1-1-1996

Therapeutic Implications of Therapists' Values For the Female Victim of Domestic Violence

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Therapeutic Implications of Therapists' Values
For the Female Victim of Domestic Violence

by
Patricia A. Warford

Presented to the Faculty of
George Fox College
in partial fulfillment
of the requirements for the degree of
Doctor of Psychology
in Clinical Psychology

Newberg, Oregon
January 19, 1996
Approval

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For the Female Victim of Domestic Violence

by

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Therapeutic Implications of Therapists' Values

For the Female Victim of Domestic Violence

Patricia A. Warford
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Abstract

Domestic violence effects 1.8 million women a year in the United States. Despite the magnitude of the problem, the issue is largely unaddressed by the mental health community. Therapists' values, which significantly impact the therapeutic interaction, have not been scrutinized as to their impact on female victims of domestic abuse. Furthermore, four widely accepted therapeutic orientations (psychodynamic, behavioral, humanistic, and family systems) have historically promoted values which fail to provide a framework for understanding healthy female development, the experiences of women in general, and the
experience of women who have endured domestic violence in particular.

Feminist developmental theory (particularly the work of Chodorow, Gilligan, and the Stone Center writers) provides a foundation for understanding female victims of domestic violence that values women’s empathic and relational tendencies. By applying feminist developmental theory, therapists are equipped to work with female domestic abuse victims in a manner that is empathic, supportive, and empowering for the client.

Feminist developmental theory provides therapists with an orienting belief that is consistent with the personal experiences of this population. This increases the probability of a positive outcome as it is congruous with women’s developmental tendencies. Literature pertaining to the role of therapists’ values, a model for healthy female development, and the dynamics of domestic violence will be reviewed.
Acknowledgements

I would like to express my sincere gratitude to my dissertation committee, Dr. Michelle Dykstra, Dr. Kathleen Kleiner, and Dr. Carol Pahlke. To Dr. Dykstra, thank you for chairing this project. I also thank you for serving as professor, advisor, mentor, and best clinical supervisor throughout my graduate experience. Your encouragement, support, and prodding toward excellence have been invaluable. To Dr. Kleiner, thank you for bringing a researcher’s eye to this endeavor. To Dr. Pahlke, thank you for sharing your wealth of knowledge as a clinician. To all of you, thank you for enduring changes in topic and multiple drafts. You made the process enjoyable as well as intellectually stimulating.

I would also like to acknowledge aid from more people than I can list here: friends and colleagues who contributed names of specific books, articles, and authors, as well as full bibliographies; those who endured my rambling on about this project; and those who celebrated with me each step of the way. A special
thank you to Yvette Ward and Riohdet Corser, who were with me through the anxiety-provoking ritual known as "final orals"—your presence was appreciated.

I would be remiss if I did not acknowledge the support of my family. First and foremost, my children, Candice and Nathanael, thank you for accepting the times we could not do things because mom needed to work on her dissertation, for tolerating the stacks of books and articles engulfing the dining room as I began to write, and for your patience during the lean financial years of graduate school. To my husband, Gary, thank you for your faith in me and encouragement without which I might never have started this undertaking.
Dedication

To my mother, Rosa, who taught me that women can endure domestic abuse but can also be strong and get out of it with dignity and integrity. To my husband, Gary, who showed me that women don’t have to endure it. To my friend, Michelle (and other "trench workers"), who deal with the reality of it everyday. To my clients who have been victims and who have endured both the abuse and the blame too often and for too long.
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INTRODUCTION

Domestic abuse statistics paint a grim picture for women. It is the leading cause of physical injury to women age 25-34 (Birns, Cascardi, & Meyer, 1994). In the United States, a woman is beaten every 15 seconds and at least four women are killed every 24 hours by their batterers (Kaschak, 1992). Estimated reports state that 1.8 million women are abused by a male partner in an average year (Browne, 1993); prevalence estimates of spousal-abuse range from 20 to 60% (Walker, 1980). The U.S. Justice Department reported that 95% of all reported assaults on spouses are committed by men (Dobash, Dobash, Wilson, & Daly, 1992; Fortune, 1993; Margolin & Burman, 1993).

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1Recent media claims have raised questions regarding inflated figures. Some domestic abuse victims' advocates claim that 4 million women are battered annually. Since the 4 million figure is disputed, I have chosen to stay with the more conservative 1.8 million women figure.
Although domestic abuse has been (and continues to be) a prevalent social problem, the mental health profession has largely ignored this field, viewing the issue as a legal matter (Jordan & Walker, 1994). Research on violence in the home is relatively recent, dating to 1975 (Browne, 1993; Walker, 1980). Yet, even with 20 years of data, few professionals receive training on how to assess or treat battered victims (Brown, Lent, & Sas, 1993; Walker, 1980).

Spousal abuse tends to be under-assessed in traditional mental health settings. In a study of community mental health outpatients, Jordan and Walker (1994) discovered that the number of patients disclosing domestic violence doubled when the intake interview specifically included questions about victimization, something not typically done in standard intake interviews. Additionally, the pair found "that 68 percent had experienced major physical or sexual assault or both, but that 71 percent of those patients had never before disclosed the experience of abuse to a clinician" (p. 147). As a result, victims of spousal abuse frequently are undetected by mental health professionals (Goodman, Koss, & Russo, 1993).
Clinicians are not oriented to assessing spousal abuse for a myriad of reasons. Clinicians are enculturated in the same society that minimizes or fails to identify domestic violence as a social problem. They bring values into the therapeutic arena—values which may or may not orient them to the issue. For example, a clinician who values the sanctity of marriage as primary may fail to pursue information regarding domestic abuse in an attempt to hold the marriage together rather than focus on the safety of the client who is being assaulted.

