistic society values the opposite—autonomy. This creates a double bind for women, who have to choose between being good, caring women or independent, agentic "men."

A second, *socialization* model extends this reasoning to all feminine socialization—arguing that most feminine traits are devalued, causing women who hold these characteristics to feel inadequate relative to the cultural (masculine) ideal. Consistent with this logic, instrumentality/**agency** is linked to stronger self-esteem and lower depression (Hermann & Betz, 2004), and women who constantly put concerns for others ahead of concern for themselves ("**unmitigated communion**") are more likely to report depression (Katz et al., 2002).

The third and fourth social role models emphasize the differing roles women and men enact. One model highlights the *stresses* that accompany women's roles, and the other concentrates on the *lack of support* afforded women in the fulfillment of their roles. Interpersonal stress plays a role in depression for some women and girls—more commonly than for men (Davis et al., 1999) and boys (Moran & Eckenrode, 1991). Although women typically derive support from their more expansive social networks than do men, these networks can also be sources of interpersonal stress (Turner, 1994) and criticism (Gruen et al., 1994). Involvement in conflicted networks is associated with depression for both African American and White women (Woods et al., 1994). The potential supports and risks of social networks are evident in a study of college women who were asked to describe the expressiveness of their families (Cooley, 1992). Women were more prone to depression when their families were more negatively than positively expressive, in contrast to depression-resistant women in families showing net positive expressiveness.

A fifth model argues that women are vulnerable to depressed self-esteem and hence depression because of societal *discrimination*, which blocks their achievement of personal mastery and is related to women's lesser power and status (Nolen-Hoeksema & Keita, 2003). For example, women who reported more exposure to sexist treatment also exhibited more symptoms of depression, anxiety, and **somatization** (Klonoff et al., 2000), and psychological distress (Moradi & Funderburk, 2006). Furthermore, sexism predicted African American women's psychological distress (Szymanski & Stewart, 2010), and among college women, this relationship between sexism and distress was partially mediated by reduced feelings of control (Landry & Mercurio, 2009).

Two reviews link gender inequality across cultures with women's heightened mental health disorders (Andermann, 2010)—specifically identifying poverty, limited access to resources (nutrition, education, employment, and health care), workplace harassment, and exposure to disasters as major threats to women's mental health (Chandra & Satyanarayana, 2010). Most provocatively, Soraya Seedat and her colleagues (2009) concluded that the narrowing of gender differences in major depression across generations (**cohorts**) worldwide is linked to changes away from the traditionalism of women's roles.

Distress that results from other forms of discrimination also impacts some women's mental health. For example, race-related stress increases anxiety and obsessive-compulsive symptoms for African American women (Greer et al., 2009; Greer, 2011); (Go to *pwq.sagepub.com* to listen to a podcast interview with Dr. Tawanda Greer.) Racism serves to undermine African American women's sense of mastery and thus makes them feel less psychologically resilient (Keith et al., 2010). Similarly, internalized homophobia is associated with heightened psychological distress among sexual minority women (Szymanski & Owens, 2008), as well as mental health problems and substance use (Lehavot & Simoni, 2011).

Body image and mental disorders. We saw in Chapter 10 that some women report greater dissatisfaction with their bodies than do men. Among both depressed outpatients and general college students, body image is the single most influential factor in distinguishing women's from men's depression (Santor et al., 1994). Specifically, among women and girls who emphasize the importance of appearance, body dissatisfaction predicts depression (Koenig & Wasserman, 1995). The root of this dissatisfaction for White women is concern about weight as a central component of how their femininity is physically enacted (Bay-Cheung et al., 2002). Given this centrality of weight, at least in some women's psyches, it is no surprise that depression and eating disorders appear together (Harrell & Jackson, 2008).

Two specific diagnoses compose the category of eating disorders in the DSM-IV. **Anorexia nervosa** is characterized by a refusal to maintain a minimally acceptable body weight. **Bulimia nervosa** is distinguished by recurrent episodes of binge overeating followed by inappropriate compensatory purging behaviors such as self-induced vomiting; laxative, diuretic, or other medicinal abuse[6]; fasting; and/or excessive exercise. An essential feature of both disorders is a disturbance in perception of body shape and weight. Bulimia occurs at least five times more often than anorexia (Marecek, 2001). Both are described in DSM-IV as disorders with greatest incidence in young women. As we expected, researchers narrow these demographics even further to mostly White women (Lucero et al., 1992) and heterosexual women (Herzog et al., 1992).

Characterological approaches emphasize the personality traits associated with eating disorders. Some examples include ambivalence about emotional expressivity (Krause et al., 2000), dissociative experiences (from daydreaming to blocking out thoughts; Lyubomirsky et al., 2001), underidentification with masculine/agentic qualities (Klingenspor, 1994) and over-identification with femininity (Burns, 2004), adherence to a superwoman ideal (Mensinger et al., 2007), strong desires for perfectionism (Minarik & Ahrens, 1996) and hyper-competitiveness regarding appearance (but not academic or career achievement; Burckle et al., 1999), and beliefs that dieting and thinness lead to overall self-improvement (Hohlstein et al., 1998).

As we saw in Chapter 10, **objectification** theory posits that personality predispositions in women like those above prepare them to internalize messages from a "culture of thinness," that values a thin physique, sets up dieting as normative, links thinness to some athletic and occupational pursuits, and stresses thinness in media and medical advice (Fredrickson & Roberts, 1997; White, 1992). It comes as no surprise to us that researchers find evidence in support of objectification theory's prediction that self-objectification is associated with disordered eating (Calogero et al., 2005; Noll & Fredrickson, 1998; Tylka & Hill, 2004).

