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Feminist Therapists: A Qualitative Exploration of Values and Practices within Context

Joy Heafner
University of Connecticut - Storrs, joy.heafner@uconn.edu

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Feminist theorizing has had a marked impact on the field of marriage and family therapy (MFT). By connecting issues of power and societal context to the sphere of the family, feminist MFTs have been able to adapt systemic therapy models to account for pervasive social inequalities. Some scholars in the field have noted that feminist family therapy is more aptly described as a sensibility rather than a therapeutic model, as feminist therapists tend to adopt an identity that permeates their therapeutic work rather than perform a particular set of therapeutic interventions. Yet, previous research has shown that this sensibility is commonly operationalized through a number of behaviors, such as equalizing power between the therapist and client and discussing gender and other realms of social inequality with clients. To date, however, little work has examined how feminist therapists experience and apply their feminist values to professional contexts beyond the therapy room. As a result, scholarship overlooks how feminist therapists themselves are embedded in a mental healthcare system, where issues of power and societal context influence to their ability to conduct feminist therapy. The current study remedies this gap by investigating how feminist MFTs engage and enact their feminist values in professional contexts beyond the therapeutic encounter. Specifically, this study addresses three primary research objectives: (a) explore how feminist MFTs enact their values in relation to their colleagues, (b) examine strategies of feminist MFTs in relation to the overarching institutional structure of managed care, and (c) examine strategies of feminist MFTs in relation to the current diagnostic system for mental disorders. Data were gathered from 21 self-identified feminist MFTs through semi-structured qualitative interviews and analyzed with techniques associated

with grounded theory methodology. Results revealed how feminist MFTs negotiate their feminist values and practices with respect to power and institutional structures. These findings are discussed in the context of the medicalization of mental health and the labor that feminist therapists perform in order to achieve their goal of providing clients with access to high-quality mental healthcare.

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Joy Heafner

B.S., Illinois College, 2006

M.A., University of Chicago, 2008

M.A., University of Connecticut, 2014

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Feminist Therapists: A Qualitative Exploration of Values and Practices within Context

Presented by
Joy Heafner, B.S., M.A.

Major Advisor

_____
Rachel Tambling

Associate Advisor

_____
Kari Adamsons

Associate Advisor

_____
Marysol Asencio

Associate Advisor

_____
Laura Mauldin

University of Connecticut
2018

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CHAPTER 1: INTRODUCTION

Feminism is a social and political movement that calls for a restructuring in power

relations between historically advantaged and disadvantaged groups, primarily men and women

(Osmond & Thorne, 1993). This movement has had a marked effect on the field of marriage and

family therapy (MFT), and led to a subfield of MFT: feminist family therapy. Feminist family

therapy is an approach that applies feminist principles to the context of the family with a

therapeutic aim. This approach is generally considered to be an underlying philosophy, or

sensibility (Luepnitz, 2002), that permeates the identity and actions of a feminist clinician rather

than a clearly delineated treatment model. Though a feminist approach is considered an

underlying sensibility rather than set of techniques, previous research has shown that there are

various practices common to how feminist MFTs engage with clients in the therapeutic

encounter. These include addressing power differentials within families and between families

and society with an aim to promote egalitarian relationships and social justice. Feminists MFTs

expanded family systems theory, which had previously focused on intra-family dynamics, to

address how families are embedded within broad social systems.

Despite previous findings on how feminist MFTs apply their values to therapeutic

practice, there is a dearth of research on how feminist MFTs engage in professional contexts

beyond clinical interventions. As a result, the literature in feminist family therapy overlooks how

feminist therapists themselves are embedded in a mental healthcare system, where issues of

power and context may impact their ability to conduct therapy according to feminist values. In

fact, feminist therapists are frequently embedded in healthcare contexts undergirded by a

positivist epistemology that is counter to a postmodern framework that many feminist theories

espouse.

The overarching purpose of the current research is to address the gap in the literature by exploring the lived experiences and practices of feminist MFTs with particular attention to multiple contextual factors relevant to their work. Specifically, this study will contribute to the body of literature on feminist family therapy by addressing three research objectives: (a) explore how feminist MFTs enact their values in relation to their colleagues, (b) examine strategies of feminist MFTs in relation to the overarching institutional structure of managed care, and (c) examine strategies of feminist MFTs in relation to the current diagnostic system for mental disorders.

In the following second chapter, the theoretical rationale of the current research is presented. Additionally, the literature on feminist perspective as it relates to MFT is reviewed. In the third chapter, the methodological design of the current study is presented. Results and analyses of the current research are presented in the fourth chapter. Finally, the fifth chapter presents a discussion of the results and future directions for research and practice.

In addition to the subject of this research, the process is also intended to be a reflection of my, the researcher's, feminist identity and values. One way that I make this project feminist is to draw a connection between myself as the researcher and the research itself. To do so, I will use first person pronouns throughout the paper to highlight how knowledge is *constructed* by individual researchers, and that there is a connected relationship between knower and known (Thompson, 1992). I will expound on my connection to the research more thoroughly in the chapter on methodology.

CHAPTER 2: LITERATURE REVIEW

Feminist theorizing has had a substantial impact on the field of marriage and family therapy (MFT). Standards in clinical practice have evolved to incorporate basic tenets of the feminist perspective, which calls for a restructuring in power relations between historically advantaged and disadvantaged groups, particularly men and women. Practices that are common to feminist MFTs include directly addressing power relations within families and connecting family system dynamics to social systems external to the family. However, little research has examined how feminist MFTs engage in professional contexts beyond clinical interactions with their clients. The current study seeks to address this gap in the literature by revealing how feminist MFTs practice their feminist values in spaces and interactions beyond the therapy room.

In this section, I will present a brief overview of how feminist theorizing has impacted MFT, followed by a review of the literature on feminist family therapy. In particular, I will highlight feminist values and three ways they are operationalized in the clinical practice of feminist family therapists. Then I will describe how feminism calls for an examination of broad structures and how they influence therapists' actions beyond clinical interactions with clients. To do so, I will describe how a sociological perspective intersects with a feminist perspective to inform the current research project. I argue that this intersection is particularly relevant to examining how MFTs engage with and within institutional structures in mental healthcare. I will then discuss two relevant structures in mental healthcare – managed care and the construct of diagnosis – and how they influence therapists' professional roles. Finally, I will present the research questions that guided the present study.

Feminist Influences on Marriage and Family Therapy

Both proponents and opponents of "feminism" have defined the term in a multitude of ways. bell hooks defined feminism as "a movement to end sexism, sexist exploitation, and oppression" (2015; p. 1). This definition reflects, by its ordering, the evolution of feminist thinking. With roots in seeking equality of the sexes, feminism has historically been the analysis of women's subordinate position in relation to men with the purpose of changing that unequal relationship (Osmond & Thorne, 1993). Enns (2004) elaborated on the latter "oppression" aspect of hooks's definition to stipulate that "feminist consciousness also includes a commitment to ending all forms of domination, oppression, and privilege that intersect with sexism and gender bias, including (but not limited to) racism, classism, colonialism, heterosexism, ethnocentrism, white supremacy, ageism, and ableism" (p. 8). Feminism in general has evolved from "the women's movement" to encompass many definitions, the core tenets of which are recognizing, examining, and shifting imbalances in power and privilege as applied to social groups.

Despite the above similarities, there are multiple and varied theoretical perspectives that fall under the umbrella of feminism. A non-exhaustive list of "feminisms" that have impacted the field of therapy include radical, liberal, lesbian, women of color, postmodern, ecological, postcolonial, and relational-cultural. Furthermore, there are historical feminist movements that have occurred across eras and social groups that conceptualize feminisms differently (Bruns, 2010). Ways of conducting feminist research are also diverse and include positive empiricist, experiential, and social constructionist (Wilkinson, 2001). It is beyond the scope of this paper to define and delineate each feminist theory (see Disch & Hawkesworth [2016] for an overview of feminist theories); rather, I will describe how feminist theorizing as a body of work have impacted the field of marriage and family therapy.

Feminist philosophies began to influence MFT in the late 1970s and early 1980s when feminist family therapists challenged the fundamental assumptions of gender inherent in mainstream therapy models (Enns, 2004). Hare-Mustin (1978) wrote a groundbreaking piece that highlighted how harmful gender stereotypes were commonly reinforced in family therapy. For example, she pointed out that Bowen's concept of differentiation of self (Kerr & Bowen, 1988) represented a stereotypical masculinity/femininity spectrum, with "masculine" qualities (i.e., objective, autonomous, self-determined) on the optimal end and "feminine" qualities (i.e., subjective, emotional, group-influenced) on the devalued end. Even if Bowen did not intend to create this dichotomy, he failed to account for how women, as well as other marginalized minorities, experience a socialization process which may hinder them from developing the assertive and self-directed way of being that he considered essential to differentiation (McGoldrick & Carter, 2001). This aspect of Bowenian theory was by no means unique: feminist therapists found that nearly every mainstream model in family therapy espoused sexist assumptions or practices (Ault-Riche, 1986; Luepnitz, 2002; Walsh & Scheinkman, 1989).[1]

The feminist critique of the field went beyond pointing out sexism in traditional models to questioning the concept of "the family" itself. Many early family therapists' conceptualization of family was not based on a critical or historical analysis of families and their diverse forms, but on middle-class views of normalcy (Enns, 2004). Luepnitz (2002) pointed out that the stereotypical normal family (often held up as an ideal for "dysfunctional" families to achieve by theoretical paradigms based on structural functionalism [Kingsbury & Scanzoni, 1993]) is not a "whole" which offers equal benefits and protection for all its members. In fact, families are divided into distinct social groups, with different levels of power and conflicting interests for

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[1] Feminist critics allow that the pioneers of family therapy were not sexist by design; rather, they failed to recognize gender as a fundamental organizing principle in families (Hare-Mustin, 1980; Walsh & Scheinkman, 1989).

different groups (Goldner, 1993; Luepnitz, 2002; Taggart, 1985). Therapists who privilege the family as the client, and fail to recognize divisions based on power within a family, may disadvantage individual family members (Hare-Mustin, 1980). Feminist formulations of family therapy incorporate diverse family forms and recognize variations of power and influence within families (Silverstein & Goodrich, 2003).

Another important feminist critique of the field was that many mainstream family therapists simultaneously upheld oppressive values while also claiming that their work was value-neutral. Aspiring to neutrality is a constructivist approach formulated as a solution to the problem of "normalcy" described above: family therapists intended to show respect for a family's values system by not interfering with it and imposing their own values (Bograd, 1986). However, feminists pointed out that therapists cannot *not* communicate their values when they choose what to focus on, challenge, respond to, or ignore in session (Avis, 1988; Jacobson, 1983; James & Mclntyre, 1983). Rather, a feminist perspective acknowledges that every individual has an unavoidable subjective viewpoint, derived from how that individual is situated within the world, which emerges both intentionally and unintentionally. For example, a therapist's failure to challenge the patriarchal status quo conveys tacit approval and alignment with those values (Jacobson, 1983). Furthermore, clients' beliefs and assumptions about gender can play roles in problem development, maintenance, and change and are therefore a legitimate target of intervention (Walsh & Scheinkman, 1989). In addition to values regarding gender, the therapist's focus can also convey subtle cultural values of health and dysfunction. What might be considered "enmeshed" in one culture may be considered "normal" in another. Feminist writings have highlighted the importance of considering cultural and political context when discussing what is desirable or not in families (Enns, 1992).

Feminist family therapists also critiqued family systems theory itself, which is considered the cornerstone of MFT. Traditional family systems theory tended to emphasize the circularity of family members' actions in the present, without examining suprasystemic influences on the family (Osmond & Thorne, 1993). In other words, systems theory was descriptive of patterns of interaction without seeking to understand *why* those patterns were occurring across families. Sources of typical patterns of interaction, such as "overinvolved mothers" and "disengaged fathers," were not examined within the political, economic, and structural context (Avis, 1988; Luepnitz, 2002). Lambasting the field's claim that it takes context into account because it takes family environment into account, Lerner (1988) stated, "Viewed from feminist eyes, a family focus that ignores the dysfunction of the sociocultural system is equally as narrow as an intrapsychic focus on an identified patient that ignores the primary dysfunction in the family system" (p. 51). Feminists argued it is necessary to help clients see how their actions are influenced by the broad societal context, or they will revert to former patterns after therapy concludes.

With its historical focus on women, particularly White women, the feminist movement has had its own share of oppressive omissions and erasures of other social groups. Though early feminist family therapists wrote primarily about sexism in the field, contemporary feminist thinking has incorporated tenets of Black feminism by recognizing intersecting systems of oppression (Ballou, Hill, & West, 2008; Crenshaw, 1991). For example, Crenshaw (1989) first called attention to how gender and race interact to create different experiences within social groups, such as White women and Black women. It is essential to explore how experiences can vary within groups to create unique social locations by individual. Social location can be understood as the place a person inhabits within society that determines their access to resources,

power, and status (Silverstein, 2003). Aspects of identity that are often associated with social

location include sex, gender identity, ethnicity, age, immigration status, sexual orientation,

physical ability, and socioeconomic class (Brown, 1990b). While acknowledging that gender

remains a fundamental organizing factor of society and that there is still progress to be made,

feminist thinking has expanded to an exploration of how overlapping systems of power and

privilege affect all people.

The critiques of family therapy and the call for incorporation of feminist principles led to

a new perspective of therapy informed by feminist theories. There is lack of consensus in the

field whether or not this new perspective is well-defined enough to be considered its own model

(Luepnitz, 2002; Worell & Remer, 2003). Nevertheless, feminism in family therapy has a rich

history of change and growth within the last forty years and is reflective of various feminist

theoretical perspectives. In fact, it may be this very diversity of ideas in feminist theories has led

to lack of clarity about the underlying theoretical tenets of feminist family therapy and its

legitimacy as a model in its own right (Murphy, 2004). Despite contributions from theories as

different as radical feminism and liberal feminism, the underlying core values associated with

feminist family therapy are as follows: a recognition of the effects of power and oppression; the

fostering of egalitarian relationships; valuing the perspective of typically marginalized persons; a

recognition of sociocultural causes of distress; and the goal of creating social change (Brown,

2009; Enns, 1992; Goldner, 1985; Worell & Remer, 2003). Next, I will describe how these

underlying values are translated to clinical practices.

Feminist Practices within MFT

Identity as a feminist and identity as a feminist therapist are necessarily intertwined. The feminist therapist does not leave feminism behind when leaving the clinic at the end of the day. As Luepnitz (2002) put it:

> Feminism…is not a set of techniques or countertechniques; it is a body of theory. The value of any theory to us as practitioners is nil until the theory turns into who we are – into phrase and glance and gesture – until our intellectual powers and our humor settle into it… Feminism must be to therapists a *sensibility*, or it is nothing useful at all (p. 20).