Another reason clinicians fail to properly assess domestic abuse may be attributed to their theoretical orientation. They may hold to therapeutic orientations which preclude them from looking at the larger picture of domestic violence by focusing too narrowly on the client. In this case, a clinician who does not understand the dynamics of the abusive relationship may assess that a female client is resistant to change when she avoids contacting a domestic abuse shelter. Their orientation may have certain beliefs regarding women which are not consistent with the experience or development of women. An illustration would be a
Freudian psychoanalyst who maintains that women are naturally masochistic.

Institutions which train therapists also face a dilemma. As noted, frequently training for therapists has been dismally inadequate in regard to the issues of domestic violence and female development. The major focus of graduate education for most therapists has been on traditional explanations of development which focus on individuation and autonomy and are without a framework for understanding healthy female development or the dynamics of domestic violence. While recent research has spotlighted the issue of domestic violence and its impact on both perpetrator and victim, integrating research into an applicable orientation for therapists working with domestic abuse victims remains largely undone (Russo, 1990; Scarr, 1988). The purpose of this dissertation is to begin to address the need for understanding the victims in a favorable light and for application of feminist developmental theory to practice for therapists working with victims of domestic violence.

Recent work by feminist developmental theorists such as Chodorow (1989), Gilligan (1982), and the Stone Center writers (Jordan, Kaplan, Miller, Stiver, &
Surrey, 1991) provide alternatives to traditional theories which can aid clinicians in understanding healthy female development. By applying feminist developmental theory to work with clients who have been victimized by domestic violence, therapists are better equipped to value and appreciate women's relational tendencies, to understand the impact of societal gender bias, and to provide an empathic environment for their clients.

Methods

In this paper, I will present the literature examining therapists' values, female development, and domestic abuse. I will then critique how these areas are related, their contradictions, and their implications for therapy. Finally, I will integrate the literature to propose my own theory regarding which values, held by therapists, are in the best interest of their clients.

In chapter 1, I will review factors relating to therapists' values as reported in empirical data and espoused by theoretical orientations. First, a foundation is laid that psychology as a science is not
value-free. In fact, the American Psychological Association (APA) responded to charges of theorist (and therapist) gender-bias and mandated in 1979 that therapists assess possible gender-bias in their orienting beliefs.

Next, research on values is presented. One issue for experimenters was to generate a working definition for the term "values." For research purposes, Rokeach’s (1973) definition has been the most widely accepted: "an enduring belief that a specific mode of conduct or end-state of existence is personally or socially preferable to an opposite or converse mode of conduct or end-state" (p. 5). Rokeach maintained that values, while generally enduring, can be modified or changed. Others have attempted to modify this definition.

Research presented supports London’s (1986) contention that therapists’ values influence the therapy process and are influenced by theoretical orientations. Therapists’ values influence their perception of mental health, mental illness, and therapeutic outcome. Krasner and Houts (1984) discovered that differences in therapists’ values
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appear to be based on theoretical orientation more than any other variable.

Therefore, four main theoretical orientations are reviewed: psychodynamic, behavioral, humanistic, and family systems. A general overview of each orientation is given, including the goal of each type of therapy. Female development as delineated by each orientation is then reviewed.

In the second chapter, I will present factors pertaining to the female client. Healthy female development will be emphasized in the first half of the chapter. The theoretical work of Jordan et al. (1991) will be reviewed in light of current research. Research on gender awareness in children, gender bias in society, and the implications of gender bias for women will be reviewed also.

In chapter 3, I will examine domestic abuse in the context of society, of academia, and of the family. The denial and avoidance of domestic abuse issues by social institutions (and cultural tolerance of domestic abuse) is explored. Dobash and Dobash (1984) and Dobash et al. (1992) provide the cornerstone of academic endeavors regarding domestic abuse on both theoretical and empirical levels.
Two areas of academic controversy will be examined. The first is Jacobson's (1994a, 1994b) proposal of collaboration between researchers and victims' advocates which has stirred discussion by both sectors. The second is Straus and Gelles' (1988) controversial research on gender symmetry in domestic abuse. The impact of the first controversy is explored in light of the second controversy.

Moving from academic controversies of domestic abuse, I will examine domestic abuse as it occurs in the systemic context of the family. The familial factors of domestic abuse to be examined are the relationship, the male partner, the children, and the female client.

Chapter 4 synthesizes and critiques material presented in chapters 1, 2, and 3. Psychodynamic, behavioral, humanistic, and family systems theories will be compared and contrasted with feminist developmental theory and research on female development. Implications of each theory for the victim of domestic abuse will be discussed emphasizing beneficial and detrimental components. Awareness of the impact of gender and gender-bias in this society is crucial in understanding these victims; each theory
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will be assessed regarding its position on the issue of gender and gender-bias. Areas of overlap between the theories and the research will be explored. Strengths will be assessed; weaknesses will be discussed.