Objectification theory adds cultural contributions to our understanding of eating disorders, as well as expands our thinking beyond pathological disorders like anorexia and bulimia to include more normalized and pervasive symptomatology. For example, one study of 167 mostly White women at a western U.S. university found that 7% were diagnosable with a DSM-level eating disorder and 28% were symptomatic for some form of disordered eating (Mintz et al., 1997). In a larger, more diverse sample of 334 women from a southwestern U.S. university, about 10% tested as diagnosable and fully 39% were symptomatic (Cohen & Petrie, 2005).

[6]Medicinal abuse differs by race/ethnicity such that African American women typically prefer laxatives; Latinas, diuretics (Cachelin et al., 2000).

Such evidence of a "culture of thinness" shifts our focus away from characterologically deficient women to **social contexts** that encourage disordered eating. However, a few recent feminist analyses, although supportive of such refocusing outward and on objectification, argue that an exclusive emphasis on weight, attractiveness, and thinness may miss the mark for some women with eating disorders (see Thompson, 1995). Both anorexia nervosa and bulimia are found in women of color and outside Western culture (Dolan, 1991), although detecting these problems may be obstructed by stereotyping of who does and who doesn't suffer with eating disorders (Root, 1990).

Among Asian American (Hall, 1995; Lee, 1995), African American, Latina (Thompson, 1992), and lesbian (Brown, 1987) women, eating disorders may be psychological responses, not to body dissatisfaction alone, but to sexual abuse, racism, classism, heterosexism, and poverty. Along these lines, college women's eating disturbances have been linked to psychological aggression from male partners in dating relationships (Skomorovsky et al., 2006). This perspective regards eating disorders as more than seemingly narcissistic attempts to conform to cultural standards of beauty. It regards eating as a way to handle emotional distress and reassert control; for example, by changing body parts that may be considered responsible for attracting abuse or by turning to food for comfort.

Other external sources of disorders. Women's susceptibility to chronic but non-life-threatening illnesses makes physical complaints and functional limitations a source of depression (Betrus et al., 1995). Also associated with women's depression are financial strain (Mendes-de-Leon et al., 1994), poverty (van der Waerden et al., 2011), unemployment (Hauenstein & Boyd, 1994), nonemployment (Bromberger & Matthews, 1994), homelessness (Ingram et al., 1996), and physical inactivity (Wang et al., 2011). These patterns extend to other disorders as well. Alcohol and drug-related problems are exacerbated by poverty (Thomas, 1995) and homelessness (Geissler et al, 1995). Exposure to sexism predicts disordered eating among women (Sabik & Tylka, 2006). Schizophrenia is diagnosed more frequently in people with lower socioeconomic status (Greenwald, 1992). At times these risk factors may be too narrowly defined in line with stereotyping. For example, Karen Wyche (1993) contends that poor, single-parenting women are overrepresented in applied research exploring factors that affect African American women's lives.

Acculturation of women into American society may create two risks. One results from the added stresses that accompany pressures to blend in. One example is found among some Korean American women who are vulnerable to depression resulting from acculturation pressures (Shin, 1994). The second makes strongly acculturated women more vulnerable to the gendered patterns of disorders that permeate our culture. For example, stronger adoption of American culture has been related to risks of depression among Mexican American women (Masten et al., 1994) and of eating disorders among African (Pumariega et al., 1994) and Asian (Cummins & Lehman, 2007) American women.

Violence and mental disorders. Finally, there is a growing body of research linking women's depression to violence and trauma (Cutler & Nolen-Hoeksema, 1991; Hamilton & Jensvold, 1992; Howard et al., 2010). This relationship holds across a diversity of women, including African American (Barbee, 1992), Asian American (Ho, 1990), and lesbian (Rothblum, 1990) women, although each may express this connection in unique ways (Rosewater, 1990). The neglected role of trauma in women's lives comes through more clearly when

we turn our attention to the personality disorders in which women dominate: borderline (d = –.09), histrionic (d = –.13), and dependent (d = –.24); Lynam & Widiger, 2007).

Borderline personality disorder is characterized by attention seeking, manipulative behavior, rapidly shifting emotions, self-destructiveness, angry disruptions in close relationships, and chronic feelings of deep emptiness and loss of identity. **Histrionic personality disorder** is distinguished by pervasive and excessive emotionality and attention-seeking behavior. The essential feature of **dependent personality disorder** is an excessive need to be taken care of, leading to submissive and clinging behaviors and fears of separation. Think of each of these three personality disorders in the context of child sexual abuse, rape, intimate partner abuse, and so on. Researchers find that sexual and physical abuses occur in women diagnosed with personality disorders at very high rates—as much as 81% (Bryer et al., 1987; Herman et al., 1989).

Maria Root (1992) distinguishes among three forms of trauma, all of which are stressful. The most obvious forms are **direct trauma**, such as rape and abuse, which are identified by maliciously perpetrated violence. Direct traumas encompass experiences not only of being targeted for, but also of being forced to commit, atrocities (e.g., military orders to kill civilians). **Indirect trauma** is produced through secondary effects, including experiences such as pulling bodies from wreckage, watching one's mother being beaten, and witnessing homicide. **Insidious trauma** results from being devalued because of an individual characteristic intrinsic to one's identity, such as one's gender, race and ethnicity, sexual orientation, physical ability, age, and so on. Examples include women's general fear of rape (Riger & Gordon, 1981), the "terrorism of racism" (Wyatt, 1989), the legacy of racism and sexism (Greene, 1990), and fears of genocide by children of Holocaust survivors (Danieli, 1985).