In other words, feminist clinicians can incorporate various interventions and conceptualizations from a range of models, but with a feminist philosophy underlying *how* they incorporate them (Brown, 2009; Brabeck & Brown, 1997; Worell & Remer, 2003).

Though Luepnitz (2002) describes feminism within therapy as a sensibility rather than a set of techniques, previous research has explored how feminist therapists operationalize their values in their clinical interactions. Below I present a sampling of common feminist values and how therapists align their techniques to those values.

Valuing client experiences. One primary principle of feminist family therapy is to value the client's experiences without judgment. This principle is derived from feminist social constructionism (Hare-Mustin, & Marecek, 1992; Kessler & McKenna, 1978) and postmodernist feminism (Park, 2004). Central to this view is that individuals create a sense of the world by constructing meaning through language (Wilkinson, 2001). Feminist therapists attend to how language both expresses and constructs clients' experiences, and listen for the layers of meaning that clients convey (Park, 2004; Paterson & Trathen, 1994). This particularly includes clients of historically marginalized ethnicities, age groups, sexualities, gender representations, socioeconomic classes, and every other aspect of social location, in an effort to counteract

previously privileged standpoints and constructions of reality (Brown & Brodsky, 1992; Goodrich, Rampage, Ellman, & Halstead, 1988). By recognizing that this view is limited and stigmatizing, feminists create space for other views to emerge.

There are several techniques a therapist could employ to intentionally value their clients' experiences. One is simply to believe a client's stories and use the client's own language when reflecting back to them. Feminist therapists privilege the client's construction of reality rather than relabeling those realities in a reductive manner (Brown, 2009). However, feminist therapists can also use language to positively reframe the client's experience to allow for alternative interpretations, such as by reframing symptoms as coping strategies. Other aspects of conversation can include listening without interrupting, generalizing specific experiences to the universal, asking for more details and for personalized meaning (e.g. "What does that mean for you?"), and attaching importance to feelings and subjective experiences as much as to "facts" (Hare-Mustin, 1978). Therapists can also disrupt relational processes in which clients speak for each other or attempt to represent the whole family. By intentionally pointing out that one person's point of view is distinct from another's, and equally important to the therapist's understanding of the situation, therapists disentangle the dominant from the non-dominant narratives.

Recognizing and naming sociocultural causes of distress. Feminist therapy draws attention to the relevance of sociocultural context to clients' lives (Espín, 1994). This approach is derived from the feminist slogan that "the personal is political" (Hanisch, 2009; Park, 2004). In other words, distress within a family or individual may be a micro reflection of macro cultural patterns, and macro cultural patterns can lead to micro-level distress. By situating client distress

as an interaction between the client and the sociocultural environment, feminist family therapists reject the medical model of psychiatry that locates problems within the individual (Espín, 1994).

In order to understand how sociocultural context is relevant, feminist clinicians conduct integrated analyses of their clients' identities and systems of oppression that affect them, with a focus on intersectionality of identities (Crenshaw, 1989; Hill & Ballou, 1998). Sex, gender, race, ethnicity, age, sexual orientation, disability and myriad other factors of identity shape individual experiences and impact a client's presenting concern, including how they view the world and how the world views them (Bograd, 2005). Clinicians highlight how these identities interact with external social systems. Social forces that have been described as particularly relevant to families include the cultural expectations for how men and women are expected to fulfill their family roles; the economic resources available to individual family members; and social and institutional discrimination (Leslie, 1995).

In order to bring the client's identity into the therapeutic process, therapists ask clients during the assessment process how they identify in terms of gender, race, ethnicity, etc., without making any assumptions based on appearances (Brown, 1990a). Therapists also tend to help clients explore the influence of these identities on their experiences and perceived choices (Hill & Ballou, 1998). For example, therapists open up conversations about how gender socialization can influence emotional expression or beliefs about gender roles (Brooks, 2003; Enns, 2004). A major component of feminist couples therapy is to explore and challenge scripts of "natural" sex differences so that clients open themselves up to a more diverse range of options for behavior and meaning-making (Lyness & Lyness, 2007). Therapists also directly discuss their own sociocultural identity in relation to the client's, acknowledging the harmful effects of historical oppression on the client and welcoming conversations about it (Espín, 1994). Outside of the

therapy room, clinicians can work toward cultural competence by interacting with and learning about culture groups other than their own, particularly if they are members of a historically dominant group.

Equalizing power differentials. "If theory were to be distilled to a single word or concept, then in regard to feminist theory, 'power' would offer itself as a likely candidate" (Gentile, Kisher, Suvak, & West, 2008, p. 72). The feminist therapist critically examines power on multiple levels and attempts to equalize power differentials and encourage egalitarian relationships. This includes both within the client system and the client's broader social system (Espín, 1994). Therapists must use a lens that recognizes and explores their clients' multiple social locations, the power dynamics between relevant relationships, and the effects of those dynamics on client well-being. Though power relations can be practically invisible, particularly for the powerful (Komter, 1989), it is up to the therapist to bring what is unseen to the table and make it available for conversation (Parker, 2003).

Parker (2003) outlines several strategies that feminist family therapists can employ to make power dynamics visible to clients, both within their family and in the family's relation to broader social systems. She suggests therapists intentionally bring up issues related to power within the first session. For example, she asks couples how much each partner earns in order to distinguish individual earnings from household income. Other options include asking clients to describe their societal and family socialization concerning their social locations. Parker (2003) also describes the less direct option of being quietly attuned to issues of power disparity, and then asking clients how they came to arrive at that particular situation. By framing behaviors and outcomes as choices rather than foregone conclusions, the therapist invites clients to examine their situation with a critical eye (Knudson-Martin & Mahoney, 2005). Other actions that

therapists can take for the interactions within the family system include creating space for and validating the competence of the less powerful family members, and encouraging the more powerful family member to shift to a relational perspective (Parker, 1997; Ward & Knudson-Martin, 2012).

Feminist therapists also attend to the power dynamic of the therapeutic system and seek to unbalance the power hierarchy inherent in the client/therapist relationship (Espín, 1994; Hill & Ballou, 1998). For example, a "one-down" approach is a therapeutic intervention in which the therapist takes a modest and humble approach to the client, as opposed to a powerful or expert stance (Fisch et al., 1975). Rather than replicating the unequal power dynamic that may be contributing to the client's presenting concern, the therapist's goal becomes to develop egalitarian structure and relationships within the therapy experience. This includes the therapist revealing personal values that guide their practice (Leslie & Clossick, 1992), and showing respect for the client's values that guide their actions (Hill & Ballou, 1998). Self-disclosure of feminist choices in the clinician's own life may also serve as a useful model to clients, and reduces the distance between the "expert" and the client (Hill, Mahalik, & Thompson, 1989). Hall and Greene (1995) also argued that it is an ethical responsibility for White therapists to confront their own racial identity and the privilege that it entails. With a similar philosophy, McGeorge and Carlson (2009) developed a method to help heterosexual therapists deconstruct their own heterosexism when working with lesbian, gay, and bisexual clients. Broadly speaking, it is essential for therapists to examine their own identities, the privilege and oppression they experience, and how these identities interact with their clients and the sociocultural context (Worell & Remer, 2003). This involves critically examining their own power and privilege

within society and the therapy system, and seeking consultation, education, and training to address the ways in which they have not recognized their own privilege (Gentile et al., 2008).

Despite these calls for examining power related to identity and social location, the previous literature does not address therapists' power within their workplace organizations or within the structure of the mental healthcare system at large. Next I will describe how MFT has a field has approached the incorporation of contextual factors into therapeutic care, and how these approaches can be modified to highlight the contextual environment in which therapists are embedded.

MFT and Social Context

The field of marriage and family therapy has historically focused on dynamics within family systems. However, due in part to the feminist critique of MFT, the field has undergone a paradigm shift in which it has become essential for therapists to understand cultural and contextual factors, both of the therapist and the client, that contribute to client problems and the therapy process (e.g., Falicov, 1995; Hardy & Laszloffy, 1995; Hare-Mustin, 1978; McGoldrick & Hardy, 2008; Minuchin, Montalvo, Gurney, Rosman, & Schumer, 1967). This is evidenced by the American Association for Marriage and Family Therapy's (AAMFT) current core competencies. The first of six domains of the core competencies stipulates that therapists must "recognize contextual and systemic dynamics (e.g., gender, age, socioeconomic status, culture⁄race⁄ethnicity, sexual orientation, spirituality, religion, larger systems, social context)" (AAMFT, 2014, p. 2).

Additionally, the feminist strategy of connecting client problems to their social context with an aim of promoting social justice is becoming a core theme of MFT education and supervision (McDowell & Shelton, 2002; McGoldrick et al., 1999). Illustrating these principles,

Esmiol, Knudson-Martin, and Delgado (2012) describe how they intentionally foreground "culture, power, race, gender, and sexuality" (p. 577) for their supervisees in order to develop *contextual consciousness*. This approach has also been called *socio-cultural attunement* (Pandit, Chen-Feng, Kang, Knudson-Martin, & Huenergardt, 2014), in which therapists attend to the intersection of larger societal dynamics as they play out within couples' relationships (Knudson-Martin & Huenergardt, 2010). When such societal dynamics are explored, they usually refer to the client's or therapist's identity rather than the training or professional context of the therapist.

When the environment of the therapist is attended to, it is typically referred to as the *service delivery context* (Sexton, Ridley, & Kleiner, 2004), which highlights the culture of the particular organization in which a therapist works. Research has shown that features such as autonomy and power relations at one's place of employment affect a therapist's job satisfaction and level of burnout (Rosenberg & Pace, 2006). Organizational characteristics such as structure, culture, resources, and administrative requirements have also been shown to influence the feasibility of treatment implementation (McPherson, Kerr, Casey, & Marshall, 2017; Zazzali, Sherbourne, Hoagwood, Greene, Bigley, & Sexton, 2008). Previous research has also highlighted how a therapist's nationality and values therein shapes their clinical work (Platt & Laszloffy, 2013). The influence of those who create and implement models must also be taken into account when treatments are transported from one cultural context to another (Breuk et al., 2006).

The above lines of research highlight how social and cultural context are inextricably woven into therapeutic work. However, what is missed is how the broad *structural* context shapes and influences therapy. That is, less attention has been paid to the context – including how healthcare is structured and delivered – in which the therapist as a professional is embedded.

While much of previous research (including studies of feminist therapists) focuses on clinical

interactions with clients, the field has yet to examine how practitioners within a healthcare

system engage with demands that the system makes as they fulfill their social roles. Without

understanding the therapist's location and role within a broader system, factors that shape

therapeutic practice may go unrecognized, to both therapists' and clients' detriment. While it is

important to examine how clinicians engage with clients, I argue that is also important to

uncover how professional, structural contexts both facilitate and hinder how therapists enact their

values.

  Below I propose that incorporating a sociological lens allows for an examination of

structural contexts that also influence therapeutic work. I describe relevant tenets of the field of

sociology and highlight where they overlap with feminist principles. I further describe specific

analytical tools that are applicable to MFT. To operationalize a sociological lens, I highlight two

domains. First, I examine managed care to show how economic structures influence the actions

of individuals within the system. Second, I consider the role of diagnosis because it illustrates the

sociological concept of medicalization (Brown, 1995; Jutel, 2009; McGann, Hutson, & Rothman,

2011; Wilkerson, 1998).

Applying a Sociological Perspective

  The discipline of sociology is concerned with systematically analyzing social contexts in

order to better understand how the formal organization and/or norms of society impact

individuals as they fulfill their social roles. Whereas consideration of social and cultural context

has become mainstream in MFT, structural forces are far less considered or understood. In

sociology, structural context refers primarily to the patterned or formalized arrangements in

society, especially those imposed by social institutions or economic structure. Institutions keep

society working, developing patterns and rules in how we organize society on a broad level, and in turn its individuals. Medicine is an example of a social institution, and medical sociology is an area of specialization concerned with, among other things, understanding the context of health and healthcare delivery (Conrad & Leiter, 2012).

Similar to a feminist perspective, a sociological perspective examines the influence of society on individuals' agency, that is, their capacity to act independently and make free choices. Further, one of the basic claims in the discipline of sociology is that investigating the influence of social structure is about investigating power. Describing and analyzing how institutions are organized is one way to understand the influence (or power) that institutions have over individuals as they make decisions and fulfill their social role within the institution or organization. There are a variety of ways to better understand this. For example, sociological inquiry could examine the economic structure of healthcare, the individual or client experience of distress, clients' interactions with providers, and providers' experiences of working within healthcare (e.g., Barkan, 2016; Brown, 2007; Conrad & Barker, 2010; Hankin & Wright, 2010). Most relevant to the current study, one could collect data about the experiences of individuals, such as those providing healthcare services, to better understand the interactions between individuals and institutions. One of the key, broad lines of inquiry in sociological scholarship is the tension between these structures and one's agency: what is often referred to as the tension between the individual and society (e.g., Giddens, Duneier, Appelbaum, & Carr, 2013). That is, often the demands of the systems in which individuals are situated are at odds with individual needs. In medical sociology, one goal is to better understand how much agency (that is, autonomy or self-determination) individuals have within a social structure and institution like medicine.

I argue there is an affinity between a sociological perspective, family systems theory, and the contributions of feminist theorizing to family systems theory. Obvious parallels can be drawn between a sociological approach and a family systems approach: both are concerned with understanding how structure, rule patterns, and roles maintain social systems. Furthermore, feminist theorizing is concerned with connecting individual experiences to broad social and structural contexts with special attention to power relations. These theories all highlight a multilayered conceptualization of how individuals, systems, and environments are interlocking and influential upon one another.

In order to draw together the literature of feminism in MFT and medical sociology as a subdiscipline of sociology, below I will apply sociological analytical tools to examine two broad structures that are relevant MFT: managed care and the diagnostic system of mental disorders. These systems are interrelated and highly influential aspects that have been integrated and formalized into the healthcare structure. They shape and constrain the practice of therapy, yet individual therapists may not critically recognize how and to what extent.