Integrating female developmental patterns and the dynamics of domestic violence into therapists' value systems, chapter 5 offers a hypothesis regarding orienting beliefs as applied to female victims of domestic abuse for optimal benefit to the client. Based heavily on the proposal of some feminists for a healthy model of female development, I suggest that women's tendencies toward empathy and relational orientation is a fundamental strength on which women can build self-esteem. Incorporating this view into therapists' values provides the framework to view the victims' strengths as strengths which empower her and breaks the cycles of victim-blaming which entrap her. Chapter 5 also suggests how these values can be incorporated into the orienting beliefs of therapists and the therapeutic arena as well as areas of future research.
Parameters

Certain parameters are set forth in this paper. First, it will exclusively pertain to female clients. As such, further references made simply to the "client" will be understood in light of this parameter. Special notation will be made when male clients are the reference group or when the gender of the client is inclusive of both genders.

Second, women are not a monolithic group. They are as diverse as any segment of the population. While certain orienting beliefs (or values) regarding women and/or women's development may be universally detrimental to women, the proposal regarding a new value or paradigm is not intended to be universally inclusive of all women. An unfortunate fact is that most of the research focuses on Caucasians; in like manner, Caucasians are the focus of this document also. However, diversity exists even among Caucasian women. The suggestions made will be based on general tendencies with the understanding that individual experiences may vary.

Third, I narrowly focus on the values of therapists working with victims of domestic violence.
within the confines of the therapeutic arena. However, as this issue is a prevalent societal problem, a true conversion of values as set forth in this dissertation would necessitate efforts to change the cultural underpinnings which tolerate domestic violence. To address the larger mandate of challenging cultural mores would make this dissertation unwieldy and, therefore, is beyond the scope of this dissertation in practical terms but not in spirit.

Finally, this paper is theoretical in nature. A plethora of material is available in each of the three areas mentioned (therapists' values, female development, and domestic violence); however, a synthesis of these is noticeably absent. Because of this dearth, a theoretical foundation needs to be built in order to guide future research on violence against women (Russo, 1990; Scarr, 1988). In addition, what literature does exist appears to be built around two of the three areas: female development and domestic violence, therapists values and female development, therapist values and domestic violence. Subsequently, a vital integration of the three foci is missing from the discussion.
Another reason for theoretical treatise is the nature of the study which is not conducive of empirical testing. To intentionally provide women who have a history of domestic violence with care that falls short from the outset would be unethical. Similarly, many therapists are unaware of how their orienting beliefs may be detrimental and, therefore, are unlikely to volunteer for a project such as this.

Definitions Used

For the purposes of this paper, a definition of therapists' values proposed by Bergin (1985) will be used: "Values . . . are defined as orienting beliefs about what is good or bad for clients and how that good can best be achieved" (p. 290). This definition seems most appropriate given that the focus is the impact of therapists' values on therapy. In chapter 4, I suggest that four traditional orientations are inadequate in understanding female development and, specifically, domestic abuse, based both on their intent and their outcome. In chapter 5, I suggest a paradigm shift from traditional orienting beliefs to beliefs proposed by
feminist theorists, which more closely depict the natural and healthy development of women.

From the domestic abuse literature, two main terms need definition. The first is the term "advocate." As used in this paper, it is from the domestic abuse literature and refers to grassroots workers in the domestic abuse field. They tend to be female and to base their interpretations on their experience working in domestic shelters, interacting with the police and the courts, and proposing legislation (usually on a state or local level). In conjunction, "researchers" as understood in the domestic abuse literature have been primarily males involved in academic arenas.

Summary

This paper contends that therapists' values play an important part in therapy. Further, all theoretical orientations maintain implicit values regarding what is in the best interest of the client, and, in particular, they maintain implicit values concerning women. Thus, I contend that traditional orientations bring values to therapy that do not take into account female developmental and relational patterns nor do they
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address the reality and magnitude of the experiences of female clients who deal with issues of domestic violence. Therefore, traditional values are detrimental to female clients who are dealing with this issue. For this reason, I will propose that therapists who assimilate the literature on female development (as proposed by Chodorow, Gilligan, and the Stone Center writers) and on domestic violence into their value system are equipped to deal with female victims of domestic abuse in a manner compatible with the client's developmental tendencies, congruous with her strengths, and conducive for a positive therapeutic outcome.

I will begin by addressing, in chapter 1, the question of whether or not therapists' values impact therapy and will review the role of women as set forth by four of the major theoretical orientations.
CHAPTER 1

THERAPISTS' VALUES

Values serve as a foundation for endeavors undertaken by human activity; they permeate each society as well as the members of each society. They provide the "orienting beliefs" (Bergin, 1985, p. 99) for how individuals think and act. Values imply a world view and a subjective belief that an action or position is "good" or "better" than an alternative (Rokeach, 1973; Rokeach & Ball-Rokeach, 1989).

Areas once deemed to be value-free are being re-examined to find underlying assumptions. One of these areas, science, has long been held to be the bastion of value-free study. However, "philosophers, historians, sociologists, and psychologists of science ... have been arguing with increasing regularity that the assumptions underlying a value-free view of science are problematic" (Krasner & Houts, 1984). Awareness of this problem has led to research regarding values in science.
Among the sciences struggling to ascertain the role of values has been psychology, which has grappled with the role of values in the therapeutic arena (Bart, 1971; Lyddon, 1991; Smith, 1954). Early theorists who viewed psychology as a hard science in its infancy were more inclined to propose that psychology could be practiced using blank slate, value-free techniques. But as later theorists built on earlier theories, they increasingly proposed that the therapeutic alliance was the foundation for healing in therapy. This alliance no longer relied as heavily on the blank slate position of earlier proponents; instead, it incorporated the idea that the therapist as a person (with values) and the client (as a person with values) worked jointly for the psychological health of the client.