DSM-IV includes one diagnosis specifically designed to deal with direct and some indirect trauma survivors: **Posttraumatic Stress Disorder** (PTSD). To meet the diagnostic criteria for PTSD, a person must have been exposed to a traumatic incident in which the "the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others" and "the person's response involved intense fear, helplessness, or horror" (DSM-IV, 1994, pp. 427–428). For at least one month, the traumatic event is persistently re-experienced in recollections, dreams, flashbacks, symbolic cues, or similar settings, and attempts are made to avoid stimuli associated with the trauma. Persistent symptoms of increased arousal are present, such as difficulty falling or staying asleep, irritability or angry outbursts, difficulty concentrating, hypervigilance, and exaggerated startle responses.

PTSD entered the pages of the DSMs in DSM–III, mostly in response to veterans' groups and others dealing with the aftermath of military service on young men (Lerman, 1996). It is one of a handful of disorders that recognizes the importance of social factors outside the individual. Needless to say, it immediately became useful to therapists treating women survivors of rape as well as other physical and verbal abuses (Koss et al., 2003; Stovall-McClough & Cloitre, 2006), traumatic events more likely to be experienced by women than by men[7] (Tolin & Foa, 2006). Indeed, Lilia Cortina and Sheryl Pimlott Kubiak (2006) tested two models: one that looked at gender as the key determinant of PTSD symptom severity and the other that used gender as a marker for sexual victimization history.

[7]Men are more likely than women to experience traumatic events like accidents, nonsexual assault, witnessing death or injury, disaster, or fire, and combat or war (Tolin & Foa, 2006).

Their data supported the second explanation, confirming that it is sexual victimization, not gender per se, that makes women vulnerable to PTSD.

In DSM–III, the external stressor triggering PTSD was described as "outside the range of usual human experience" and as "markedly distressing to almost anyone" (quoted in Lerman, 1996, p. 49). This verbiage painted a picture of PTSD as a normal reaction to an abnormal event. This assurance disappeared in the language of DSM–IV, where "threat" takes center stage—a tightening of the criteria that some feminists fear may limit its usefulness to women surviving traumatic occurrences that aren't life threatening (such as most date rape) and that may shift our focus toward validating the veracity of the threat (Caplan, 1995; Lerman, 1996).

Does it matter so much that an abuse survivor, for example, is labeled as having a borderline personality or as experiencing PTSD? The former presumes a characterological deficiency (there's something wrong with the woman); the latter, especially in its original formulation, sees the abnormality in the precipitating event(s). This difference can play into how therapists feel about their clients. Hannah Lerman (1996) describes the label of personality disorder as one of the most stigmatizing of the DSM categories, making those who receive it different from everyone else. Therapists typically find clients so classified as difficult to work with, obnoxious, and unlikeable. However, when practitioners recognize that many of these women clients are struggling with traumatic histories, they empathetically come to regard them as distressed and in legitimate need of help. Thus, it seems that there's a lot more to a label than just a name.

Given the importance of labeling, two feminist theorists and practitioners, Laura Brown and Lenore Walker, have proposed alternative classifications to facilitate diagnosis and treatment of abused women (Brown, 1992; Walker, 1986). Both seek to capture the repetitive exposure to trauma that differentiates interpersonal violence from the discrete events that presumably underlie PTSD. For example, "Abuse and Oppression Artifact Disorder" seeks to identify the nature of the stressor by distinguishing between interpersonal (from intimates, acquaintances, or strangers) and cultural environmental stressors (overt, punitive phenomena; covert, systematic phenomena; lack of protection/denial of opportunity). This latter category recognizes the insidious forms of trauma catalogued by Maria Root.

Trauma affects more than diagnoses of depression and personality disorders. Histories of sexual abuse and other violence are overrepresented in women in substance abuse programs (Teets, 1995) and in prison (Bradley & Davino, 2002; Marcus-Mendoza & Wright, 2004), and these have been related to the development of alcoholism (Miller et al., 1987). Incest rates are higher among alcoholic than nonalcoholic women (Beckman, 1994). In studies of eating disorders, sexual abuse and/or rape are reported in half or more cases, with sexual assault experiences occurring at even higher levels (75%+) in inpatient samples (Root, 1991; also see Tripp & Petrie, 2001). Sexual abuse has been associated with **somatization disorders** (Morrison, 1989), **psychotic disorders** (Darves-Bornoz et al., 1995), and bodily self-harm (Shaw, 2002). Even when evaluated many years after a physical assault, survivors were more likely to qualify for psychiatric diagnoses than women without such histories (Koss, 1990), and recovery from eating disorders is lower among women with a history of chronic physical and sexual abuse (Hesse-Biber et al., 1999).

All of this makes a strong case for the importance of factors external to the individual. To consider an individual without considering social context confines diagnosis to presenting symptoms. This seems to miss much of what we'd expect follow-up therapy to consider, and also to pathologize the person without taking into account the possibility that *normal* people are coping with *pathological* settings. Combined with therapists' biases, the result

has been a checkered history of psychiatric treatment of women, with egregious examples of misogynous treatment appearing in women's autobiographical accounts. (About 175 of these are thematically reviewed by Jeffrey Geller, 1985). The remedy to this failure, taking a holistic look at psychological difficulties, has led some practitioners and scholars to propose feminist approaches to doing therapy—our next topic.