Managed Care

One of the most influential systems that shapes the provision of therapy is the economic context: how therapy services are paid for and by whom. The financial dealings that occur within and around the therapy room are especially important when considering access to care, and what sort of care is facilitated under what payment systems. In the U.S., mental health services have become increasingly subsumed under the umbrella of managed care. Managed care is a system in which an insuring organization (i.e., managed care organization, or MCO) provides a defined set of health services, using a defined set of service providers, in return for a fixed or regular per capita payment (Lammers & Geist, 1997). Managed care arose in the 1960s as a solution to

escalating healthcare costs (Scott, Ruef, Mendel, & Caronna, 2000) and institutional demands for efficiency and rationality (Scheid, 2000). Managed care has had positive effects, including controlling rising costs of healthcare (Cummings, 2000) and providing access to some degree of care for low-income populations (Brown, 2007). Managed care also creates connections between therapists and clients, enabling the former to have a livelihood and the latter to have treatment. Despite these benefits, "managed care" is somewhat of a misnomer. Managed care focuses not on quality of *care*, but on managing *costs* for MCOs (Cummings, 2000).

Similarly to how MFT has illustrated that individuals adapt to family organizational processes, I use a sociological lens to suggest that healthcare providers adapt to the influence of managed care. For example, the core competencies themselves are a reflection of MFT engaging with the healthcare system. A primary function of the competencies is to legitimize the field so as to be reimbursable under MCOs (Miller, Todahl, & Platt, 2010). On the micro-interactional level, managed care has been shown to influence providers from a variety of subfields to develop short-term, problem-focused treatment regimens (Austad, Sherman, Morgan, & Holstein, 1992). Time limits on sessions have been shown to influence therapists' choice of therapeutic modality, shift therapists' definition of the client's problems, and prompt therapists to be more directive with clients, which leads to concern that clinicians become more focused on symptom removal than long-term maintenance of treatment gains (Wright, Simpson-Young, & Lennings, 2012). Practitioners commonly report that managed care decreases the quality of services, increases provider workload without commensurate compensation, hinders provider autonomy and clinical decision-making, and contributes to feelings of burnout and dissatisfaction (Austad et al., 1992; Trudeau, Russell, de la Mora, & Schmitz, 2001). Additional prior research has shown that structures requiring systemic therapists to use the language of managed care (i.e., medically

oriented) results in loss of knowledge of systemic theories, reduced complexity in therapeutic

family treatment, and an increased focused on decontextualized biological explanations and

practice (Pulleyblank Coffey, Olson, & Sessions, 2001).

In a qualitative study of how managed care affects MFTs in particular, Christensen and

Miller (2001) found strong effects. These include structural aspects of practice, such as what

forms need to be filled out and what information gathered. Clinical practices are also affected,

such as terminating treatment before clients' problems are resolved due to a limited number of

authorized sessions. The therapeutic alliance can also be hindered if the treatment is hurried,

possibly creating anxiety for the client and/or therapist. Additionally, MFTs often experience

"ethical dilemmas" in which providers feel that the values of the managed care system (to

achieve low costs) and their professional values (to achieve high quality from a systemic,

relational perspective) conflict with one another (Christensen & Miller, 2001; Cohen, Marecek,

& Gillham, 2006; Scheid, 2000). These dilemmas highlight the tension between the therapist's

agency and the power of the managed care system. Next, I will explore a system that is

interwoven with managed care: our current diagnostic taxonomy.

Diagnosis

The dominant system of classifying mental disorders in the U.S. is presented in the fifth

edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5; American

Psychiatric Association, 2013; I use "DSM" to refer to the system of diagnosis described in the

various editions of the Diagnostic and Statistical Manual). The original purpose of the DSM was

to provide common language for clinicians so as to better help clients (Van der Kolk, 2015).

Despite the original clinical function, the DSM has gradually become undeniably entrenched

within the economic structures of managed care. Most organizations require a DSM diagnosis in

order to reimburse clinicians for their services (Erikson & Kress, 2006). Research funding is often based on DSM diagnoses, and training in mental health also revolves around treating particular diagnoses (Van der Kolk, 2015).

The DSM not only codifies client problems, but has come to define desired therapeutic outcomes as well. As typically conceptualized, outcomes are quantifiable and treatment success is a construct that can be observed directly (Stoppard, 1999). For example, in a review of empirically supported individual and group treatments for eleven adult mental disorders, treatments were viewed as efficacious if there was a "reduction or remission of the disorder or problem at a rate higher than that occurring with the passage of time" (DeRubeis & Crits-Christoph, 1998, p. 49). This reflects a mainstream convention that outcome measures typically assess DSM diagnosis-related symptoms, and a good outcome is viewed as reduction of the symptoms. Managed care relies on this view to determine if treatment is cost effective (Scheid, 2000).

In order to understand how the utility of the DSM has shifted from a clinical to administrative tool, I turn to literature in the sociology of diagnosis:

Diagnosis is integral to the system of medicine and the way it creates social order. It organizes illness: identifying treatment options, predicting outcomes, and providing an explanatory framework. Diagnosis also serves an administrative purpose as it enables access to services and status, from insurance reimbursement to restricted-access medication, sick leave and support group membership and so on. (Jutel, 2009, p. 278)

Not only does diagnosis serve a structural function in terms of reimbursement, it is also a "cultural expression of what society is prepared to accept as normal and what it feels should be treated" (Jutel, 2009, p. 279). Such an expression of cultural norms and values is not static, as

what is considered a medical problem changes over time. Some feminists have argued that the

DSM system for defining outcomes is more aligned with an androcentric, positivist medical

model (Allen & White, 1998; Stoppard, 1999), and that symptoms described in the DSM are

marginalizing because they reflect standards for normal human behavior that are based on the

lives and experiences of mainstream, middle-class, heterosexual cisgender White male culture

(Garner & Enns, 2012; Worell, 2001). For example, transgender identities, which are frequently

codified in the DSM-5 under Gender Identity Disorder, are overwhelmingly rejected as

disordered by transgender rights advocates (Burke, 2011). I will discuss this diagnosis further in

the Results section below.

　　　While diagnosis reflects cultural views of normalcy, the DSM also frames mental health

problems as located within an individual and fails to incorporate the contextual factors that

contribute to the client's symptoms (Eriksen & Kress, 2004), which again contradicts feminist

therapy's biopsychosocial approach (Brown, 2009; Worell, 2001). Additionally, the latest

iteration of the DSM has been widely criticized for DSM panel members having financial ties to

pharmaceutical companies (Cosgrove, Krimsky, Wheeler, Kaitz, Greenspan, & DiPentima,

2014) and for medicalizing problems previously considered part of the normal human

experience, such as bereavement (Allen, 2013; Sedler, 2016).

　　　Medicalization is the process of previously nonmedical problems coming to be defined

and treated as medical problems (Conrad, 1992; Conrad & Slodden, 2013; Zola, 1972). Though

"medicalization" literally means "to make medical," the term is widely used in the context of

critiquing the medicalization process; its usage implies *over*medicalization (Conrad, 1992).

Though there are numerous social forces that have contributed to this trend and arguments over

how it is accomplished, Conrad (2005) argues that medicalization is driven more by commercial and market interests, such as managed care, than by healthcare professionals.

Though I do not intend to minimize the importance of medical factors, an over-focus on the biomedical aspect limits the scope of how providers can assist clients in distress. The process of medicalizing and diagnosing an individual often depoliticizes or de-contextualizes the social and psychological contributors to that individual's condition (Conrad, 2005; Zola, 1972). Rather, the diagnosis emphasizes and re-defines what might be a product of social forces into an individual pathology (Zola, 1972). Key sociological, family systems, and feminist approaches is the notion that health/illness is not solely a biological phenomenon, but is in part created by social forces. Indeed, a core aspect of a systemic approach is to counteract the medicalization of an individual's distress and put particular focus on oft-neglected social and relational components (Brown, 2009). A sociological approach also contends that medical knowledge itself has power and is privileged (Zola, 1972), which can be seen in the authority of the DSM.

Feminist critiques of the DSM have looked beyond symptomatology in an effort to draw attention to client strengths rather than symptoms (Worell, 2001). Client symptoms are reframed as coping strategies, and the reduction of one "maladaptive" coping strategy does not necessarily mean it has been replaced with an "adaptive" one (Ballou, et al., 2008; Worell & Johnson, 2001). In other words, though a reduction in a distressing symptom may partially be an indicator of client improvement, feminist therapists do not rely solely on symptoms to measure treatment success, or the reduction in DSM-defined symptoms to be the sole desired outcome of therapy. Despite these critiques and reframes, the DSM diagnostic system has unquestionably become the dominant form of defining both client problems and desirable outcomes.

Feminist critiques of the DSM have not undermined the structural pervasiveness of the DSM in mental healthcare. The codes within the DSM serve a gateway function in the current managed care system. Clinicians are required to report a diagnosis to an insurance company in order to justify medical necessity of treatment, which typically leads to clients getting treatment and clinicians getting paid. Additional benefits of diagnosis may also include validation of a person's experience, access to community networks, and a common language between clinicians (Eriksen & Kress, 2006). Because of such advantages, the process of medicalization that is reflected in the DSM demonstrates a complex matrix of both helpful and harmful processes and outcomes. While providing some degree of access to services and potential validation of experiences, medicalization can also lead to the erasure of important social and contextual factors that are pertinent to mental distress. In the following chapters, I will present data that captures such a complex interplay of advantages and disadvantages.

The concept of *ambivalent medicalization* helps to account for the complexity of individuals' experience with medicalization and its structures, such as the DSM. Mauldin (2016) developed the concept of ambivalent medicalization to close the gap between the theorizing behind medicalization and the everyday experiences of those who live within it. Of ambivalent medicalization, she writes:

> Overall, it *recognizes* the capability of medicine and the relief it provides, *attends to* the accompanying profound social and ethical implications, *accounts for* the labor that medicalization often requires of patients and caregivers, and *grapples with* the fact that medicine may not always yield the best – or even the intended – results (p. 5; emphasis in original).

While the literature on medicalization tends to imply a lack of agency on the part of individuals, ambivalent medicalization allows for the agency of individuals who are empowered by medicalization, even as they are simultaneously disempowered (Mauldin, 2016). Framing the implications of medicalization as ambivalent allows for such seemingly contradictory yet co-existing processes to emerge. The current study examines this ambivalence between empowerment and disempowerment by investigating the firsthand experiences of feminist MFTs. Through exploring the interaction between individuals and the broader context, particularly the medicalization of mental health as upheld by managed care and the DSM, I show how individuals perceive and respond to the institutional power of those structures. Furthermore, this work adds to previous findings in feminist family therapy by illuminating how feminist MFTs practice their values, not only in relation to their clients, but in relation to pervasive social structures as well.

Summary

Ample literature has explored feminist theories and their applications to the practice of mental healthcare, but scant research has directly explored the experiences of feminist therapists. These therapists may possess unique characteristics that distinguish them from other groups of providers. First, feminism is more than a model or set of therapeutic techniques; it is a theoretical approach that can fundamentally transform a therapist in everything that they do (Luepnitz, 2002). Also, a core tenet of feminism in general is to not only want to know the world, but to change it (hooks, 2015; Osmond & Thorne, 1993; Thompson & Walker, 1995). If this principle of feminism is integrated into feminist therapists' identity, then feminist therapists may represent a group of people who are especially interested in actively transforming their environments.

Whereas most previous research on the practices of feminist MFTs has concentrated on critiques of therapy models and feminist clinical intervention, little is known about how this population enacts their feminist values beyond the therapy room. The current study takes an interdisciplinary approach and weaves feminist studies and methodology, family systems theory, and a sociological perspective to examine how feminist MFTs engage with individuals and structures relevant to the role of a professional therapist. The process of medicalization, which is operationalized through the managed care system and its links with the DSM-based diagnostic system, theoretically lead to quandaries for the feminist therapist. The proposed research will build on the literature in feminist studies, family studies, and medical sociology by investigating the experiences of feminist therapists who engage with these structures. The current research will explore how two aspects of identity – feminist and therapist – intersect in relation to those systems. By taking a qualitative approach consisting of semi-structured interviews and analyses derived from a modified grounded theory approach (Glaser & Strauss, 1967), I connect previous literature to novel data and findings related to the experiences of this population.

To summarize, the purpose of this research is to explore the lived experiences of feminist therapists with particular attention to multiple realms (i.e., systemic levels) of their work. The research themes are as follows:

1)   How feminist therapists experience their identity and enact their values in
         relation to their colleagues.

2)   How feminist therapists experience their feminist identity and enact their
         values in relation to the managed care system.

3)   How feminist therapists experience their feminist identity, and enact their
         values, in relation to the DSM-oriented system of diagnosis.

CHAPTER 3: RESEARCH METHODS

Feminist theorizing have had a substantial impact on the field of MFT by connecting gendered patterns within families to social and political systems external to the family. Moreover, the literature on feminism in MFT has expanded to include how intersecting social locations, including but not limited to gender, are also connected to clients' presenting concerns. Feminist thinking in MFT has not only provided feminist therapists with a theoretical understanding of the relevance of power dynamics to therapy, but multiple interventions and techniques to employ in the practice of therapy as well. Despite the theoretical and practical contributions made by feminist thinkers, little attention has been paid to how feminist MFTs experience their feminist identity and enact their feminist values outside of their interactions with clients. The current study examines how feminist MFTs do so while embedded in multiple contexts that shape their work. In particular, I investigate the following research themes:

1)   How feminist therapists generally engage their feminist values in relation to their professional colleagues

2)   How feminist therapists engage their feminist values in relation to the managed care system.

3)   How feminist therapists engage their values in relation to the DSM-oriented system of diagnosis.

In order to conduct this examination, I chose to engage with qualitative methodology as a framework for my research design. Whereas *methodology* involves "a way of thinking about and studying social reality" (Strauss & Corbin, 1998, p. 4), *qualitative methodology* provides a grounding place for researchers to understand social issues or problems by privileging subjective and multiple points of view (Hesse-Biber, 2017). This is distinct from quantitative

methodologies, which are undergirded by a positivist framework and involve quantifying data and generalizing results to a broader population (Hennink, Hutter, & Bailey, 2011). A qualitative framework is more appropriate for investigating the current research themes in that it allows for a detailed understanding of participants' underlying motivations and beliefs, as well as the processes of and contextual influences on their behaviors and reasoning. Additionally, this project was intended to be exploratory in nature as the population and phenomena of interest are diverse and understudied. Rather than measuring prevalence or generalizable patterns, which would require a quantitative framework, my goal was to develop an initial yet thorough understanding of processes and contextual factors of a specific group of people.

One paradigm of qualitative methodology is the interpretive approach, which enables the researcher to examine the meanings that research participants themselves give to any given phenomenon (Hennink et al., 2011; Saldaña, Leavy, & Beretvas, 2014). Qualitative methodology is also interpretive in that the researcher maintains an open, curious, and flexible stance toward the meanings that participants provide, while also interpreting the phenomenon in terms of those meanings (Hennink et al., 2011). This enables the identification of issues from the perspective of the study population. A qualitative stance also seeks to take contextual influences of those meanings into account (Hennink et al., 2011). Qualitative methodology is appropriate for providing in-depth, nuanced views of processes that individuals engage in, such as making choices and how those choices are connected with their values (Hennink et al., 2011). Qualitative methodology also aligns with feminist standpoint theory, which seeks to connect individual experiences to social contexts (Smith, 2005). I chose a qualitative framework because it is the most appropriate methodology to generate rich, initial data from the perspective of the sample in this understudied field of inquiry.