As research into therapists' values increased, most theoretical orientations came to freely acknowledge that values play a role in the therapeutic process (Norcross & Wogan, 1987). Values which influence the interaction between the therapist and the client were found to be not only those of the client, but those of the therapist and of the society at large. Over time, research shifted from focusing on the client's values to focusing on those of the therapist.
As with clients, therapists acquire values from individual life experiences, from their societies, and from the zeitgeist\(^2\). However, therapists have an added source for their values (barring the possibility that the client is also a therapist) in that the theoretical school to which they adhere also has a value system. Orientations expound beliefs as to the nature of humans, the roots of pathology, and the process for health. Browning maintained that theoretical orientations were closer to being "systems of practical moral philosophy than . . . simply scientific or clinical psychologies" (1987, p. 238).

The implications for therapists are profound. No longer are therapists operating from a technical manual, rather they operate on beliefs inherently brought to the therapy session. The role of therapists is such that their values influence sessions from positions of power. Therapists choose a particular method of therapy based on a subjective belief (often consistent with therapists' personalities) that it is better than other therapies, direct the course of

\(^2\)Society is distinct from zeitgeist in that society is related to a specific geographic location while zeitgeist is related to an era or time period.
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discussions by their questions, and affirm some areas for clients while challenging others. Therapists hold values relating to behavior which define mental health and express themselves in therapy (Beutler, Crago, & Arizmendi, 1986).

Such values do not only evaluate present behavior. They also judge the influence of past events on current situations; for example, values determine the importance placed on the interactions between parents and children in explaining the adult-child’s functioning. A therapist may minimize current circumstances by maintaining that the client is merely repeating past relationship patterns.

If, in the course of making such judgements, circumstances regarding individuals and the zeitgeist are taken into account, then the evaluation may be expected to have more validity than if these aspects are ignored. However, if the conclusion is based on a faulty understanding of the surrounding circumstances, the resulting judgement will also be faulty. For example, using the American Puritan work ethic to explain the concept of siesta in Catholic Latin America, the interpretation would probably be, at the least, inaccurate, if not outright misleading.
The psychological community acknowledges that, in addition to cultural differences, gender differences exist. For this reason, the American Psychological Association (APA) proposed ethical guidelines for therapists counseling women. Among the guidelines were:

Counselors/therapists are aware that the assumptions and precepts of theories relevant to their practice may apply differently to men and women. Counselors/therapists are aware of those theories and models that proscribe or limit the potential of women clients, as well as those that may have particular usefulness for women clients.

. . . Counselors/therapists ascribe no pre-conceived limitations on the direction or nature of potential changes or goals in counseling/therapy for women. . . .

Counselors/therapists are aware of and continually review their own values and biases and the effects of these on their women clients.

Counselors/therapists understand the effects of sex-role socialization upon their own development and functioning and the consequent values and
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attitudes they hold for themselves and others.
[emphasis added] (APA, 1979, p. 21)
These guidelines specifically address the issue of
gender in regards to the therapist's personal and
professional value system.

These guidelines are especially relevant in light
of the work by Broverman and her colleagues (Broverman,
Broverman, Clarkson, Rosenkrantz, & Vogel, 1970) who
discovered a double standard among therapists when
defining mental health—a standard relying heavily on
stereotypic, gender-congruent behavior (Chesler, 1989;
Kaschak, 1992; Sherman, 1980; Stiver, 1991b). Their
findings presented female clients with a quandary.
Gilligan (1982) summarized their findings:

The repeated finding of these studies is that the
qualities deemed necessary for adulthood—the
capacity for autonomous thinking, clear decision-
making, and responsible action—are those
associated with masculinity and considered
undesirable attributes of the feminine self . . .
leaning more toward an autonomous life of work
than toward the interdependence of love and care.
(p. 17)
While characteristics of mentally healthy adults correlated closely with those of a mentally healthy adult male, female characteristics were expected to conform to stereotypic gender ideals which correlated significantly with characteristics clinicians labelled as those of an immature adult. As a result, a woman could be labelled a healthy (though immature) adult female or an unfeminine healthy adult.

These findings are neither new nor surprising. Sex bias has been acknowledged in the literature for some time. Karen Horney (1974) recognized that favorable male bias underlies much of psychotherapeutic thought and addressed the issue as early as 1926. Unfortunately, her rebuttal of Freudian thought regarding women never gained the stature of Freud's work (Dujojvne, 1991; Small, 1989).

Erik Erikson (1974) addressed this issue in 1968. He noted that the psychoanalytic view of women (the dominant theoretical orientation of his day) focused on pathological women (and thereby "doomed" women to pathology) and attempted to "understand the female psyche with male means of empathy" (p. 338). Erikson called for women to take a greater role in defining themselves. Additionally, he acknowledged male
resistance to such an endeavor and noted that "the defensiveness of men (and here we must include the best educated)" (p. 335) clung to their treasured position; "where dominant identities depend on being dominant it is hard to grant real equality to the dominated" (p. 336).

Originally published in 1972, Chesler's (1989) *Women and Madness* examined the disproportionate number of female clients labeled "abnormal" by a predominately male profession. She challenged the psychiatric and psychological communities to examine the extent to which their values perpetrated "certain misogynistic views of women and of sex-role stereotypes as 'scientific'" (p. 61). Her work became a springboard from which theorists (particularly female and feminist

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3 Whether the "feminization" of psychology will change this remains to be seen. It is also quite possible that women who make it through the system will be those who are indoctrinated into the status quo. Another possibility is that, since more diversity exists within genders than between them, women who achieve the higher echelons of the profession may be those who tend to think in ways considered "masculine."
theorists) proposed alternative explanations (Brown, 1992a; Caplan, 1989; Gilbert, 1980; Greenspan, 1993; Jordan et al., 1991; Sherman, 1980).