THE THEORY OF FEMINIST PRACTICE

The above critique of the DSM implies a lot about what feminist therapy should *not* be, but it doesn't tell us much about what feminist therapy is. We need to explore the theory of feminist therapy—*not* to describe specific techniques of therapy, but rather the conceptual underpinnings of a feminist *approach* to doing therapy. Feminist therapy is not a stand-alone technique, but rather is an approach to doing therapy that can be applied widely across techniques such as cognitive-behavioral (Hill & Ballou, 1998) and humanistic (Morris, 1997). Furthermore, it is not practiced in any single, standard way (Marecek & Kravetz, 1998a).

Principles for Doing Feminist Psychotherapy

The defining elements of feminist therapy are outlined comprehensively and clearly in a series of 11 guidelines developed for the American Psychological Association's Practice Directorate (American Psychological Association, 2007). These guidelines were developed by a task force created jointly by two APA Divisions (Counseling [Div. 17] and Psychology of Women [Div. 35]) that was charged to update and consolidate earlier work in this area by creating guidelines that honor the complexity of the lives of girls and women across multicultural contexts. For our purposes, these guidelines encompass most, if not all, of the points developed in other expositions of feminist therapy theory (Enns & Byars-Winston, 2010; a special issue of *Women and Therapy*, 2011, 34[1-2]).

The guidelines are organized into three clusters focusing on: (1) diversity, social context, and power (Guidelines 1–3), (2) professional responsibility (Guidelines 4 and 5), and (3) practice applications (Guidelines 6-11). The first section draws on what we have learned in this book about gender as a social identity and about gender-role socialization, laying the groundwork for the applied principles outlined in the remaining two sections. Because we all have a gender, these guidelines as recommended practices apply to both women and men across all their diversity. Their purpose is not to dictate what therapists do in practice, but rather to raise awareness and sensitivity so that all consumers of psychological practice (not just clients and health professionals, but also students and research participants) benefit.

My goal is not to offer a rationale for each of these points,[8] but rather to understand how each is conceptually linked to putting feminism into psychotherapy practice. Each of these points views therapy as a process that is negotiated between therapist and client, not as some technique that is used on a passive recipient. Throughout the following I draw heavily on illustrative examples as a way to link theory with practice.

[8]A careful and thorough rationale for each of these principles is documented in the *American Psychologist* article that introduced them (American Psychological Association, 2007). They also should be evident from much of our earlier discussions throughout this book.

> *Guideline 1*: Psychologists strive to be aware of the effects of socialization, stereotyping, and unique life events on the development of girls and women across diverse cultural groups.

This opening recommendation draws on two of the key concepts we have developed throughout this book: (1) recognizing the importance of **social context** (socialization, stereotyping, and experiences) and (2) girls' and women's diversity. We have seen that individualism without context (assuming that pathology resides in characterological defects within a person) ignores many social forces that have been implicated in women's mental health, such as body dissatisfaction, poverty, acculturation, and trauma. Thus, the first part of this guideline puts gender front and center in understanding and working with clients.

It is important to understand that being nonsexist is not the same as being gender-sensitive. A nonsexist approach presumably is gender-neutral or gender-inclusive: being gender-neutral ignores gender; being gender-inclusive fails to be responsive to differences between the experiences and social contexts of women and men. In contrast, feminist therapy puts gender at the core of our analyses.

Carol Mowbray (1995) uses examples from actual cases contributed by members of a Michigan state committee on women's mental health issues to illustrate how practices by ostensibly nonsexist therapists inadvertently can be *nonfeminist* in their effect by ignoring the contexts of women's lives, imbalances of power between therapists and clients, and the importance of self-determination for women. Consider the following woman's frustration with her therapy which ignores the context of her life:

> We were a two-career couple. I had a 50-hour a week job that was responsible, stressful, and demanding. Yet, I also had the major responsibility for childcare and family functioning in economic and social arenas. A major part of the communication problems that brought us into marital therapy was a smoldering resentment over these inequities that kindled into explosive anger in conflicted or stressful circumstances. Yet we never had a discussion in therapy or set goals around redistributing the inequities and lowering my underlying hostility. When I raised these concerns, the discussion always reverted back to how I could better communicate my feelings. Yet, no matter how much I worked on better communication, the inequities in the relationship still did not change (Mowbray, 1995, pp. 15–16).

The structure and function of the family, especially regarding gender roles and power, go unanalyzed and pass without confrontation in this gender-neutral approach. This creates an outcome (maintenance of gendered inequities in this interpersonal relationship) that is far from feminist. In contrast, a feminist therapist would ask questions that simultaneously challenge the domestic arrangements of this couple, the patriarchal hierarchy that has come to characterize the American family, and the devaluation of household work.

This initial guideline, emphasizing a core point that permeates all 11 guidelines, requires a full multicultural understanding to capture the diversity of women's lives. For example, the roles of ritual and spirituality in women's lives may be overlooked by some therapists. Teresa LaFromboise and her colleagues (1994) describe how a Navajo woman's interpersonal problems and alcohol abuse declined remarkably after she ritually disposed of her mother's ashes, freeing her mother's, as well as her own, spirit. Julia Boyd (1990) cites

Latina women who return to using their native language, American Indian women who turn to purification rights, and African American women who find solace in religion as sources of personal strength that should not be discounted by feminist therapists (Mattis, 2002).

Similarly, Boyd (1990) describes the case of a young Southeast Asian woman, recently immigrated, who was ordered by the American courts to therapy for shoplifting. After several nonproductive sessions with a White therapist in which the client refused to detail her reasons for stealing, the therapist remanded her back to the judge with the labels of withdrawn, non-communicative, and depressed. An Asian paralegal took note of the case and realized that the same product (sanitary napkins) was being stolen repeatedly from the same store. In the context of her culture, her actions didn't reflect depression but rather embarrassment, both from the prospect of publicly purchasing this needed product and from discussing it with strangers. Cultural context, not characterological pathology, explained all.