There are many research methods that fall under the umbrella of a qualitative framework, such as ethnography, focus group discussions, and interviews. I chose to conduct interviews as the method of data collection. This method allowed for research participants from a variety of contexts to describe their experiences in their own words, which allows for complex, individualized standpoints to emerge in everyday language (Thompson & Walker, 1992). Data were gathered through semi-structured interviews guided by a series of broad, open-ended questions and prompts that were derived from previous literature. Rather than other types of interviews, such as life histories, the semi-structured format limited the scope of the interviews to the research themes. However, the flexibility of the structure ensured that areas of interest were covered while also allowing room to explore particular meanings with each interviewee (Burck, 2005).

In addition to semi-structured, qualitative interviews as method, I also chose to engage in analytical techniques that are associated with grounded theory (Charmaz, 2001b; Strauss & Corbin, 1998). Grounded theory was first articulated by Glaser and Strauss (1967), who advocated for developing theories from data rather than deducing testable hypothesis from existing theories (Charmaz, 2001b). Similar to the methods developed by Glaser and Strauss (1967), this project consisted of an iterative process that included simultaneous involvement in data collection and data analysis. Though this study was not intended to be "pure" grounded theory (as outlined above, previous literature has informed the research themes), I employed systematic and detailed analytical processes associated with grounded theory. These are described in further detail below in the "Data Analysis" section.

The choice to conduct semi-structured interviews blended with a modified grounded theory analytical approach represents a balance between deductive and inductive strategies for

knowledge and theory development. On one hand, I used deductive reasoning to engage in an

ongoing dialogue with previous literature, which led to the development of the research themes

and interview questions. On the other hand, I allowed for an inductive conceptual framework by

creating room in the data collection and analysis processes for new concepts and theory to be

derived from the data (Hennink et al., 2011). This approach aligned with the goal of the project

because it allows for the process of simultaneously addressing previous findings while also

allowing for generative questions in an area with an under-studied population and phenomena

(Worell & Remer, 2003).

Finally, the design of the project is a reflection of my feminist framework as outlined by

Thompson and Walker (1992) in their paper *Feminist Methodology for Family Studies*, which

notes that feminist methods are reflected in the researcher's agenda, epistemology, and ethics.

My research agenda consists of locating personal experiences within a broader social context. In

order to accomplish this, I asked questions to connect the participants' personal experiences to

both their immediate contexts (e.g., training background and clinical practice setting) and

broader context (e.g., healthcare systems and markets). My feminist epistemology leads me to

privilege the standpoints of feminist therapists and seek to understand experiences through their

everyday lives and language. This perspective also leads me to analyze these relations within

their sociohistorical context (Thompson & Walker, 1994). Furthermore, this research will reflect

my feminist ethic through a commitment to justice and equality. As "research is a *process* not

just a product" (England, 1994, p. 82), it was my intention to align this project's values with the

feminist values that I am exploring.

In summary, a qualitative framework, semi-structured interview design, and modified

grounded theory analytical techniques are most appropriate for addressing the research questions

in a manner that aligns with my feminist values. This methodology examines and amplifies the lived experiences of individuals while also connecting those experiences to their social and structural context.

Participants

The purpose of this study is to examine the values and practice of feminist marriage and family therapists. Participants were eligible for this study if they identified with both categories *licensed marriage and family therapist* (LMFT) and *feminist therapist* so as to inform on the intersection of these categories (Patton, 1990). First, licensure in the state or province of residence was stipulated in the inclusion criteria so as to ensure that participants had sufficient opportunity to gain professional experience relevant to the study themes. Second, Enns (2004) defined a feminist therapist as a person who chooses to approach therapy in a way that is compatible with feminist values *and* who also self-identifies as a feminist. Participants were considered qualified to participate if they agreed that this definition applies to them (this definition was included in advertising materials; see Appendix A). The term *feminist* was left purposefully ambiguous during the recruitment process so as to capture a wide variety of feminist identities. The qualitative nature of the research design was not prescriptive in terms of what it means to be a feminist, but descriptive and grounded in the participants' understandings and meanings of feminism. During the recruitment process, several potential participants asked me if they were eligible to participate because they did not know if they could be categorized as a "feminist therapist." I would repeat Enns's (2004) definition of feminist therapist to them, particularly the latter portion about self-identifying as a feminist. If individuals said they did not know if they identify as a feminist then I informed them they were not eligible to participate, as this study seeks to examine those who unequivocally identify as such.

Recruitment. Recruitment was purposive (Patton, 1990) in order to reach individuals who, due to their professional position and identity as a feminist, were uniquely positioned to contribute to knowledge about the research themes. Participant recruitment took place from May 2016 to March 2017. Recruitment was open to all states within the US in order to include as many potential participants as possible. All advertising and informational materials were approved by the Institutional Review Board (IRB) at the University of Connecticut and described the purpose of the study, qualifications to participate, study procedures, risks and benefits of the study, how data were to be protected, and participant rights. Recruitment took place via multiple methods in incremental steps to adjust for the respondent rate and scheduling of interviews.

Recruitment centered on personal and professional MFT networks. My first recruitment strategy involved reaching out to individuals personally known to me and whom I knew identify as feminist therapist. I had met these individuals through my own professional networks in the state of Connecticut. This method yielded five initial interviews. I provided each of these participants with recruitment materials that they could distribute among their colleagues that they thought may be qualified and interested in participating, in effect to achieve snowball sampling. I continued this snowball sampling strategy throughout recruitment. Through snowball sampling, six individuals in the final sample contacted me after being referred by someone who had already participated.

The second recruitment strategy took place at the 2016 national conference for the American Association for Marriage and Family Therapy, which I attended. Through professional networking I was able to provide my contact information and advertising materials to several people, who in turn distributed that information among their colleagues. This method yielded seven additional participants. My third and final recruitment strategy involved posting the

advertisement (see Appendix A) to a Facebook group for wellness professionals in Connecticut. This method yielded my three final participants.

My goal was to collect data from at least 20 and up to 30 participants, which is typically the number of interviewees needed to achieve saturation (Creswell, 2012). Data are considered "saturated" when new data spark no fresh theoretical insights or reveals new properties of my core research questions (Charmaz, 2006). Ultimately I collected 21 interviews. At that point my analysis of the data developed no more additional categories or themes; thus, saturation was achieved.

Sample Characteristics

Fifteen of the participants identified as cisgender women (71%), one as a trans woman (.05%), and five as cisgender men (24%). Eighteen participants identified as White (86%). The remaining three (14%) identified as multiracial. Five of the women identified as queer, and the remaining women and men identified as straight. Average age of the participants was 34, with a range of 26 to 55. All participants had earned a Master's degree with specializations in MFT. Two participants (10%) had continued their education to earn a doctorate in MFT and two (10%) were currently enrolled in an MFT doctoral program.

The final sample generally reflects the demographic make-up of the field of marriage and family therapy. The field primarily consists of White people [82.78% of the population (Membership Survey Report, 2012)], most of whom are women [78% of the population (California Board of Behavioral Sciences, 2007)]. Educational levels range from Master's to doctoral degrees, with the 67% of the population having Master's degrees and the remainder having doctoral degrees (Membership Survey Report, 2012). Interestingly, my sample has a

slight overrepresentation of males despite the historical association between feminism and femaleness. This may reflect changing connotations of feminism.

In terms of employment setting, thirteen (62%) of the participants were licensed and practicing in Connecticut, and eight (38%) were licensed and practicing in a variety of other states. Nine (43%) worked in private practice only; five (24%) in a community agency; three (14%) in both a private practice and community agency; and four (19%) in settings that provide medical supervision, such as a partial hospitalization program. Two participants (10%) also worked in an academic setting. These sample characteristics are also generally representative of the MFT population, in which 49% of members work in a private practice, 15% in a community agency, 5% in a medical environment, and 12% in an academic environment (Membership Survey Report, 2012). The current sample has a slight overrepresentation of therapists working in a medical environment. Additionally, therapists working out of Connecticut are largely overrepresented.

Data Collection

All procedures were approved by the IRB at the University of Connecticut prior to any study activities. Individuals who expressed interest in the study were e-mailed a written information sheet that described the study procedures (this sheet also served as the consent form; see Appendix B). Participants were assured that their participation or lack thereof would not be used to evaluate them in any way. Participants were informed of the risks and benefits of participating, and that there was no compensation or cost to them for participating. I informed participants that the interview would take between one and two hours, and that they could stop participation at any time and/or decline to answer particular questions if they wish.

Ten (48%) interviews took place in person and eleven (57%) were conducted over the phone in accordance with preference of the interviewee and feasibility of meeting in person. There were no systematic difference between the in-person and phone interviewees except all of the in-person interviews took place with individuals practicing in Connecticut (though four of the phone interviewees were also from Connecticut). Though there appears to be no evidence to date that demonstrates these methods produce equivalent data (Sedgwick & Spiers, 2015), it is highly advantageous to have phone interviewing as an option because it allows for a geographically dispersed sample. Interviews lasted between 51 and 115 minutes, with an average of 88 minutes.

Interview process. At the beginning of each interview, I reviewed a consent form with each participant and obtained their verbal consent to participation before beginning each interview (see Appendix B). I then read a brief orienting paragraph (see Appendix C) and then invited the participants to ask questions about the interview process. I then confirmed again with each participant that they consented to be audio recorded. All participants agreed to be recorded.

Interview protocol. I used a semi-structured interview guide (Hennink et al., 2011) as a memory aide during the interview process (see Appendix D). For my first five interviews with participants who were personally known to me, I began the interview with questions about feminist identity. However, for subsequent interviews, I realized that I needed to begin the interview by asking background questions about the interviewees' employment setting and history. These closed-ended questions served two purposes. They both facilitated rapport as well as enabled me to tailor my subsequent interview questions. Throughout the entire process of data collection I took a flexible approach and made decisions along the way about which questions were appropriate for the participants. For example, one contextual factor that determined my questions was where the participant was currently working, namely if they were in private

practice or in a community agency. Another factor included their level of education: participants

with a doctoral agree were generally more knowledgeable of feminist theories than participants

with a terminal Master's degree.

Following the opening background questions, each interview was guided by the three

broad themes. The first theme was feminist identity and its expression in professional contexts,

such as "What does feminism mean to you?" and "How do you think being a feminist comes out

in the way you practice therapy?" In order to elicit the theme of professional interactions with

colleagues, I asked questions such as "What's it like to be a feminist therapist where you work?"

The second theme was experiences within managed care, which I began by asking participants

what their understanding of the term "managed care," if they currently or have ever worked

under managed care and what that was like, and how a managed care structure aligns or does not

align with feminist values. I also asked participants if managed care has helped and/or hindered

their practice of therapy and how they manage hindrances. The third theme was experiences

under the DSM system of diagnosis. Among other questions, I asked each participant if and how

they use the DSM in their practice, and how they personally conceptualize client progress, as

well as how their place of employment does so. I asked questions about their workplace

environments, including rules and various protocols (such as required paperwork) to address the

goal of connecting individual experiences with larger structures and contexts.

Throughout each interview, I endeavored to foster a sense of collaboration with the

participants by conducting the interviews in an interactive, dialogic manner (Creswell, 2012). I

also tailored my interview style to the needs of each participant with a variety of prompts (Ivey,

Ivey, Zalaquett, & Quirk, 2007). These include attending prompts (e.g., expressing interest and

respectful silence), tracking prompts (e.g., restating key words), and active listening prompts (e.g., paraphrasing and synthesizing).

After covering the main research themes through the interview questions, I then gathered common demographic descriptors from the participants, such as age, gender identity, religious affiliation, nationality, race, ethnicity, sexual orientation, and annual income (as an indicator of socioeconomic status). I also gathered information relevant to their professional history, such as states where licensed, if this information had not been discussed during the interview (see Appendix E for a list of the demographic questions).

After acquiring demographic information, I ended each interview by asking as set of closing questions (Hennink et al., 2011; see Appendix D). First I asked participants if there was anything else they'd like to tell me about their experiences as a feminist therapist that we had not covered. I asked this question to allow for the participants to discuss any topics that the semi-structured, rather than unstructured, nature of the interview had precluded. I then asked the participants how the interview was for them and if they have any suggestions for me for when I conduct future interviews. I asked these questions to further engage in a feminist research process by which I privileged the standpoints of the participants, not just in their professional lives but also in the interview process (Thomas & Walker, 1994).

Across interviews, I adjusted the interview guide to allow for the revision and reorganization of questions. I also piloted the study with three participants and then re-evaluated the study design. Because I did not significantly modify my interview protocol after the pilot, I chose to include the first interviews in the data analysis process. However, as stated above, I added background questions early on in each interview after I had already conducted five interviews. However, questions were modified and tailored to each interviewee. For example, at

times I reordered or reworded the questions in order to follow the natural flow of the

participant's narrative.

       Data management. I recorded each interview with an Olympus Digital Voice Recorder.

I transcribed the first three interviews verbatim into Microsoft Word documents in order to

evaluate the interview protocol. All subsequent interviews were transcribed by the online

professional transcription service GoTranscript.com, which also provided transcripts in

Microsoft Word documents. I reviewed each transcript to remove any personally identifying

information about participants. I then listened to each audiotape while simultaneously reading

the transcript. I corrected each file for transcription errors. Next I uploaded each transcript into

NVivo for Mac, which is a qualitative analysis software. NVivo enables researchers to highlight,

label, and organize textual data.

Data Analysis

       As the goal of this project is to uncover firsthand experiences of feminist MFTs, I chose

to engage with data analytic techniques that are primarily associated with grounded theory.

Grounded theory is a form of analysis initially developed by Glaser and Strauss (1967) in which

the researcher allows theory to emerge from data through an interpretive yet systematic process

(Charmaz, 2006; Corbin & Strauss, 1998). There are several underlying principles of grounded

theory that influence the data analytic process. For this project, data analysis occurred in a

circular process whereby tasks overlapped, repeated, or were conducted simultaneously (Rubin

& Rubin, 2005). This included data analysis occurring during the data collection process.

Beginning after the third interview and through the final interview, I engaged in coding, which

means attaching labels to segments of data to indicate the researcher's understanding of what that

segment is about (Charmaz, 2006). Additionally, I used the technique of making constant

comparisons throughout the analysis process to define and refine concepts (Corbin & Strauss, 1998). This involved comparing data against data to find both similarities and comparisons.