Observing gender bias in Kohlberg's work, Gilligan (1982) wrote, "Kohlberg and Kramer imply that only if women enter the traditional arena of male activity will they recognize the inadequacy of [their] moral perspective and progress like men toward higher stages" (p. 18). She conjectured that women develop in a more relational manner than their male counterparts. This female mode of development has not been properly represented in the literature, according to Gilligan, because "the voices of men and the theories of development that their experience informs" (p. 173) dominated the field.

Feminist writers have sought to correct this imbalance by redefining women and female development. They have been hindered, unfortunately, by the language of a culture which is predicated on men speaking and women listening, leaving a vacuum when attempts are made to express women's experience from the female point of view (Belenky, Clinchy, Goldberger, & Tarule, 1986; Gilligan, 1982). Lerner (1989) suggested that this void has led feminist writers to a
"reinterpretation of current psychoanalytic theory" (p. 243) which "reaffirm traditional female values of nurturance and connectedness" (p. 244) while failing to expound new, distinctly female perspectives. Also, according to Lerner, these perspectives are limited because they fail to "locate male-female differences in any social context" (p. 247). However, the feminist writers warrant attention given that Chesler (1989) and Erikson (1974) found a lack in the previous literature of women interpreting female development and women's experiences. While a female perspective of female development will be more thoroughly explored in chapter 2, the point here is that traditional orienting beliefs have been unfavorable to women.

Therapists do not intentionally hold values detrimental to their clients. In fact, many therapists, while admitting that they do hold to particular theoretical orientations, maintain that their system in practice is value-free. Thus, the role of therapists' values in therapy will be discussed first; this includes theoretical and empirical research in regards to values in general. Following a general view of values in therapy, I will review the values (or orienting beliefs) of four traditional therapeutic
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orientations: psychodynamic, behavioral, humanistic, and family systems.

The Psychological Research on Values

An article in the American Psychological Association (APA) Monitor read, "We're saying that psychotherapy is not a valueless process" (Sleek, 1994, p. 8). This is a major paradigm shift from Freud's contention that therapy should be free of the therapist's influence (Bergin, 1985; Freudenberger, 1990; Hartmann, 1960) and conducted in a value-free manner similar to the medical model consisting simply of techniques (Humphries, 1982; Jensen & Bergin, 1988).

In the intervening years since Freud, the field of psychology has recognized and studied the role of therapists' values since the early 1950s (Kelly, 1990; Kessel & McBrearty, 1967; Vachon & Agresti, 1992).

In addressing the 1953 meetings of the APA, M. Brewster Smith confronted the issue of professional responsibilities for psychologists in regard to values. He noted that values were implicit and explicit:

I will assume that our new code of ethics indicates that we are in fair consensus on a
number of generally acceptable values. Our ethical problems, it seems to me, may have more to do with the relation of our values to what we actually do as psychologists than with what our values happen to be. (1954, p. 513)

He further warned that "psychologists have on occasion offered or imposed their own partial values as absolutes blessed in the name of science" (p. 514).

Norcross and Wogan (1987), in summarizing Smith, noted that "therapeutic action is irresponsibly taken unless the values and assumption underlying the action are clearly understood" (p. 7).

This 1953 symposium appears to have had an effect on values research. In 1955, Rosenthal’s study, one of the first regarding therapists' values, was published (cited in Glad, 1959). He found that therapists' reports of positive outcome was closely connected to clients assimilating therapists' values. Rosenthal's finding, supported by later research, is of great significance. If therapists hold values which are detrimental to their clients, positive outcomes, as assessed by therapists, may not necessarily mean positive outcomes for their clients. This issue will be revisited in chapters 4 and 5.
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Definition of Values

As a result of Rosenthal's research, interest in the impact of the therapists' values grew. The first order of business for empirical research on the topic was an operational definition of the term. As a result, researchers attempted to define the term "values" without much support from their colleagues. A universally accepted definition is difficult to find (Patterson, 1989).

Many researchers appear to have based their empirical investigations on Rokeach's (1973) classic work. Rokeach defined a value as "an enduring belief that a specific mode of conduct or end-state of existence is personally or socially preferable to an opposite or converse mode of conduct or end-state existence" (p. 5). This is the most frequently utilized definition in the literature. Basic to his research is a belief that, while enduring, values can and do change: "values, attitudes, and behavior can undergo lasting change when people become aware of certain contradictions within themselves . . . these have practical implications, especially for the fields of guidance and selection, education and therapy" (p. 330). The enduring nature of values and the ability of
values to change with awareness is the crux of Rokeach’s definition of values.

Other attempts to define "values" appear to solicit modifications from subsequent writers. In spite of variations, one aspect remains invariable within the diverse definitions (see Appendix A). Values undergird an individual’s belief system and influence his or her behavior.

For the therapist, attitudes are brought to the therapy session, techniques are chosen, and behaviors are endorsed. Values underpin theoretical orientations. Schools have values which impact the client and the therapy process. The intent of these values is to do "good" for the client.

Having a working definition of values, researchers attempted to determine which values held by the therapist effect clients and how. While therapists' values have been found to impact therapy, little success has been achieved in answering "which" and "how" (Bergin, 1991; Beutler et al., 1986).