> *Guideline 2*: Psychologists are encouraged to recognize and utilize information about oppression, privilege, and identity development as they may affect girls and women.

From the first chapter of this text, we have talked about the importance of understanding oppression, privilege, and power. Not surprisingly, then, a key component of feminist therapy revolves around issues of power, both generally in girls' and women's lives and specifically in the therapist-client relationship.

The therapist's role encompasses the power to label and to act as an authority, both in reality and symbolically. The well-educated and often relatively affluent position of the therapist may contribute to status differences, and other sociodemographic differences can tip the balance of power. The therapist-client relationship can be used to explore issues of unequal power that then can be generalized to other settings. This process may be especially poignant for women with physical disabilities, many of whom experience powerlessness in their interactions with institutional, medical, and bureaucratic settings, as well as within interpersonal relationships (Olkin, 1999; Prilleltensky, 1996). Ironically, failure to acknowledge one's power as a therapist can be related to the abuse of this power (Brown, 1994a).

The point that may be even more difficult to realize about this guideline's challenges concerns exploring privilege. Indeed, it is this charge that seems central to engaging in feminist approaches with male clients. Jack Kahn (2011) discusses the usefulness of feminist approaches with men when practitioners reject essentializing men, understand that men's gender identity is diverse, help men sort out how to deal with pressures to conform to limiting norms defining masculinity, and confront the **unearned entitlements** of male privilege.

> *Guideline 3*: Psychologists strive to understand the impact of bias and discrimination upon the physical and mental health of those with whom they work.

In Chapter 7, we explored the combination of prejudice, stereotyping, and discrimination (**sexism**) in girls' and women's lives. The additional point that is important to consider here is that sexism is experienced differently by diverse women because it can combine with other forms of oppression. This understanding is so central to doing feminist therapy that I have purposively selected an example that incorporates multiple, intertwined forms of oppression to illustrate it.

Consider the case of "Maria," a 30-year-old woman of Cuban American descent involved in a physically abusive relationship with her lesbian partner, "Susana" (Kanuha, 1994). Violence was hard for outsiders to see in this relationship both because the nature of the relationship itself was disguised as non-intimate to avoid homophobic reactions and because women are stereotypically regarded as nonviolent. Susana maintained power over Maria by threatening to "out" her to her employer and family, potentially disrupting the strong family bonds of Maria's Latina culture. Sensitivity to multiple forms of oppression and how they worked together in Maria's life were needed by this therapist to work effectively with her.

Guideline 4: Psychologists strive to use gender and culturally sensitive, affirming practices in providing services to girls and women.

The remaining guidelines apply the general principles of diversity, social context, and power that we saw developed across the first three guidelines. Guideline 4, along with 5, focuses on the responsibilities of health practitioners—looking first at what they do with their clients. A somewhat less obvious point concerns the responsibility of therapists, not clients, to provide such training. Feminist therapists agree that the responsibility for continuing education rests on the shoulders of the therapist, not the client (Porter, 1995).

Julia Boyd (1990), an African American therapist, describes the "homework" she did in advance of sessions with a Southeast Asian woman. Her background work paid off because she was able to integrate what the client revealed with what she had learned about the value of family loyalty and harmony between self and nature in Asian culture. The result was a more culturally sensitive and ultimately effective treatment for this client's depression. The National Multicultural Summit, held every two years since 1999, is an excellent resource for practitioner training in these areas (*www.multiculturalsummit.org*).

Guideline 5: Psychologists are encouraged to recognize how their socialization, attitudes, and knowledge about gender may affect their practice with girls and women.

This second practice recommendation directed at health professionals concentrates on the practitioner herself or himself. One important aspect of dealing with the intrusion of one's own perspectives into a therapist's relationship with her or his client concerns setting and maintaining boundaries. Indeed, ethical questions arise about what constitutes appropriate behavior. Is it right to ask a client to take her or his therapist to pick up a car at the repair shop? Should a therapist hug a distraught client? Laura Brown (1994b) explores such *boundary confusion* by first debunking three myths, concluding instead that (1) there are no clear, universal rules detailing appropriate and inappropriate behavior; (2) that boundary violations are not always easy to detect; and (3) it is possible to violate boundaries even if rigid rules are followed to the letter.

Rather than constructing lists of do's and don'ts, Brown argues that we must understand the basic characteristics of unethical boundary violations to lessen the risks of committing them. Although clients ultimately determine when lines have been crossed, they are not the sole arbitrators of this decision. Rather, the responsibility for maintaining appropriate boundaries rests with therapists.

Boundaries are crossed when the client is **objectified**, when the therapist acts from impulse, and when the needs of the therapist come before those of the client. Clients can be

objectified when they are used by therapists to teach them (for example, about their different cultural experiences), to entertain them, and to listen to the emotional disclosures of the therapist. Therapists act impulsively, not when they draw on intuition, but when they act without diagnostic clarity; that is, without thinking through the impact of their actions on their client.

Regarding therapists' needs, therapists always must play a supporting role in relation to their clients, relinquishing center stage. For example, Julia Boyd (1990) relates how a White woman therapist's preoccupation with her African American woman client's rape alienated the client, whose most pressing, immediate concern was the robbery that accompanied her rape and stripped her of her last $25. Brown offers this conceptual analysis of boundaries as a means from which therapists and each of their clients can work together to define and maintain appropriate boundaries specific to their own relationship.