Throughout each stage of the data collection and analysis process, I wrote memos to capture in detail my thoughts, interpretations, and decision-making (Charmaz, 2006; Saldaña, 2016). Through memos, I kept track of my evolving impressions of the data and codes, and how they were both informing and being informed by the research process (Birks, Chapman, & Francis, 2008). My goal through writing memos was also to spur theoretical thinking by making connections and hypotheses between codes and categories (Saldaña, 2016).

Preliminary analysis. I began the analytic process after having conducted and transcribed the first three interviews. Using NVivo, first I conducted initial coding of the participants' responses. Code chunks ranged from large (whole paragraphs) to small (individual words or phrases). Consistent with a grounded theory analytical process, these codes were provisional (Charmaz, 2006). I then proceeded with data collection, while simultaneously continuing the initial coding process of incoming cases. I engaged in a recursive process of creating new codes with new data, and then going back to previous cases to add or modify codes.

Focused coding. Following the completion of data collection and the initial coding phase, I then entered the second major phase in coding: focused coding. This involved synthesizing and explaining segments of data after having arrived at several strong analytic directions (Charmaz, 2006). Using NVivo, I created additional codes to designate general themes and aggregated the initial codes into these themes. At this point in the analysis process, I recognized that there were several potential ways to organize and group the initial codes. As described above, I kept memos to record my decision-making process. These themes and their sub-themes are described in further detail in the Results chapter.

Theoretical coding. After having grouped initial codes into focused codes (i.e., thematic codes), I began the process of writing rich descriptions of the codes, finding representative quotations in the data, and closely examining contextual factors that influenced the phenomena represented in the quotations (Hennink et al., 2011). The analytic process of description enabled me to continue to theoretical coding, in which I began to understand and note possible relationships between the focused codes (Charmaz, 2006). Theoretical codes are also described in the Results chapter.

Presentation of findings. The study findings are presented as short embedded quotations, standalone paragraph-length quotations that I have italicized, synopses of individual narratives, and my summaries of responses across individuals. I chose not to uniformly report frequency counts of codes or themes in accordance with Saldaña's (2016) assertion that "frequency of occurrence is not necessarily an indicator of significance" (p. 41) and that code *quality* over quantity is more reflective of underlying theory (p. 253; emphasis in original). Throughout the results section there are a few instances in which I do report frequency of codes if it is relevant to the theme I am describing. I also use the terms "many," "some," and "a few" to provide a general sense of coding frequency. However, codes that appear more often are not necessarily meant to hold greater meaning or significance than those that appear less often.

Reflexivity

It is a hallmark of contemporary qualitative methodologies for the researcher to critically examine their own identities and influence in relation to the work. This is the process of *reflexivity,* which involves calling attention to questions of context and meaning within which actions take place, such as the positionality of the researcher (Hopf, Kratochwil, & Lebow, 2001). Charmaz (2001a) notes that "what observers see and hear depends upon their prior

interpretative frames, biographies, and interests as well as the research context, their

relationships with research participants, and modes of generating and recording data" (p. 637). It

is important for the researcher to recognize when their own biases, assumptions, and beliefs are

intruding into the research process so as to address these biases and gain a richer level of analysis

(Strauss & Corbin, 1998). For this project, this involves reflecting on the impact on the project

that I, with my multiple identities, and other contextual factors may have on the project. As the

leader of this research endeavor, I incorporated reflexivity into each stage of the research

process. Throughout data collection and analysis, I kept a journal of my own personal

experiences as the researcher. Journal entries included notes regarding my reactions during and

in between interviews, as well as how I perceived the participants' reactions to the interviews.

Through journaling I was able to continuously reflect on how my positionality influenced the

work (Corbin & Strauss, 2015), with particular attention to "insider" versus "outsider" status.

   Negotiating "insider" and "outsider" status. "Insider" versus "outsider" status

connotes the level of similarity or difference, respectively, that the researcher has with the

research participants at any given moment in the research process (Hesse-Biber, 2017; Naples,

2003). Having insider status can assist with gaining access to a population, which applied to this

research project. I knew during the study design phase that I would be able to achieve access to

recruitment sites for feminist MFTs because I am also a member of this population. Despite my

insider access to this population, through reflexivity I recognized arenas in which I perceived

myself as having outsider status, particularly in relation to power differentials between the

participants and myself.

   As a feminist researcher, I strive to be attuned to power differentials in social

interactions. Prior to data collection, I recognized that my social position affords me substantial

power that has the potential to influence participants' responses. I am a White, middle-class, cisgender woman with two Master's degrees enrolled in a doctoral program. I experience many privileges because of the intersections of my identities, particularly my race, social class, and education. My academic degrees provide me with credibility, and I have access to educational resources and individuals who are capable of making societal changes. My identity and access to resources may have given me power in relation to interviewees depending on their social locations. However, a majority of the participants fell into similar demographic categories as myself. For those who did not (particularly three individuals who are racial minorities), I strove to take a "one-down" approach (i.e., humble and curious; Fisch et al., 1975), particularly when discussing matters of racial identity.

Another salient feature of my identity that I frequently wrote in my journal was my perceived status as an expert on feminism. As I was known to the participants as a doctoral student researching feminist therapy, I found that some participants (particularly those with a Master's degree as opposed to doctoral degree) expected me to know the "right" way to be a feminist or the "correct" way of incorporating feminist principles into therapeutic work. Upon becoming attuned to this dynamic, I would make clear to the participants that I was interested in *their* ways of being and doing feminism, rather than a standard or academic way.

Most commonly, I perceived myself to have outsider status when I discussed the participants' work environments and how their feminist values were connected to mental healthcare structures. Even though I am also a practicing MFT, I have experience with only one type of workplace organization: a small community agency in a rural region of Connecticut. Through the interview process I quickly recognized my outsider status with participants who work in private practice, hospitals, residential facilities, large agencies, and agencies in urban

areas. Furthermore, I work as a therapist part-time whereas all but one of the participants are full-time clinicians. I found that being an outsider while discussing these environments and workloads led me to ask questions that I may otherwise have taken for granted.

Confidentiality and Protection of Participant Information

Every effort was made to ensure participant confidentiality, such as de-identifying the data (i.e., using case codes in place of participant names to identify recordings) and storing data on a password-protected external hard drive. Additionally, verbal rather than written consent was obtained in order to reduce chances of loss of confidentiality. In this dissertation and other research documents, I assigned pseudonyms to each participant.

Summary

The research questions that this project investigates – namely, how feminist therapists enact feminist values in relation to individuals, systems, and structures beyond the therapy room – are best answered by a qualitative methodological framework. In particular, semi-structured qualitative interviews that both respond to previous literature on these topics as well as create space for novel data and theory are the most suitable data collection method. A primary strength of this project is the sample, which is reflective of the demographics of the field of marriage and family therapy. Overall, the research design, data collection, and analytic choices of this project reveal the central phenomena of interest, while also integrating a feminist approach theoretically and methodologically.

CHAPTER 4: RESULTS

Previous literature on feminist family therapy primarily consists of critiques of established therapy models and how feminist therapists can conduct clinical interventions in a feminist manner. Despite the important theoretical and practical contributions of prior feminist thinkers in MFT, little research has examined feminist values and actions external to the therapist/client system. The present study aimed to explore ways of being a feminist therapist in various environments from the perspective of individual feminist therapists. The qualitative methodology of this project speaks to previous work by addressing self-reported ways of being a feminist therapist through clinical interventions, while also allowing new data to emerge on feminist ways of being outside of the therapy room. While prior research has shown that this population is concerned with power dynamics within family systems and within the therapist/client system, the current research went beyond those arenas and revealed how feminist MFTs engage with their colleagues and with the broader mental healthcare system. The theoretical foundation of this project is interdisciplinary, drawing from systems theory, feminist studies, and medical sociology.

To address the research questions regarding the values and practices of feminist MFTs, I collected data through semi-structured qualitative interviews with 21 members of this population. Following transcription of the audio files of the interviews, I then analyzed the textual data using techniques associated with grounded theory (Glaser & Strauss, 1967). Specific interventions reported in previous literature include analyses of gender roles and power relations within families, within the therapist/client system, and between the client and their sociocultural context (Hill & Ballou, 2010; Silverstein & Goodrich, 2003). These were behaviors frequently reported throughout each interview of the current study. Participants were conversant in the common

interventions of this approach, which indicates some degree of consistency and validity of the

term "feminist therapist." In addition to these feminist clinical interventions, previous work has

illustrated that feminism is a sensibility or lens that feminist therapists apply uniformly across all

situations (Leupnitz, 2002). The findings that I report below are an initial step toward

understanding ways of being a feminist therapist that addresses how feminism as a sensibility is

operationalized in contexts beyond clinical interactions with clients. Due to the semi-structured

nature of the data collection method, themes that emerged were guided by the interview

questions. These questions were designed to elicit feminist values and beliefs "outside of the

therapy room." Themes that emerged through the data analysis process included the following:

(1) feminism at the micro level with colleagues, and (2) feminism at the macro level in relation

to managed care and diagnosis. Each of the themes is described in detail below with

representative quotations.

Feminist values and practices with colleagues

Most of the feminist therapists that I interviewed are employed at work sites with other

mental healthcare providers. Examples of such sites include group private practices, community

agencies, intensive-outpatient facilities, and hospitals. Participants discussed in great detail how

they engaged with their colleagues within their particular organizations. This included aspects of

power that speak to their relationships with colleagues and within the broader mental healthcare

system. I define *power* similarly to how Bischof, Lieser, Taratuta, and Fox (2004) defined this

term in their study of power and gender issues for medical family therapists in a hospital

environment: "having to do with one's place in the hierarchy, the ability to exert influence in

decision-making and economic considerations, and how much accommodation was required to

be included in the system" (p. 27). I chose this understanding of power because it speaks to a

professional context and has been applied to a population of therapists. Furthermore, the concept

of assessing and restructuring power relations is one of the core tenets of feminism in general

(Osmond & Thorne, 1993) and feminist therapy in particular (Worell & Remer, 2003). The

respondents in the current study expressed awareness of their position of power at work, and how

they regulated their feminist ways of being according to their perceived place within the

hierarchy. Perceived power, or lack thereof, derived from many places, including the

respondents' age and gender, educational attainment, seniority at their workplace, and

education/profession. Next I will present thematic codes that I derived from these data

concerning power and hierarchy in the workplace.

Overt relational activism. In cases where participants perceived themselves to be on the same

level or above their colleagues in terms of power, they described various strategies to

demonstrate or share their feminism. These interactions represented *overt relational activism*,

which I define as *using relational tools when in a perceived position of power*. I adapted this

construct from a previously developed understanding of *relational activism*, which calls attention

to the way that "relationship-building work contributes to conventional activism and constitutes

activism in and of itself" (O'Shaughnessy & Kennedy, 2010, p. 551). The concept that I am

originating in this paper is the addition of an overt or covert element to relational activism that is

dependent on the power differential between the feminist activist and the person or group with

whom they are interacting. In the context of this study, the goal that the participants frequently

expressed was to share or propagate their feminist values in professional therapeutic practice.

Kendra[2], a 28-year-old multiracial woman employed as an in-home therapist, expressed

an example of overt relational activism in answer to my question of how her feminism appears in

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[2] Participants' real names have been replaced with pseudonyms to provide confidentiality.

her work (outside of interactions with clients). She said, "Really uniting with my colleagues, since a lot of my colleagues are women. Teaching them about that, like let's not hate women or ever say those type of things." She went on to describe how she intentionally discusses feminist issues in the news with her colleagues, as well as feminist issues that are important to her such as critiquing stereotypes about motherhood. Several other therapists also described taking a didactic or mentorship role with colleagues, at times in their role as a clinical supervisor.

Other participants in the sample used their power in relation to their colleagues to assist them economically or professionally. Julie, a 27-year-old clinician/manager at an intensive outpatient program (IOP) told me how she has been working very hard for months to increase the pay of the all-female staff at the organization. Joanna, a 39-year-old White woman running a group private practice, decided to create a feminist, woman-only business. She said that when she started her business, she thought:

> I think women in general, covertly, without saying it, think, "I can't own my own business, I can't make the same money as a man can make, I can't support myself, I can't have--." Right away I wanted to pull in two women to share this [business] with me.

The above experiences shed light on how feminist therapists seek to address inequalities in their workplaces, often through interactions with their colleagues and even the economic systems at their organizations. In each case, the participant perceived herself to be in a position of relative power and used that position to advance feminist values and goals.

Covert relational activism. What became difficult for many participants was knowing how to navigate their feminist identity in situations where they perceived themselves to have less power than their colleagues. These situations often consisted of *covert relational activism*, which I define as *using relational tools when in a perceived lower position of power*. Again, in this study the participants described their goals as propagating feminist-informed therapeutic care. Carrie, a

29-year-old White woman who was relatively new to her place of employment at an IOP,

described subtly trying to teach her colleagues about a feminist approach to therapy. She said:

> *Sometimes I'll try to, when we're in consultation, I will try to throw in questions that I feel*
> *are narrative or feminist-informed that I think the therapist could benefit from but it's not*
> *like I'm explicitly saying, "This is a feminist question, you should use it."*

This code frequently occurred for participants who work in medical settings. They noted

the delicacy of deferring to the authority of medical professionals because of those professionals'

relative power and privilege, while also trying to create feminist-informed, systemic change.

Brian, a 31-year-old White male working in an integrated care setting at a hospital, spoke of the

power differential between medical doctors and mental health providers:

> *I found that directly challenging it is not really allowed, hasn't really resulted in many*
> *benefits, and so working within it and then trying to encourage change I have found to be*
> *beneficial, because it is similar to anything really, once you have a relationship with*
> *someone and then you challenge them, it goes a lot better.*

These feminist therapists attended to power hierarchies and adjusted their mode of interacting

with others as a strategy to advance their feminist values within their work sites. As Brian

described above, this labor at times consists of suppressing an initial urge to challenge the system

in order to align with the climate of the organization. Next I turn to another realm for

examinations of power and mode of engagement: feminist therapists' interactions with the

mental healthcare structures in which they are professionally embedded.