Literature Regarding the Therapist’s Values

Research has found that therapists not only bring their values to the therapeutic arena, but therapeutic
outcomes appear to be labelled "successes" or "failures" based on whether or not the client assimilates these values. As noted previously, in an article published in 1955, Rosenthal found a correlation between assimilation of the therapist's values by a client and positive outcome as reported by the therapist (Glad, 1959; Kelly, 1990).

This data has been replicated in later studies. Beutler, Arizmendi, Crago, Shanfield, and Hagaman (1983) examined values convergence between therapist and client and its relationship to improved outcome ratings. They consistently found evidence suggesting "that value convergence is associated with therapists' ratings of improvement, indicating that therapists value patients who come to see the world as they do" (p. 242). In another study between therapists' values and outcome, Kelly and Strupp (1992) noted that therapists "tend to rate higher patients who have assimilated their values" (p. 39).

In addition, literature reviews reveal similar results (Beutler et al., 1986; Kelly, 1990; Kessel & McBrearty, 1967; Vachon & Agresti, 1992). Using stringent criteria to review only the empirical literature regarding therapists' values and
psychotherapy, Kelly (1990) found three consistent conclusions: (a) the values of the client and the therapist converge as the result of therapy, (b) the convergence of the values of the client and the therapist is positively correlated with the therapist’s rating of improvement, and (c) a complex relationship exists between the client and the therapist in regard to their initial values similarity and therapeutic outcome. Kessel and McBrearty (1967) concluded:

the therapist communicates his values to the patient, the patient responds to such communications. . . . psychotherapy may at least in part consist of a didactic situation in which the patient learns and adopts the values of the therapist, the therapist as a controller of behavior is responsible for concern with the issues of values, and mental health, and psychopathology are, at least in part, value problems. (p. 682-683)

Therapists’ values are conveyed to clients. In turn, due to the differential power between therapists and clients, clients perceive these values as being definitive of pathology and/or of health. This places a greater responsibility upon therapists to ensure that
their orienting beliefs are in the best interest of the client.

Several other authors also hold the therapist responsible for the implications of his or her orienting belief system. In his classic work, The Modes and Morals of Psychotherapy, London (1986) argued that therapists attempt to influence their clients, positively reinforcing behaviors deemed desirable by therapists. He labelled psychotherapy a moral endeavor. Humphries (1982) noted that others concurred; "they see it as a religiously oriented or value oriented enterprise masquerading in the guise of a medical treatment with scientific credibility" (p. 128-129). Thatcher (1987) and Doherty (1995) pointed out that clients can ascertain therapists' values by the questions asked.

Once they had established in general principle that therapists' values effect therapy, researchers sought to assess particulars regarding therapists' values and the therapeutic arena. While researchers have not been able to determine which specific values held by therapists impact therapy (Bergin, 1991; Krasner & Houts, 1984), similarities in the values of therapists have been found. In other words, while
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Therapists appear to adhere to general values, individual values have not been able to be sufficiently isolated to determine the influence each may have on therapy. Bergin (1991) found a "high consensus" of general values regarding mental health which:

- may be described as being a free agent, having a sense of identity and feelings of worth;
- being skilled in interpersonal communication, sensitivity, nurturance, and trust;
- being genuine and honest;
- having self-control and personal responsibility;
- being committed in marriage, family, and social relationships;
- having a capacity to forgive others and oneself;
- having orienting values and meaningful purposes;
- having deepened self-awareness and motivation for growth;
- having adaptive coping strategies for managing stresses and crises;
- finding fulfillment in work;
- and practicing good habits of physical health. (p. 394-395)

Mental health is viewed as being primarily based in autonomy with other aspects being secondary. If mental health is determined based on therapist values, a logical deduction would seem to be that mental illness
be defined as being incongruous with the value systems of therapists.

Other research on values held by therapists has been mixed. Studies have not found values differences between religious and non-religious therapists (Gibson & Herron, 1990). Conversely, Krasner and Houts (1984) did find differences pertaining to theoretical orientation. Krasner and Houts found that behaviorists tended to endorse "factual quantitative, empirical, and objectivist approaches" more than a comparison group of non-behaviorists who advocated a more "humanistic and subjectivist approach to psychology" (p.847). Another study found psychoanalytic therapists maintained that they withheld their values from the therapeutic arena more than any other school of therapy (Norcross & Wogan, 1987). Differences appear to be based on theoretical orientation more than any other variable.

Theoretical Orientations

Values held by individual therapists are not alone in impacting therapy. Theoretical orientations have therapeutic values which consist of a "belief in the value of freedom, independence, and individuality, and in individual’s rights, privileges, and
responsibilities" and are "inherent in the theory of therapy held by the therapist" (Gibson & Herron, 1990, p. 7). Additionally, clinicians tend to choose theoretical orientations that most closely reflect their personal value systems (Gregory & McConnell, 1986; Shapiro, 1986; Trepper & Barrett, 1986), while schools of psychotherapy themselves have intrinsic value systems (Bergin, 1985; Glad, 1959; London, 1986; Patterson, 1989). Just as therapists vary on the degree to which they will overtly recognize the impact of their values on therapy, acknowledgment of the role of values in therapy by schools of thought also runs on a continuum. Some schools such as Reality Therapy readily admit to incorporating value judgments (Thatcher, 1987). Others, particularly those behaviorally oriented, consider themselves to be scientifically based (Kantrowitz & Ballou, 1992; Kelly, 1990; Krasner & Houts, 1984; Smith, 1954).