> *Guideline 6*: Psychologists are encouraged to use interventions and approaches that have been found to be effective in the treatment of issues of concern to girls and women.

The remaining six guidelines apply the principles of diversity, social context, and power to the services provided by health practitioners. The first of these, Guideline 6, challenges researchers to establish the effectiveness of feminist approaches and charges practitioners to continually expand their repertoire of therapeutic techniques so that they can tailor their use to specific clients.

There is no one-size-fits-all approach to doing feminist therapy, nor is there an agreed upon set of outcomes that are specific to doing effective feminist therapy. Although these understandings certainly complicate researchers' lives, there is building evidence that taking a gender-sensitive approach to practice benefits clients. For example, Charlene Senn and her colleagues (2011) documented that having women explore their own sexual values and desires as part of a sexuality education program increased women's confidence that they could defend themselves if attacked. In another study, career interventions targeting women survivors of intimate partner violence effectively promoted these women's career-search efficacy (Chronister & McWhirter, 2006). The key understanding, then, for practitioners who wish to comply with this recommendation is to seek out research on interventions specific to the client they seek to help and the outcomes they mutually value.

As for expanding therapists' toolboxes, Lillian Comas-Díaz (1994) explores the concept of womanhood for many women of color who define themselves as women, not as autonomous individuals, but rather within the contexts of extended units such as family and community. Given this understanding, she finds *family narratives* to be a useful therapeutic technique. These cultural stories include family history as well as describe values, lessons, the client's place in their social network, and so on. In one example, Comas-Díaz describes a client who reported sudden fears of falling (among other problems), part of which could be traced to a family "lesson" learned from a beloved sister who fell to her death. Part of the therapy process allowed this client to grieve for her sister and provided reassurances about the likely safety of the client's daughter, now the age of the client's sister when she died.

> *Guideline 7*: Psychologists strive to foster therapeutic relationships and practices that promote initiative, empowerment, and expanded alternatives and choices for girls and women.

This recommendation raises serious questions about the goals of therapy: what are the desirable outcomes and who sets them—the client or the therapist? Feminist therapists have reacted strongly to a history of misogynous practice wherein women were expected to adjust to oppressive situations, rather than work to change them or leave them. The most egregious examples came in settings of abuse where women were urged to "stand by their man," learn not to aggravate him, and, in essence, to be a "good wife." These pressures are especially strong for women of color who want to avoid becoming just another oppressor in their men's already oppressed lives (Greene, 1994).

This history speaks to some outcomes that should be avoided, whereas this important guideline directly addresses goals to be achieved. Drawing on a social justice agenda that unites feminist psychology with critical and positive psychologies and is consistent with the general dictum for practitioners to maximize positive psychological functioning and minimize distress (American Psychological Association, 1999), the general goals of counseling are to promote individual well-being and liberation, both from oppression and toward empowerment (Lopez & Edwards, 2008; Prilleltensky & Prilleltensky, 2003). Furthermore, there is developing evidence to link these positive outcomes with women's endorsement of feminist beliefs (Yoder et al., in press).

As for who sets these goals, what happens when the client's goals conflict with the therapist's? Consider the following woman's disappointment with her therapist:

> One time, after I had recounted a recent incident of my husband's unpredictable and explosive anger, my therapist asked me, "Why do you stay in this relationship?" I explained quite calmly that I had thought about this a lot and decided that in another relationship things could be a lot worse, e.g., substance abuse, violence, physical absence and abandonment, etc. My therapist breathed a deep sigh and almost seemed to bow and shake his head in disgust, disbelief, or sorrow. There was no verbal support for my statement, not even acknowledgment! I felt robbed and cheated. If this was my decision, why didn't I get help to better carry it out? Instead, I felt that I was being castigated by my therapist for not being more independent or assertive in my relationship (Mowbray, 1995, p. 18).

Does this mean that feminist therapists have to accept client's wishes regardless of their beliefs, (and arguably, regardless of what many would say are in the best interests of the client)? Additionally, might a therapist's revulsion toward violence conflict with cultural settings that find such behavior "acceptable," or at least widespread enough to be almost normative? Although feminist therapists agree that violence against women is oppressive and intolerable regardless of a woman's social or cultural background, therapists' approaches to dealing with it need not be rooted in American, masculine models of self-determination and autonomy (Ho, 1990). Rather, a feminist model must embrace ethical decision-making that empowers the client (Hill et al., 1998).

> *Guideline 8*: Psychologists strive to provide appropriate, unbiased assessments and diagnoses in their work with women and girls.

We talked about **androcentric bias** at the start of this book, so it is not surprising that feminist therapy should react against this bias as well. A revealing tale of how this bias can

infiltrate therapy is told through some uses of psychological tests (Brown, 1994a, Chapter 7). The most widely used psychological test, the Minnesota Multiphasic Personality Inventory (MMPI), routinely over-diagnoses people of color, especially African Americans, as paranoid; raises questions about sexual orientation based on deviations from gender stereotyping; and can label people with progressive political views as pathologically deviant. Although feminist therapists have used the MMPI as a diagnostic tool for uncovering some cases of abuse by intimates (M.A. Dutton, 1992), some common interpretations can support androcentric bias.