Feminists Navigating Mental Healthcare Structures

Whereas most literature on feminist therapy focuses on therapeutic processes between the

clinician and client, little is known about how feminist therapists enact their values outside of the

therapy room. In the previous theme, I described how feminist MFTs express their feminist

identity in relation to their colleagues, which is dependent on a number of contextual factors

including social position in a power hierarchy. Next I will turn to how feminist MFTs engage

with broad structures in the mental healthcare system. The findings presented below demonstrate

that feminist therapists are concerned with pathways by which clients can access mental

healthcare. As a core value of feminism is to restructure power relations so as to achieve justice

for marginalized populations (Osmond & Thorne, 1993), intersectional feminists are aware of

economic disparities and seek to improve access to healthcare for the economically

disadvantaged. Furthermore, feminists are concerned that healthcare is high-quality, meaning

that it is appropriate for the clients' needs. First, this section explores how feminist therapists

conceptualize and engage with one of the key contextual, structures factors in mental healthcare

that is meant to provide access to high-quality care: managed care. Second, I will describe how

feminist therapists navigate diagnosis, which is interlinked with managed care.

Understanding and navigating managed care. "Managed care" is an umbrella term to

describe many different kinds of payment systems, particularly insurance, in which therapists

work. Because the term encompasses many types of structures that vary according to workplace

environment, in each interview I asked participants what their understanding of the term

"managed care" is. The following categories emerged from participant's responses regarding

impressions of managed care: (a) insurance control and (b) fighting for insurance. Both are

framed in terms of one of the core feminist values that emerged: providing access to high-quality

care.

Insurance control. One of the core values of feminist therapists is to create pathways to

high-quality treatment for clients, particularly those with complex mental healthcare needs. I

began the portion of the interview that was focused on managed care simply by asking

participants what their understanding of that term is. Many of the participants' responses

reflected their experience that their ability to provide access to high-quality treatment is regularly

impinged upon by the requirements of MCOs, such as billing and treatment documentation requirements. To capture this experience, I created the thematic code *insurance control.* One common example of *insurance control* is time limits on therapy sessions. For example, Jenny, a 27-year-old White woman working in a community agency, responded to my question about what "managed care" means, she said, "The insurance companies control what kind of care you're getting." When I asked Jenny to elaborate, she stated:

> *Because insurance companies decide how long appointments are. You can't have anything longer than 52 minutes unless it's pre-approved, which makes no sense because if someone is in crisis, how can you pre-approve that?... It makes me very upset because insurance companies have no idea about mental health. They don't know their particular registered insured person. They don't know what they're going through. They don't know what they need, but they're deciding how long they're getting what they're getting.*

Jenny's experience highlights the binds that therapists are often put in by insurance companies in which operational procedures conflict with the therapist's clinical judgment of the clients' needs.

The quotation from Jenny above also reflects the emotional cost of feeling constrained by the structures of managed care. When I asked Wendy, a 38-year-old White woman working in a partial hospitalization program (PHP), what "managed care" means to her, she stated:

> *Treatment through a medical lens, and insurance, insurance, insurance. And when I hear "managed care" immediately what else comes up for me is "time-sensitive" and... it's like when you have a bunch of meat that's going across the conveyor belt... And they're getting stamped, and they're moving on to the next thing."*

For Wendy, managed care also evokes the limits on time that was a core feature of Jenny's response. Her response also notes that managed care also necessarily involves treatment from a medical lens. Her graphic metaphor about meat on a conveyor belt evokes standardization of care, dehumanization of clients, and callousness by treatment providers.

Several respondents seemed to echo Wendy's thought that managed care impacts how providers view clients. For example, another therapists reported another type of *insurance*

control in which they felt pressured to emphasize clients' problems in order to make sure they

qualify for care. Patrick, a 32-year-old White male in private practice, noted:

> *One of the things that I don't especially like is that there's a pressure that to get your services approved, you need to make your clients sound as bad as possible so they won't be denied services. That is something that makes me uncomfortable as a person which also I believe it's partly being uncomfortable as feminist. I think it's demeaning to people. Just make them sound as bad as possible so they can get services. Especially because some of these things stick with them for a long time.*

Though Patrick's statement is based on his experience in private practice, I noted

throughout my data collection that there is a stark contrast between perceptions of *insurance*

control in organizations, such as community agencies or hospitals, versus private practice. A few

private practitioners reported no conflicts with MCOs, or little to no levels of *insurance control*.

Michael, a 31-year-old White male, stated, "Most of my interactions with the insurance

companies, for the clients that have insurance, have been very, very good and very supportive."

Indeed, many of the private practitioners in the sample described the advantages of private

practice over agency work in terms of escaping from managed care. When I asked Ashley, a 31-

year-old White woman with a private practice if she works under managed care, she responded:

> *Yes. I do and I don't though. It's very different. I have to follow the guidelines of the insurance companies but would they ever invest time and money on me to really audit and go through my records? It's highly unlikely. My records do need to fall into line in case that happened but it's very unlikely. When I was doing agency work everything has to be to the teeth. You are constantly being hounded if your documentation is falling into line and are you doing things according to the medical model? I do really know both extremes.*

Here, Ashley explicitly associates managed care with the medical model. She also notes

that insurance companies exert extreme control over required documentation. However, Ashley

only felt burdened when she was previously employed at a community agency. As a private

practitioner, even though she does take insurance, she does not fully consider her current

situation to fall under managed care. Ashley's point of view illustrates how medicalization and control appear to be the defining features of managed care.

Despite the relative ease of being a private practitioner, at times the data revealed subtle forms of *insurance control* for this population. For example, when I asked Stephanie, a 28-year-old Hispanic White woman how her private therapy practice fits with a managed care model, she said, "I could really care less about the managed care model. I tell them whatever they want to hear. I don't care. Right? And then I just do what I want to do." Stephanie indicates she is comfortable working under managed care. However, she also reveals that she has learned to balance the demands of managed care with her clinical judgment by overtly, via the paperwork she submits to insurance companies, following the insurance company's rules. Her response indicates that private practice provides more space to literally practice privately, but therapists still present a public persona of compliance. Similarly to how feminist clinician in medicalized settings engage in covert relational activism, feminist clinicians in private practice must also act covertly in accordance with their values.

A sense of *insurance control* also varied within the sub-sample of private practitioners. Although Ashley reported very little concern about the possibility of an audit, the respondent in my sample who had been working the longest was currently in the process of being audited at the time of our interview. Barbara, a 57-year-old White woman who has been practicing for 25 years, told me that she was feeling conflicted about a decision she was currently weighing – whether or not to stop taking insurance altogether:

> *I'm not 100% sure I am because it's very nice for those clients to be able to come in and say, "Here's five dollars. Here's 10 dollars," but it's because of this audit. It's because they seem to have more right to ask for progress notes which I feel like that's really, should be illegal… It's not ethical, to me.*

Here, another form of *insurance control* is represented by a potential loss to clients' confidentiality. Barbara also stated that she thinks the audit is an "intimidation practice" that the insurance company was deliberately using to dissuade clients from using their insurance. Barbara's response further reveals the difficulty of satisfying two feminist values at once – providing access to affordable treatment while also protecting clients' privacy – while under managed care. Barbara then went on to strongly recommend to me that in my future career I keep two separate sets of case notes: one that is for the insurance company that contains no private information, and one strictly for myself to help with case conceptualizations. Her advice, much like Stephanie's public appearance of compliance, illustrates that feminist therapists devise various strategies to reconcile their values with the constraints that managed care often entails.

All but three of the therapists in the sample reported that they currently work in some form under managed care. Of those three, one was currently employed by a grant-funded agency providing in-home therapy. The other two exceptions had previously accepted insurance while working in private practice, but had stopped. Pamela, a 43-year-old White woman, described how she made the decision to not take insurance because of low reimbursement rates and burdensome paperwork requirements. However, she described how leaving managed care created a new dilemma for her:

> *On the one hand, as a feminist, I feel like my values are, do everything possible to increase people's access for poor people, working class people, and even middle class people... I really want to, for them I want to increase access, and to make my skills as an increasingly senior clinician available to people... Yet, it's still really complicated for me as a feminist, because I know that there are still tons of people who would be well-served by me who can't afford my services. Can't even necessarily afford my intern's services. I know that that is a piece of oppression that I perpetuate.*

Here Pamela considers that fact that she does *not* participate in managed care as perpetuating oppression.

The cases above reflect a trend that emerged from the data of a common developmental trajectory for professional therapists. Due to licensing requirements in most states, many therapists who newly graduated typically find employment in community agencies where clients are more likely to be on state assistance. They experience a form of managed care with high level of control. Overwhelmed and over-burdened by that control, many leave that environment to start private practices. Relatively free from control, it appears that many therapists at this stage thrive in their profession, despite subtler forms of insurance control. Finally, after many years of taking insurance, some private practitioners ultimately leave managed care altogether. As Pamela said:

> *There's this whole split in our system where the most needy, most complicated, most vulnerable people get services from, generally, the least well-trained folks, because they're being seen by even pre-graduation trainees with the least amounts of experience, but that's who will work for free at the community center.*

There appears to be an inverse relationship between insurance control and therapist satisfaction. As client level of need rises, so does insurance control. Increased insurance control leads to therapist burnout in environments like community agencies, compelling them to go into private practice where they are less likely to see clients with complex problems, such as multiple mental health disorders, alongside socioeconomic and cultural barriers to much-needed care.

Thus far I have shown how participating in managed care can lead feminist therapists to experience conflicts in their values because it impinges on clinical judgment and standards for quality of care. On the other hand, the responses reveal that managed care can facilitate the feminist value of access to care, as it creates connections between therapists and clients. Below will elaborate on this latter feature of managed care.

Fighting for insurance. Though *insurance control* and its corresponding structural systems was a prominent theme throughout the interviews, another theme that emerged was the

perceived benefits of managed care. Though these two themes may appear to be mutually exclusive, they reveal the nuanced nature of the data and the participants' stance toward managed care. Therapists in this sample widely acknowledged that insurance leads to increased access to care for clients, particularly low-income clients. Medicaid and various other state-subsidized insurance programs were praised for providing abundant access to outpatient therapy for clients living below an income threshold. Insurance was also acknowledged to be essential for sub-populations of clients. The theme *fighting for insurance* reveals a layer of the participants' attitude toward the managed care system. For example, Rebecca, a private practitioner who frequently serves transgender clients, spoke about the necessity of insurance to pay for her clients' mental and biomedical healthcare needs. She said:

> *I'm really good at just working with insurance companies to get things covered and I know all the questions to ask them and I know how to talk to a supervisor and I know how to push authorizations and stuff like that, and I give those skills to my clients.*

For Rebecca and her clients, navigating the managed care landscape is difficult. It requires copious amounts time and energy to wade through a bureaucratic structure that requires extensive proof of medical necessity in order to provide healthcare coverage, particularly for individuals with transgender identities which is an extremely marginalized population. Despite the difficulty, navigating this landscape is an invaluable and necessary skill. Participants recognized that while managed care is flawed, abandoning it is not an option because of the benefits that it provides to individual clients.

In addition to improving access for individual clients, managed care was also reported to provide economic viability for businesses that offer mental health services. Several participants told stories in which they had previously worked at non-profit agencies that did not participate in managed care, but that those organizations were under-resourced or unsustainable. These

observations reflected how, despite being against managed care philosophically, such structures

provide practical benefits. When I asked Karen, a White woman in an integrated care setting to

discuss what it's like to be a feminist in that setting, she said:

> *It's hard to just say dichotomously it's harder or not harder because it all depends on how you want to slice the pie. In a non-profit everything might be, 'Kumbaya, total access for everyone,' and guess what? We ran out of [medication] a week and a half in because we don't have any funding. Well, for that week and a half things were awesome, [clients] got everything they needed, blah blah blah, but we ran out of money.*

Karen and one other participant comprised a small sub-sample of medical family

therapists (MedFTs). Medical family therapy is an offshoot of marriage and family therapy

(Hodgson, Lamson, Mendenhall, & Crane, 2014). With the goal of integrating behavioral health

into biomedical healthcare settings, MedFTs strive to understand the language, logic, values, and

goals inherent in the medical model (Hodgson et al., 2014). Rather than resisting the tide of

medicalization, MedFTs seek to effectively and strategically collaborate within the biomedical

framework (Trudeau-Hern, Mendenhall, & Wong, 2014).

Both MedFTs in the sample shared how they and others in their subfield are engaged in

political advocacy to further establish MFT in integrated healthcare settings. Though it appears

that managed care does limit many of the participants' ability to assist clients (described under

insurance control above), being excluded from managed care systems entirely is clearly an even

greater barrier to clients' access to high-quality care. As Julie, a 27-year-old clinician/manager at

an IOP stated:

> *It is challenging because in many respects we are a business, so we need to run as such, but we are a business that is meant to provide services to help people. I think something that I find myself really stuck between a rock and a hard place is that client care is most important to me. However, being able to stay in a program is also important as well. Because if we can't have the program, then we can't have client care.*

Based on both themes above, *insurance control* and *fighting for insurance*, it appears that the managed care system can be either a tool for feminist values, or a tool for oppression – and sometimes both, simultaneously. As Karen succinctly put, "It's almost like in every way the context can constrain or facilitate a feminist movement depending on what angle you look at it." These findings speak to the difficult "between a rock and a hard place" positionality of feminist therapists embedded in managed care structures. Next I will present findings on a topic that overlaps with managed care: diagnosis.

Understanding and navigating diagnosis. The dominant system of classifying mental disorders in the U.S. is represented by the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5; American Psychiatric Association, 2013; "DSM" refers to the system of diagnosis described in the manual). Despite its original clinical function, the DSM has gradually become a tool that upholds managed care. The following section explores how participants described the use of the DSM and diagnosis in their practice. Analyses of the data revealed two themes throughout the participants' responses: (a) critiquing diagnosis and (b) access to resources. Throughout this section I will connect these themes to feminist values.

Critiquing diagnosis. Most organizations require a DSM diagnosis in order to reimburse clinicians for their services (Erikson & Kress, 2006). Many participants in the current study expressed that the primary function of the DSM is to provide codes to acquire insurance reimbursement. When I asked Lisa, a 45-year-old White woman, how she uses the DSM, she said, "I do use it because I have to give a diagnosis. For insurance purposes. There has to be a diagnosis." Lisa's statement that she "has to" use the DSM was echoed by nearly every participant. Though most participants appeared to accept the requirement of providing a diagnosis in order for clients to use their insurance, many participants described feeling

uncomfortable using the system. Common critiques of the DSM-based diagnoses presented by

the participants reflect feminist arguments previously presented in the literature, such as the

DSM being individually-based, pathologizing, and oppressive to women and other minorities

(Allen & White, 1998; Eriksen & Kress, 2004; Stoppard, 1999).