Several authors have discussed the value inherent in theoretical schools of thought (Brown & Ballou, 1992; Corey, 1986; Corsini & Wedding, 1989; Glad, 1959; Hillner, 1984; Jones & Butman, 1991; Kaplan & Yasinski, 1980; London, 1986). An overview of traditional schools of thoughts will be presented next. However,
as the current number of psychotherapy systems is over 200 according to Corsini (1989), four main orientations will be reviewed (psychodynamic, behavioral, humanistic, and family systems).

The position of the original patron of each school will be reviewed, with particular attention given to the work of Sigmund Freud. Freud is the benchmark by which other theories are compared within psychiatry and psychology. He heavily influenced the work of others, both those who were his contemporaries and those who followed (for further discussion see Appendix B.)

Adherents to the four main orientations built on the work of the original theorist for that school. Writers such as Freud, Skinner, Rogers, and Maslow provide the theoretical foundation and framework. Their assumptions and values are continued, though perhaps in modified form, by current writers. While later writers may address particular items, the originating authors provide the global aspect of each orientation. The groundwork laid determines the stability of the structure built upon it and must be examined.

Within each of these orientations, two areas will be emphasized. The first area will be the goal of
therapy. The second component, the orienting belief regarding female development, is important, especially given the extensive literature accumulated by social psychologists on ways in which one’s expectations, perceptions, and reactions are shaped by the gender or presumed gender of an interaction partner, it is highly probable that therapists, like people in general, are influenced by the gender of their clients (Marecek & Johnson, 1980, p. 67).

Gender is a significant variable in human interactions and, as such, is as consequential to therapy as is the goal of any given orientation.

Psychodynamic Theory

Psychodynamic theory is the first major school to be addressed. It is based primarily on the works of Freud and his disciples, many of whom modified Freud’s works. The goal of psychodynamic therapy is for the client to gain insight and resolution of internal conflicts that stem from the client’s childhood. This is achieved by progressing through the stages of "resistance, transference, and interpretation" (Hillner, 1984, p. 216). This orientation
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assumes that all human behavior is determined by psychic energy and early childhood experiences. . . . it is necessary to understand the behavior's roots in largely unconscious conflicts and motives. . . . [that] are irrational and strong, and most often related to aggressive sexual impulses. . . . the goal is to illuminate critical life events in the formative childhood years in order to resolve the "problems in living" that emerge throughout the remainder of the life span. . . . through greater self-knowledge and self-control can mature adults increase their capacity to "love and work" effectively. (Jones & Butman, 1991, p. 66-67)

For the psychodynamic therapist, conflicts in current relationships are secondary to internal conflicts which stem from childhood experiences (Okun, 1992; Rosiers, 1993). As Scharff and Scharff succinctly wrote, "Our external relationships are in interaction with our internal psychic structures" (1992, p. 4).

Psychodynamic orienting belief regarding female development. Of the four orientations to be reviewed, psychodynamic theory, relying heavily on Freud's writings, offers the most thorough theory of the
development of women and, therefore, will be covered in
detail.

In 1925 Freud (1974a) wrote an essay entitled Some
Psychical Consequences of the Anatomical Distinction
Between the Sexes. He noted

In examining the earliest mental shapes assumed by
the sexual life of children we have been in the
habit of taking as the subject of our
investigations the male child, the little boy.
With little girls, so we have supposed, things
must be similar, though in some way or other they
must nevertheless be different. The point in
development at which this difference lay could not
be clearly determined. [emphasis added] (p. 28)

Two paragraphs later, Freud continued, "As regards the
prehistory of the Oedipus complex in boys we are far
from complete clarity" [emphasis added] (p. 29). Yet,
in the following paragraph, he declared, "I have been
able to reach some conclusions which may throw light
precisely on the prehistory of the Oedipus relations in
girls" [emphasis added] (p. 30).

That Freud, who was "far from complete clarity"
for males, was able to "throw light precisely" on the
development of girls is vital information. This
contradiction must be remembered when evaluating Freud’s view of women and, later, in reviewing literature on women’s development.

According to Freud, psychosexual development for the female child and the male child is identical up to around age 5 (see Table 1), when the Oedipal stage begins (Kaplan & Yasinski, 1980; Small, 1989). Freud stated that during the Oedipal stage the female notices the penis of a male. The result is that they “at once recognize it as the superior counterpart of their small and inconspicuous organ and from that time forward fall a victim to envy for the penis” (Freud, 1974a, p. 31).

Penis envy becomes the center of development for females (Freud, 1974a; Ogden, 1987; Sagan, 1988; Torrey, 1992; Young-Bruehl, 1989). Females are devastated by discovering they lack this superior appendage. They seek to make up for this loss through bearing a male child or vicariously by mating. Freud did not recognize “the role that the girl’s own genital may play in her development” (Bernstein, 1990, p. 151).

In addition, the mother is perceived to be inferior by children (Dujovne, 1991; Small, 1989; Torrey, 1992). Little boys, according to Freud, learned to dismiss their mothers as inferior due to
Table 1
Freud’s Stages of Development

<table>
<thead>
<tr>
<th>Age</th>
<th>Stage</th>
<th>Gender/Pass?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st yr</td>
<td>Oral</td>
<td>Male pass/Female pass</td>
</tr>
<tr>
<td>2nd yr</td>
<td>Anal</td>
<td>Male pass/Female pass</td>
</tr>
<tr>
<td>3rd yr</td>
<td>Phallic</td>
<td>Male pass/Female unable to pass</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(Substages of this phase beginning about age 5: Oedipal in boys/ Electra in girls)</td>
</tr>
<tr>
<td>7th yr</td>
<td>Latency</td>
<td>Male pass</td>
</tr>
<tr>
<td>Puberty</td>
<td>Genital</td>
<td>Male pass</td>
</tr>
</tbody>
</table>

their lack of a penis. On the other hand, little girls come to resent the mother for not giving them the envied anatomical part (Freud, 1974b; Caplan, 1989; Kaplan & Yasinschi, 1980).