Laura Brown (1994a) describes how the MMPI and other androcentric biases influenced the custody case of "Alina," a Middle Eastern woman married to a White American man. Although he had verbally abused both Alina and their children, he came across fine on the MMPI and Rorschach (inkblot) tests; in court he appeared cool, calm, and collected. In contrast, Alina expressed anger that her husband left her for another woman; she tested as a "mixed personality disorder with histrionic and borderline features." The custody case was swinging toward the abusive father. The feminist therapist consulted by Alina convinced the courts to initiate another series of obviously more relevant tests by sending observers to watch parent-children interactions. Even knowing that he was being observed, the father verbally berated his children, disparaged their mother to them, used age-inappropriate language, allowed them to play with potentially dangerous objects, and failed to respond appropriately to their needs. In contrast, the presumably mentally disordered woman behaved as a loving and responsive mother. The court's final judgment favored the mother.

This guideline also raises concerns about the sociodemographic match between a therapist and a client. Some feminist therapy theorists have argued quite persuasively that women clients should see women therapists (Cammaert & Larsen, 1988), even arguing that therapists and clients be matched on other qualities, such as sexual orientation and race and ethnicity.[9] Oliva Espín (1994) notes that such specific matches are advantageous because they facilitate firsthand understanding, promote the therapist as a role model, reduce some unequalizing status differences, and heighten the therapist's investment in the client's success. Indeed, she provides a case in point whereby a Latina client was empowered by her Latina therapist's aversion to domestic violence. For this client, having a Latina challenge what the client regarded as pervasive acceptance of violence in her community benefited her therapeutic progress.

The reality, though acknowledged by Espín, is that matches are not always available nor do they ensure cultural sensitivity. In these cases, feminist therapists must work with these differences. For example, a major obstacle that may stand in the way of White women therapists' effectiveness with clients of color is a misunderstanding of the role of racism in their clients' everyday lives. For many White women, the impact of race on their own lives, while far from nonexistent, is invisible and privileged (Frankenberg, 1993; Roman, 1993). For White women therapists to work sensitively with clients of color, they must understand the privileges afforded by their own race in American culture, acknowledge the role of racism in their clients' lives, and actively engage in self-education (Espín, 1994).

[9]Also often implicit in these discussions is the assumption that clients in feminist therapy should be restricted to women, although feminist therapy with men has been described (for example, see Worell & Johnson, 2001). Additionally, researchers conclude that the sex of one's therapist does not directly affect treatment outcomes; rather, the story, as I argue here, is more complex (Blow et al., 2008).

The point here is not to confuse the issues of the therapist with those of the client. Lillian Comas-Díaz (1994) describes a case in point. A Jewish woman Holocaust survivor as therapist was matched with an American Indian woman as client on the basis of their shared cultural experience as targets of genocide. The client elected not to continue this relationship beyond initial contact because the therapist drew so many parallels between their ethnic commonalties that she failed to acknowledge differences, such as the role alcoholism played in the American Indian woman's community. This therapist did not move beyond her own issues to relate to the uniqueness of her client.

Guideline 9: Psychologists strive to consider the problems of girls and women in their sociopolitical context.

Approaching therapy with the realization that "the personal is political" highlights the view that individual experience does not take place in a vacuum, but rather is informed by the social and cultural context in which it takes place (Brown, 1994a). In this framework, what happens to individual women often reflects broader sociopolitical forces that devalue women and women's experiences, including racism (Comas-Díaz, 1988), ableism (Prilleltensky, 1996), classism, ageism, and so on. Making linkages between individual experiences ("the personal") and general trends that affect many women ("the political") connects women to other women and makes public these common bonds. *Consciousness raising* becomes a legitimate and important part of individual and group therapy designed to help women relate their personal difficulties to social context (Marecek & Hare-Mustin, 1991).

Although the common bonds that associate one woman's experiences with others' are critical for making connections between the personal and the political, this linkage must be balanced against honoring each client's unique experiences of reality (Brown, 1994a). Just as individualism without context can limit our understanding of women's full lives, so can context without the individual serve to invalidate the personal. Just because other women experience rape, for example, raising serious questions about who has power and how it is used, an individual woman's experience of and coping with such trauma cannot be discounted because of these broader connections. A critical dynamic in feminist therapy is to negotiate this balance between individuals and social context.

Guideline 10: Psychologists strive to acquaint themselves with and utilize relevant mental health, education, and community resources for girls and women.

Psychotherapy doesn't take place in a vacuum; rather, it is embedded within a potentially supportive environment upon which this guideline challenges the practitioner to draw. For example, Melba Vasquez (1994) describes how she used a Latina woman's wanting to care for others, not *against* her by labeling her dependent, but *for* her by encouraging her to extend these community-based principles of caring toward herself (and, through herself, toward her children) (also see Weiner, 1999). This approach validated her caring and connection to others and simultaneously enhanced her self-esteem and personal empowerment—necessary ingredients to terminating abuse from within the relationship or by leaving it. Similarly, Christine Ho (1990) suggests that strong family ties and a hierarchy of elders in Asian communities can be employed to abused women's advantage by drawing on these resources for support and to intercede on their behalf.

Guideline 11: Psychologists are encouraged to understand and work to change institutional and systemic bias that may impact girls and women.

As we have seen, a central goal for feminist psychotherapy is to empower women—to help women gain control of their lives (Espín, 1994; Worell, 2001). Such empowerment assists women to be aware of the deleterious effects of sexism and other forms of oppression; to perceive themselves as agents for solving their own problems; to understand how the personal is political; and to work toward broader, societal change. This last part of empowerment moves both the therapist and the client beyond individual change (psychotherapy) to social change. A distinguishing feature of feminist therapy is the realization not only that the personal is political, but also that the political is personal.[10] In other words, with personal empowerment comes the responsibility to actively work for social changes that promote the well-being of women in general (Barrett, 1998; Morrow & Hawxhurst, 1998; Weiner, 1998). How feminists do this depends on the form of feminism they espouse because there are multiple approaches to doing feminism, as we discussed in Chapter 2 (Brown, 1994a). This challenge will be the major focus of the final chapter of this book.