In addition to critiques of the diagnoses themselves, another theme that emerged from the

data was critiques of the DSM as an administrative tool. For example, several therapists noted

that clients can accumulate dozens of (sometimes inaccurate) diagnoses in their medical records

over time. Brian, a 31-year-old White male working in an integrated care setting, told me about a

client he had recently been assigned with 35 diagnoses already on their chart. He said:

> *What we have is a system where you have a whole chart and you see all these things, and
> you say, this person – you almost lose hope, honestly, when you see somebody with a
> chart with that many things on it.*

Therapists were particularly concerned with clients, especially children, being permanently

labeled with a potentially stigmatizing diagnosis. Diagnoses "follow" clients throughout their

lives once they have been submitted to an insurance company, even years after clients have made

a full recovery. These complaints are not about the underlying philosophical underpinnings of

the diagnoses. Rather, they are critiques of the DSM as a tool within the managed care system.

Diagnosis and access to resources. Above, I noted that a common descriptor of the DSM

is that it provides reimbursement codes so that providers can bill insurance companies for their

services. A construct has to be in the DSM in order for it to be "reimbursable." This means that

only disorders that appear in the diagnostic codebook can be formally submitted to an insurance

company in order for that company to pay the clinician for the service they provided to the client.

In this way, the DSM provides clients under managed care with some degree of access to

affordable care. Therapists also benefit by getting paid, to some extent, for their services.

In addition to financial reimbursement, the data revealed that diagnostic codes in some settings also facilitate more comprehensive healthcare treatment. Again, the two MedFTs in the sample had a unique and broad view of how the DSM fits into the mental healthcare landscape. They noted that making mental treatment available to people in a healthcare setting is an uphill battle, and part of that is persuading medical doctors to diagnose mental health problems at all. Karen stated:

> *My big fight right now is to introduce, for physicians to actually be diagnosing mental health. So right now it just goes undiagnosed. Right now more times than I'm comfortable with it goes undiagnosed and untreated... My goal is to bring them full circle, to have them actually acknowledge the DSM.*

In order for mental health problems to be treated, the problems must be diagnosed. In this way, the DSM is an essential tool for access to care. Rebecca recognized this link and argued:

> *It's particularly important with my transgender clients, since so many of their needs are often being met by the medical system, we have to be able to speak that language and diagnose and, in fact, giving them a diagnosis or confirming a diagnosis, actually, can be very helpful in getting access to the care that they need.*

Some clinicians in the sample, recognizing that a diagnosis leads to access to care, argued for more diagnoses. One participant described efforts to create a code for suicide ideation specifically, rather than putting it under the umbrella of depression. Another participant recognized a need for more precise diagnoses of eating disorders. Therapists also recognized that diagnoses enable collaboration with other providers, especially psychiatrists, and that diagnoses are often the gateway to services in schools for children. These arguments for more diagnoses, which coincide with arguments against the underlying philosophy of the DSM, again reflect the nuanced nature of feminist therapists' stance toward the construct of diagnosis.

Despite the necessity of using the DSM to diagnose so that clients have care, another theme that emerged is exactly the opposite: sometimes the diagnostic system is used to deny

clients access to care. If the criteria for a diagnosis are not met, or criteria for a "wrong"

diagnosis are met, then managed care can deny services. One particularly striking example was

related by Hannah, a 29-year-old White woman who had recently left a community agency. She

described how in her state, Medicaid only reimbursed for mental health services if clients had

what was literally called an "access to care" diagnosis. There were only five of these diagnoses

and they represented severe impairment, such as a psychotic disorder or major depressive

disorder. Hannah said:

> *It forced us, especially those of us doing intake - it's a really weird ethical grey area,*
> *because people were coming in saying, "I want services, but I'm experiencing anxiety,"*
> *and then I would be forced into the position of saying, "Okay, well, either I could turn*
> *you away, because I don't want to give you a diagnosis you don't have, or I just fudge a*
> *diagnosis that you really don't have just so you can get services." I never fudged*
> *diagnoses; I might ask different questions to see if I could elicit more detailed responses*
> *that might identify a diagnosis that qualified them, but that felt really unfair.*

Hannah's experience illustrates the tension between feminist values of privileging the client's

construction of reality rather than relabeling it in a reductive manner (Brown, 2009), and

providing access to care. I heard many stories of this tension, and there was a wide range of

opinions regarding "fudging" diagnoses. Some therapists were entirely against this diagnostic

practice, and others felt no qualms about it. For Hannah, the strategy to adapt her questions so

that she elicited qualifying symptoms fell into a "weird ethical gray area." Her strategy of

finagling the intake questions to elicit an "access to care" diagnosis, in spite of her discomfort,

illustrates how therapists can be both empowered to assist clients while simultaneously

disempowered from fulfilling an aspect of their feminist values. I discuss this dynamic further

below.

   The greater goal. Thus far I have described the nuanced and seemingly contradictory

attitudes toward managed care and diagnosis that the participants hold. While engaging with

insurance systems appears to constrain and control feminist therapists, particularly those working in community agencies or hospital settings, the same systems also facilitate feminist values and practices. Similarly, diagnosis as a construct can be both limiting and enabling. While recognizing the ambivalence that the participants experience when confronted by these structures, the data also revealed an overarching motivation to maximize positive outcomes both for themselves and for their clients. Ultimately I came to label the concept for such gray areas that feminist therapists confront under managed care, which I call *the greater goal*. I found the name for this concept from my interview with Karen:

> *It's all for this greater goal of working within systems that reimburse the good work that you do behind a closed door. And sometimes you have to do things that make you uncomfortable in order to get that outcome.*

Though participants often described "having to" engage in behaviors that made them uncomfortable, I found that in nearly all situations, participants described creating immediate pathways to treatment while also being paid for their work as their ultimate goal.

Summary

Through careful analysis of the qualitative data, I arrived at several themes that speak to the labor that feminist therapists engage in while embedded in professional contexts. At the micro-organizational level, feminist therapists regularly describe engaging in labor characterized by recognizing power differentials with colleagues and regulating their expression of feminist values. In particular, feminist therapists who perceive themselves to be less powerful than their colleagues, which depended on social location and workplace environment, described employing a strategy that I call covert relational activism. This strategy enables them to enact and propagate their feminist values but with careful consideration for power relations. While engaging with broader, macro systems such as managed care, feminist therapists also engage in various types of

strategies to fulfill their feminist values. These strategies are steeped in a context of increasing

medicalization of mental healthcare. The participants' narratives reflect the process of

ambivalent medicalization, which involves a simultaneous empowerment and disempowerment

that varies by context and in relation to the demands and policies of entrenched mental

healthcare structures.

CHAPTER 5: DISCUSSION

The overarching purpose of this study was to contribute to the body of literature on

feminist values and practices in the context of therapy. While previous findings tend to

investigate microinteractions between therapists and their clients, the current research goes

beyond that subsystem to show how therapists engage with their colleagues and with broad

mental healthcare structures. By using an interdisciplinary approach that draws from feminist

studies, family systems theory, and medical sociology, I investigated processes underlying how

feminist marriage and family therapists employ their feminist values with particular attention to

contextual factors that influence those processes. The study was guided by the following research

themes: (1) how feminist therapists enact their values with colleagues, (2) how feminist

therapists experience their feminist identity, and enact their values, in relation to the managed

care system, and (3) how feminist therapists experience their feminist identity, and enact their

values, in relation to the DSM-oriented system of diagnosis and outcome measurement.

To explore the above themes, I engaged with a qualitative methodological framework

that allowed for the individual standpoints of each research participant to emerge. I collected

data via semi-structured qualitative interviews. This data collection method enabled me to draw

from and support previous findings on these topics while also allowing new concepts to emerge.

I conducted interviews with 21 self-identified feminist marriage and family therapists (MFTs).

The themes that arose from the interviews included overt and covert relational activism,

insurance control, fighting for insurance, critiquing diagnosis, diagnosis leading to access to

resources, and the utmost importance of facilitating high-quality client care. These themes

inform the discussion of the results below. Discussion of the findings is contextualized both in

the literature of feminist family therapy and medical sociology. The chapter concludes with a

discussion of the study's limitations, implications, and suggestions for future research.

Navigating power relations at work. Most of the research participants practice therapy in a

workplace setting with other mental healthcare professionals. These participants were able to

speak to how they enact feminist values in relation to their colleagues. They described being

attentive to power dynamics and devising both overt and covert strategies of relational activism

to extend their beliefs and values regarding feminism to their colleagues. The finding that

participants were attentive to power relations with their colleagues is reflective of prior work in

feminist therapy that illustrated how feminism is a sensibility that this population employs across

all situations with their clients. The current findings show how feminism as a sensibility is also

present in relationships beyond the therapist/client system. Furthermore, one of the hallmarks of

the body of feminist theories is critical attention to power with the intention of equalizing unjust

power dynamics.

Here I turn to the construct of emotional labor to address the work that feminist therapists

engage as part of feminist practice while at their workplaces. I argue that relational activism,

coupled with the decision to employ either a covert or overt style based on context, represents a

subtype of emotional labor. Emotional labor is a concept originally developed by Arlie Russell

Hochschild (1983) to critique women's exploited emotion work in service industries. It is "the

silent work of evoking or suppressing feeling" (Russell Hochschild, 1983, p. 333). A large part

of therapeutic work entails emotional labor throughout interactions with clients. Therapeutic care

work involves regulating facial expression, voice, tone, and body language. There is less

understanding of how therapists conduct emotional labor at the level of the workplace

organization. The current findings reveal how feminist therapists carefully negotiate power

relations at work, which is a type of emotional labor that involves suppressing emotion. Adding a layer of covertness to the enacting or spreading of feminist values is additional labor.

These findings align with previous research that shows that therapists who engage in feminist therapeutic practices are nonetheless hesitant to openly identify as feminist (Dankoski, Penn, Carlson, & Hecker, 1998). What is revealed in the current study is the relevance of complex contextual factors that influence such decisions. For example, therapists in private practice perceived themselves to have more power which directly stemmed from a sense of professional autonomy. Many therapists explicitly addressed the difference between the two types of environments and attributed lack of power as the impetus to starting a private practice. Overall, therapists who work in hierarchically-structured environments, such as community agencies or integrated care clinics, were more frequently in the "one-down" position (i.e., less powerful; Fisch et al., 1975). Even within these environments, perceived power differed according to social location. These findings reveal that self-expressions of feminist identities and values were carefully regulated according to the participants' awareness of their positionality in terms of power at their workplaces.

Access to care as a feminist value. Findings from the current study also reveal that feminist MFTs consider clients' economic situations and strive to facilitate access to high-quality care. The field of marriage and family therapy has increasingly become concerned with making sure that clients, regardless of economic situation or insurance coverage, have access to appropriate therapeutic services. I contend that the focus on access to care is a reflection of a mainstreaming of intersectional feminism but with the focus being on clients' social class and economic standing. This shifting coincides with the rise of the critical social justice lens in multiple realms of healthcare (Anderson et al., 2009). In MFT, there are increasing studies using a social justice

framework while there are decreasing studies using a feminist framework (Seedall, Holtrop, &

Parra-Cardona, 2014). However, Seedall et al. (2014) argue that a social justice framework

encompasses many of the core tenets of feminism. According to Pascale (2007), a social justice

analysis of power highlights how institutions or societal structures perpetuate inequalities in

subtle, overlooked ways (Pascale, 2007). The design and findings of the current study reflect the

overlap between a feminist framework and a social justice framework.

Ambivalent medicalization. The findings from the current study reveal the complex

negotiations that feminist therapists undergo when embedded within structural systems that can

both obstruct and facilitate their values. Results show that the managed care system and its

ancillary system of diagnosis can be either tools for feminist values, or tools for oppression,

depending on the context and how they are used. On one hand they facilitate the feminist value

of providing clients with some degree of care. On the other hand, there are often restrictions on

that care and those restrictions compel clinicians to engage in behaviors that conflict with their

values.

Here I return to the construct of *ambivalent medicalization* as a framework for

understanding these contradictions. Ambivalent medicalization is the sociological concept that

describes how "individuals are both empowered by *and* surrendering to the process of

medicalization" (Mauldin, 2016, p. 4; emphasis in original). Managed care is empowering

because it provides resources and pathways to treatment (exemplified by the theme *fighting for*

insurance). However, managed care is disempowering because it supports the medicalization of

mental health, which is often in contradiction to feminist, systemic values and philosophies of

the participants in this study. Medicalization is supported by the structure of managed care

through restrictions on session length, as well as limits to privacy and burdensome paperwork so

as to justify "medical necessity" for treatment (exemplified by *insurance control*). Insurance

systems serve a gatekeeping function, which both allows and prohibits access to treatment. The

diagnostic process is similar. While Mauldin (2016) is primarily focused on the biomedical

sphere and technological advancements in medicine, I propose that the construct of ambivalent

medicalization is also relevant to feminist mental healthcare providers. In particular, providers

such as feminist MFTs, whose core philosophies are counter to the biomedical model, are a

particularly appropriate population for examining ambivalent medicalization in practice.

Feminist MFTs in this study describe an ambivalence regarding their role in both alleviating and

perpetuating harm toward their clients in their relations with various aspects of the mental

healthcare system, particularly managed care and diagnosis.

The dilemma that feminist MFTs experience is similar to previous discussion in the field

of MFT related to how contextual factors shape families' experiences:

> "Can we really assume a pro-couple, pro-family stance while simultaneously and
>
> tacitly colluding with any number of broader societal forces that create havoc in
>
> families and the individuals that participate in them? Do we direct our attention
>
> and energy to matters of professional survival such as vendorship, licensure, and
>
> so on, or do we concern ourselves with [social justice]?" (Hardy, 2001, p. 19).

While Hardy was referring to social systems such as racism and sexism, his quote is also

applicable to structural systems such as managed care and diagnosis. His questions

highlight the difficult matter of where to place precious resources such as time and

energy. I apply his quote to the dilemma that many of the participants expressed when

they seemed stuck between short-term goals of providing immediate assistance to clients

and long-term goals of critiquing and changing entrenched structures.

Previous research has asked how highly informed feminist therapists are "complicit in using power in a way that [is] oppressive" (Goodwin, Kaestle, & Piercy, 2013, p. 247). Participants in that qualitative study generally viewed complicity in oppression as a passive act, such as not saying anything when they hear others making sexist or racist remarks. The findings of the current study reveal how feminist therapists can be complicit in oppression, but that their complicity is typically an effort to achieve "the greater goal" of providing as much relief as they can at any given moment to their clients. I argue that the dynamics described by the feminist MFTs in the current study revealed their own power as gatekeepers to mental healthcare while also revealing their simultaneous lack of power to provide care that they consider to be of the highest quality - that is to say, feminist.