Summary of Therapy Theory

These 11 guidelines organize ideas about feminist theory of therapy, and the examples described throughout this section link this theory to actual practice. One way to bring this all together is to explore the common ground that unites feminist practitioners doing feminist therapy. Bonnie Moradi and her colleagues (2000) examined the therapy behaviors reported by 101 self-identified, practicing feminist therapists (also see Chester & Bretherton, 2001; Marecek & Kravetz, 1998b; Szymanski, 2003). Strongly identified feminists (1) emphasized an understanding that the personal is political, (2) recognized issues of oppression and their interrelationships, and (3) paid attention to experienced socialization. They engaged in these behaviors with both women and men clients.

Additionally, practitioners did not have to endorse a feminist label to report using some of these core identifiers of feminist therapy. This suggests that some therapists who don't think of themselves as feminist draw on feminist approaches as simply good ethical practice. Thus, key elements of feminist theory may infuse more of actual practice than the self-labeling of therapists might imply. This is a good example of how psychology is transformed, often without overt acknowledgement of the root causes of the adopted changes.

CHAPTER SUMMARY

Throughout this chapter, we have taken a critical look at the existing medical model of "mental disorders" as embodied in the DSMs. We saw that this model yields similar overall prevalence rates for women and men, but that gendered patterns emerge for specific diagnoses, including agoraphobia, alcohol and substance abuse, depression, eating disorders, and three personality disorders (borderline, histrionic, and dependent).

[10]For a fuller discussion of how individual "psychological" problems can mask broader sociopolitical oppression, see Prilleltensky & Gonick (1996).

In contrast to the assumptions of the DSMs, which root the causes for these gender differences primarily in women's and men's biologies or within their psyches, a feminist perspective expands our focus to consider definitional ambiguities surrounding what is and is not deemed pathological, to move beyond exclusively biological explanations and drug treatments, and to explore extra-psychic influences such as the infiltration of gender stereotyping into definitions of disorders, stereotyped therapists' judgments, and neglected contextual factors. These contextual influences may include threats to women's self-esteem, interpersonal stress, body dissatisfaction, physical illness, finances and employment, acculturation, and direct, indirect, and insidious forms of trauma.

We also reviewed a general feminist approach to practice that encompasses practice recommendations explicated by a variety of feminist therapy theorists. Throughout this review of theory of feminist practice and exemplary cases, we have stressed the importance of making the personal political and vice versa, of linking gender with other forms of oppression and to power, and of privileging women's experiences so that they move from the margins of therapy theorizing to center stage. By both critiquing traditional approaches to "mental disorders" and offering an alternative approach (feminist therapy), we are striving to develop theory and practice in psychology that will work effectively and sensitively for all women whose true psychological pain must be considered at the heart of these discussions.

SUGGESTED READINGS

Widiger, T. A. (1998). Invited essay: Sex biases in the diagnosis of personality disorders. *Journal of Personality Disorders, 12*, 95–118.

In this accessible essay, Thomas Widiger makes a case for the role sex biases (including biased thresholds for diagnosis, biased diagnostic constructs, biased applications of diagnostic criteria, etc.) play in creating and sustaining gender differences in the prevalence of personality disorders (differences confirmed by meta analysis; see Lynam & Widiger, 2007), making arguments that underlie the general propositions about such biases made in this chapter.

McHugh, M. C. (2008). A feminist approach to agoraphobia: Challenging traditional views of women at home. In J. C. Chrisler, C. Golden, & P. D. Rozee (Eds.), *Lectures on the psychology of women* (4th ed., pp. 393–417). New York: McGraw-Hill.

Maureen McHugh makes the personal political by exploring the case of her mother, highlighting how an understanding of social context can normalize what otherwise can appear to be pathological behavior.

Kranz, K. C., & Long, B. C. (2002). Messages about stress in two North American women's magazines: Helpful? We think not! *Feminism & Psychology, 12*, 525–530.

Karen Kranz and Bonita Long's brief commentary explores how women's stress is simultaneously normalized and problematized in women's magazines and how the advice these magazines offers promotes internalizing stress and individualism and, by ignoring the political in the personal, helps maintain the status quo.

Koss, M. P., Bailey, J. A., Yuan, N. P., Herrera, V. M., & Lichter, E. L. (2003). Depression and PTSD in survivors of male violence: Research and training initiatives to facilitate recovery. *Psychology of Women Quarterly, 27*, 130–142.

Mary Koss and her colleagues illustrate the limitations of the DSM using the examples of depression and PTSD in the context of male violence against women and link these shortcomings to broader public policy issues.

Walsh, E., & Malson, H. (2010). Discursive constructions of eating disorders: A story completion task. *Feminism & Psychology, 20*, 529–537.

Eleanore Walsh and Helen Malson report their analyses of British undergraduates' responses to an incomplete story about a woman exhibiting either anorexic or bulimic eating behaviors. (Students may be encouraged to first complete the task on their own.) The authors' analysis raises provocative questions about the normalizing of dieting and about how women with eating disorders "should" be treated (e.g., involuntary hospitalization and their personal responsibility for recovery).

Geller, J.L. (1985). Women's accounts of psychiatric illness and institutionalization. *Hospital and Community Psychiatry, 36*, 1056–1062.

Jeffrey Geller puts a human face on diagnosed women, setting the stage for engaging discussions about the way things were, continue to be, and should be.