Implications

Suggestions for practitioners. Feminist therapists with critical awareness of entrenched mental healthcare structures often described feeling immobilized in the face of what appear to be insurmountable barriers. However, there are many ways that MFTs can use their power within the parameters of such structures. With a broad perspective of the mental healthcare system, therapists can begin to make intentional, strategic choices about how their own actions fit into the system beyond what they are already doing. For example, currently the system is arranged such that what gets diagnosed is what gets reimbursed, and what gets reimbursed can easily become synonymous with what matters. Even though relational codes (i.e., V codes in the DSM) are not (currently) reimbursable, one way that feminist MFTs can insist that relational conceptualizations of problems matter is to include them in the diagnosis. In this way, submitting a diagnosis to an MCO can become a tool to propagate systemic, relational thinking that is the

cornerstone of MFT, rather than render it invisible. Similarly, MFTs can include relational goals on treatment plans and measure progress by family functioning or therapeutic alliance rather than individual pathology. Relational perspectives become more powerful when they are written into formalized documents that are read and evaluated by individuals within MCOs.

MFTs can also begin to recognize that ethical dilemmas may sometimes be the tension between their autonomy as clinicians and larger social forces at play. In their interactions with clients, MFTs can qualitatively adjust how they negotiate this tension by maintaining a systemic perspective while fitting into the parameters of those forces. For example, if clinicians must use a treatment plan template that is required by an MCO, they can still conduct the treatment planning process in a collaborative, rather than formulaic, manner (Wubbolding, Casstevens, & Fulkerson, 2017). Kress, Hoffman, and Eriksen (2010) note multiple ethical dilemmas regarding diagnosis from a relational perspective, and they endorse open communication with clients. Their recommendations include obtaining informed consent to diagnose and educating clients about the risks to confidentiality inherent in engaging with an MCO.

At the professional level, therapists can do their own information-gathering and decide where to establish themselves according to their values and priorities. Across state lines and the mental health organizations therein, there is exceptional variety regarding funding and reimbursement for mental healthcare, as well as rules and culture of diagnosis. Feminists therapists with a critical understanding of where to place their values in context will be better equipped to join a workplace environment that supports their values.

Curriculum development. The current study findings reveal that feminist MFTs, and MFTs more broadly, lack power to make changes at an institutional level. I argue that the propagation of feminist, social-justice informed therapy necessitates that training programs

incorporate a critical and sociological view of the mental healthcare structure in which the field

is embedded. Therapists should be trained to take the skills they use when treating families –

such as assessing power, motivation, rules, incentives, and so on – and apply them to broader

structures such as managed care and diagnosis. Not only will therapists be able to assess and

modify their own experiences, they can also become more effective and active agents the

continuation of their values.

There have already been calls for MFTs to take the roles of educating MCOs and

lobbying for change (Patterson, Baron, McIntosh-Koontz, & Bischoff, 1997). Yet, critical

awareness of what changes are needed, as well as the logistical knowledge of how to achieve

such changes, are not part of the MFT core curriculum. I suggest that programs not only provide

training on how to navigate mental healthcare structures, but also how to be critical, vocal, and

engaged in local and national political and economic structures. Goodman, Morgan, Hodgson,

and Caldwell (2017) provide a continuum of involvement in advocacy, ranging from activism to

litigation. Policy-making strategies on the continuum include volunteering one's time and/or

funds; contacting local and national leaders; and writing policy briefs or articles to provide

accurate information, among others. Current policies that are relevant to feminist marriage and

family therapy include just healthcare laws, family-centered care, and the ability to

independently practice (Goodman et al., 2017). Only when individual therapists are equipped

with the tools of recognizing and critiquing broader professional systems will a body of feminist

therapists be able to harness our own structural power to have a role in shaping policy, both on

the institutional and organizational levels.

Limitations

As with any research, this study has several limitations. The findings and interpretations I have presented should be considered with those limitations in mind. Below I discuss how the sample, data collection method, and my positionality as a researcher may have affected the results.

Representativeness of the sample. A limitation of the sample is reflected in geographic clustering of the participants. Due to the nature of recruiting via personal networks and snowball sampling, most of the study participants work in the state of Connecticut. The state where participants practice is relevant because state laws and regulations, as well as the local culture that is influence by state regulations, influence the managed care system in which the participants work. Even though there were some participants outside the state of Connecticut, some states and regions of the U.S., particularly the South, were not represented at all in this study. As such, this study provides limited insight into how feminist values and practices vary by location and relevant laws and regulations.

Data collection methods. This study employed semi-structured interviews in an effort to capture the participants' firsthand accounts of their interactions with their colleagues and broad structures in mental healthcare. However, because I relied on the perspectives of the participants, I was not fully ably to capture an *interaction* between them and their environments. Other data collection approaches, such as institutional ethnography, analysis of textual or conversational exchanges, or content analyses of formal paperwork would have provided a fuller perspective of how the context was both shaping and shaped by the participants themselves. Though the strategy to conduct interviews is not a flawed data collection method, nonetheless it provides a limited window into the bidirectional interplay between the participants and their contexts.

Self of the feminist therapist researcher. All ways of conducting research are subject to bias of the researcher. Undoubtedly my position as a feminist marriage and family therapist influenced the data and analyses of this study. As I noted above, my stance as an intersectional, social-justice oriented feminist directed the questions and thus participants' responses largely to economic aspects of care. Whereas I do not view this as a limitation, but rather a focus of the research questions, I recognize that I may have missed relevant data or theory due to my personal interests and feminist framework.

I cannot know with any certainty how and to what extent my background shaped how the participants interacted with me. However, qualitative methodologists acknowledge and confront biases that are potentially obstructive to the research endeavor through the process of reflexivity. To address potential bias on my part, from study conceptualization to writing and presenting, I engaged in reflexive practices such as memoing and reflecting with my advising team. By building reflexivity into the study design, I strove to account for my positionality as a member of the study population.

Future Directions

Though this study provides initial findings that show how feminist therapists engage with others outside of the therapy room, there are many areas where future research is warranted. A primary question raised by this study is how medicalization will increasingly affect feminist therapists and the field of marriage and family therapy, as well as medical family therapy. While the results suggest that private practice is somewhat of a safe haven for feminist clinicians who seek autonomy in their clinical decision-making, the one participant in the study with the longest career was currently considering whether or not to leave managed care because she was under an

intrusive audit. This finding begs the question of how the tide of medicalization and insurance control are flowing toward the private practice realm.

Another direction for future research is to examine the process of therapists "aging out" community agencies (or other sites where clients exhibit great clinical need) to the relative freedom and ease of private practice. Additionally, a sociological perspective could also enable future researchers to study how the current mental healthcare structure leads to such a migration of therapists from one work setting to another, and how the structure can be modified to incentivize experienced clinicians to stay with populations that have complex problems.

Conclusion

This scholarship reveals feminist clinicians' previously obscured practices at multiple systemic levels beyond the therapist/client system. The present study makes a contribution to the literature in feminist family therapy by expanding the focus of inquiry to incorporate novel sites of feminist work and activism. Though there are innumerable ways to be a feminist, this study provides insight into several patterns of feminist values and practice that emerge in the context of professional therapy.

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Appendix A

Adverstisement

UCONN
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Volunteers Wanted for a Research Study

➢ Contribute to research about the experiences of feminist therapists!

➢ If you are a licensed marriage and family therapist (LMFT) who identifies as a feminist *and* who approaches therapy in a way that is compatible with feminist values, then you are eligible to participate.

➢ Participation includes one 60-120 minute interview about your experiences as a feminist therapist at a location of your choice, over the phone, or via Skype. All interviews will be audio-recorded.

➢ This research is conducted by Joy Heafner, under the direction of Dr. Rachel B. Tambling, out of the Department of Human Development and Family Studies at the University of Connecticut.

➢ **To learn more please contact Joy at joy.heafner@uconn.edu or 773-850-1569. Thank you!**

Appendix B

Consent Form

Information Sheet for Participation in a Research Study

Principal Investigator: Dr. Rachel Tambling, PhD, LMFT
Student Researcher: Joy Heafner, MA
Study Title: Feminist Therapists: A Qualitative Exploration of Values and Practices within Context

Introduction

You are invited to participate in a research study to talk about your experiences of being a feminist therapist. If you are a licensed mental health clinician (LMFT, LCSW, LPC, etc.) who identifies as a feminist *and* who approaches therapy in a way that is compatible with feminist values, then you are eligible to participate.

Why is this study being done?

The purpose of this research study is to understand how some people come to identify as feminists, and how feminism can be used in therapeutic settings.

What are the study procedures? What will I be asked to do?

If you agree to take part in this study, you will be asked to participate in an interview that will last anywhere from one to two hours. Interviews will take place either in person, over the phone, or through Skype. If the interview takes place in person, we will meet at a mutually agreed upon location per your suggestion. All interviews will be audio-recorded. You will be asked questions related to how you came to identify as a feminist and how feminism is represented in your work as a therapist. You may also be asked if you wish to be contacted in the future to provide further data or your impressions of the project.

What are the risks or inconveniences of the study?

The only risk to participating in this study is the potential for you to become uncomfortable when telling me about your personal experiences during the interview.

What are the benefits of the study?

It is my hope that you will benefit from the opportunity to share your experiences and reflect on your participation with a researcher who is interested in your lived experiences. While the individual participants may not receive direct benefits from the knowledge we gather through this study, the results of this research will help researchers understand clinicians' experiences within the healthcare system and how these affect client experiences. Ultimately this research may provide societal benefits of improving the mental healthcare system so that client needs can be met with optimal care.

Will I receive payment for participation? Are there costs to participate?

There is no compensation or cost to participate in this study.

How will my personal information be protected?

The following procedures will be used to protect the confidentiality of your data. The researchers will keep all study records (including any codes to your data) locked in a secure location. Pseudonyms will be used in all data, and a master key that links names and pseudonyms will be maintained in a separate and secure location. The master key and audiotapes will be destroyed after transcription of all interviews. All electronic files (e.g., database, spreadsheet, etc.) containing identifiable information will be password protected. Any computer hosting such files will also have password protection to prevent access by unauthorized users. Data that will be shared with others will be coded as described above to help protect your identity. At the conclusion of this study, the researchers may publish their findings. Information will be presented in summary format and you will not be identified in any publications or presentations.

We will do our best to protect the confidentiality of the information we gather from you but we cannot guarantee 100% confidentiality. You should also know that the UConn Institutional Review Board (IRB) and Research Compliance Services may inspect study records as part of its auditing program, but these reviews will only focus on the researchers and not on your responses or involvement. The IRB is a group of people who review research studies to protect the rights and welfare of research participants.

What happens if I am injured or sick because I took part in the study?

In the event you become sick or injured during the course of the research study, immediately notify the principal investigator or a member of the research team. If you require medical care for such sickness or injury, your care will be billed to you or to your insurance company in the same manner as your other medical needs are addressed.

If, however, you believe that your illness or injury directly resulted from the research procedures of this study, you may be eligible to file a claim with the State of Connecticut Office of Claims Commissioner. For a description of this process, contact the Office of Research Compliance at the University of Connecticut at 860-486-8802.

Can I stop being in the study and what are my rights?

You do not have to be in this study if you do not want to. If you agree to be in the study, but later change your mind, you may drop out at any time. There are no penalties or consequences of any kind if you decide that you do not want to participate.

Whom do I contact if I have questions about the study?

Take as long as you like before you make a decision. We will be happy to answer any question you have about this study. If you have further questions about this project or if you have a research-related problem, you may contact the principal investigator Dr. Rachel B. Tambling at rachel.tambling@uconn.edu, or Joy Heafner at joy.heafner@uconn.edu or 773-850-1569. If you have any questions concerning your rights as a research subject, you may contact the University of Connecticut Institutional Review Board (IRB) at 860-486-8802.

Documentation of Consent:

I have read this form and decided to participate in the project described above. Its general purposes, the particulars of involvement and possible hazards and inconveniences have been explained to my satisfaction. I understand I can withdraw at any time. I have received a copy of this form.

If you agree to participant in this study, please verbally indicate as such.

Appendix C

Orienting Paragraph

Thank you very much for taking the time to talk with me today. During the course of our conversation, I'd like to learn about your experiences as a feminist and as a therapist. Specifically, I'm interested in hearing about: your educational background, how you learned about feminism and what it means to you, how you learned about therapy and what your work entails, you experiences as a feminist and therapist, the relationship between your work and your personal values, and the relationships between your background and your professional goals. I'd like to understand how you came to decide about becoming a therapist based on the people and structures that influence your life.

You are also welcome to talk about aspects of your experience that I haven't mentioned. Perhaps you could begin by telling me about your educational background and the setting of where you work.

Appendix D

Interview Schedule

Themes and Sample Questions

Theme 1: Feminist Therapist Identity

• How did you come to identify as a feminist therapist?
  • Have you had any formal education or training in feminist therapy?
  • Have you had any informal training or mentorship in feminist therapy?
  • Are you a member of any feminist therapy professional groups?
• How did *feminism* become a theoretical orientation of yours?
• Who/what has influenced you as a feminist therapist?
• What does being a "feminist therapist" mean to you?
• How do you think being a feminist comes out in the way you practice therapy?
• What's it like to be a feminist therapist where you work? What are the positive/negative aspects?

Theme 2: Values and Practices within the Mental Health System
• In general, what has your experience been like as a therapist? • Do you feel like your theoretical orientation as a therapist fits with a managed care perspective? Why or why not? • How do you think being a feminist comes out in the way you handle managed care, client fees, reimbursements, etc.? • How, if in any way, has managed care affected your practice of therapy?   • Has it hindered/helped your practice? • What about being a feminist that makes your work more difficult? Or easier?
Theme 3: Values and Practices related to Diagnosis

• How do you use the DSM in your practice?
• What have you found to be helpful/not helpful about the DSM?
• How do you conceptualize client progress in your personal clinical practice?
• How does your agency/institution/practice measure client progress?
  • What forms do you use, and how were they developed? (e.g., blank treatment plan, blank case note form)
  • What works well about these methods?
• If you could improve these methods, how would you?
• Have you experienced any ethical dilemmas regarding diagnosis and/or measuring outcomes?

Closing the Interview
• Is there anything else you'd like to tell me about your experiences as a feminist therapist? • How was this interview for you? • How do you think the experience of this interview might change anything about the way you practice therapy? • What advice do you have for me for when I conduct my next interview? • Are there any questions you think I should be asking, but I didn't?

Appendix E

Demographic Questions

Demographic Questions

History as a Therapist
• Year graduated from training program
• Length of time as a practicing therapist
• Degrees earned (MA, PhD, MSW, PsyD, MD, etc.)
• States where licensed
• Specializations (children, adults, couples, etc.)
• Setting of practice (private practice, community agency, etc.)
• Typical client (insurance, socioeconomic status, presenting concern)
Social Location
• Age (generation)
• Gender identity
• Race/Ethnicity
• Religious affiliation
• Sexual orientation
• Geographic region
• Nationality
• Annual income