Freud maintained that the Oedipal-stage child needed to repress the mother-image internalized during pre-Oedipal stages in order for the (male) child to become a fully functional adult. Freud suggested that while good mothering benefitted nothing (the father played the major role in the Oedipus complex), poor
mothering resulted in pathology (Freud, 1974b; Sagan 1988). By identifying with the father, the child moved on to develop normally (Neubauer, 1985; Ogden, 1987). He believed that only men were able to successfully traverse the Oedipus complex.

Females, on the other hand, identified with and remained attached to the mother even after the phallic stage. Thus, they were incapable of reaching the maturity levels achieved by men (Sagan, 1988). Instead, women naturally became passive, masochistic, and narcissistic (Dujovne, 1991; Greenspan, 1993; Kaplan & Yasinski, 1980; Small, 1989; Young-Bruehl, 1990).

Some psychodynamic analysts have argued that Freud's views are dated and have been updated by current theorists. While Freud's theories have been re-evaluated, many aspects of his views on women remain central tenets (Caplan, 1985; Chesler, 1989; Giannandrea, 1985). Many continue to maintain that early oedipal development is the source of difficulties encountered in treating female clients (Dahl, 1989; Ogden, 1987). Others have attempted to meld classical Freudian theory with current thought (Dujovne, 1991; Okun, 1992). In addition, "many of Freud's ideas have
become deeply ingrained in our society" (Greenspan, 1993, p. 15); for example, concepts such as penis envy, the Oedipal stage, and justification for the devaluation of women. As Small (1989) noted, much work yet remains in this area.

**Summary.** The orienting belief for psychodynamic therapy is that the resolution of intrapsychic conflict, which stems from early childhood experiences, will enable the client to resolve problems of the present. These early childhood experiences center around the mother until the Oedipal stage (age 5). In addition, its early view of women was that their development was flawed and inferior to that of men. Later theories have attempted to change the term from inferior to different while continuing to hold Freud's view of the importance of the Oedipal stage and penis envy as the gold standard.

**Behavioral Theory**

Unlike psychodynamic theory which was based on interpretations of observations, behaviorism was based on the empirically-derived research conducted in the laboratories of J. B. Watson and B. F. Skinner (Kantrowitz & Ballou, 1992). Both men believed the primary focus of human study should be an organism's
behavior which was the result of an input-output operation.

Watson's classical work explained an organism's conditioned response to an environmental stimulus. In his now famous Little Albert experiment, Watson sought to show that emotional responses were the result of conditioning. He and his partner were successful (Watson & Rayner, 1920/1983).

Skinner provided data to show that a behavior could be increased or decreased based on a system of reinforcements and that organisms learned to interact with their environment based on operant conditioning (Hillner, 1984; Skinner, 1956/1983). He maintained that only external behaviors which were observable and could be empirically and scientifically scrutinized were important. In addition, external behaviors were the results of some cause-and-effect type of input. By controlling the input, one could also predict and control the outcome. Skinner assumed all behavior is determined, or controlled by environmental contingencies, such that the locus of behavioral change must reside in the external physical and social environment. The fundamental question is not whether control does or should
exist; the basic problem is one of benign and efficient control. (Hillner, 1984, p. 176)

Skinner maintained that behavior could be changed by changing the patterns of reinforcement.

Later, cognitive-behaviorists incorporated into behaviorism the notion that an information processing ability functions as an intermediary between a stimulus and an organism's response. Cognitive-behaviorism attempts to change behavior by altering dysfunctional thought processes.

According to Bart (1971), the purpose of therapy is the "elimination of symptoms thus increasing the patient's comfort--general value on rationality" (p. 117). Goals are determined by the client and defined behaviorally (Wilson, 1989). As a result, behaviorism is seen as reductionistic (Jones & Butman, 1991; Kantrowitz & Ballou, 1992). The behaviorist focuses on behavior and the cognitive-behaviorist focuses on cognitions without due regard to forces external to the client and the therapeutic arena which may be impinging on a positive outcome.

Behavioral orienting belief regarding female development. Behaviorists and cognitive-behaviorists do not differentiate between males or females in terms
of behaviors. However, women live in a real world that is not gender-blind. An illustration of the consequence of this may be the issue of assertive versus aggressive behavior. Skinner (1956/1983) maintained that "no behavior is itself aggressive by nature" (p. 367); yet studies show that when males and females act in equally assertive fashion, females are perceived as being aggressive (Blechman, 1980; Kantrowitz & Ballou, 1992). In fact, Blechman noted, "Construction of repertoires of competent behavior for women is hard, because adult women have traditionally been expected to be ineffective at some major adult pursuits" (1980, p. 225).

In truth, behavior is often understood as being gender-specific. One author recounted that

Expert and peer men and women judges identified comparable noncoercive behaviors as assertive when enacted by men but aggressive when enacted by women . . . approved of successful men but not of successful women . . . and judged men as more skillful than women. . . . Much behavior that is now statistically typical of women is well regarded neither by men nor by women. Both college men and women reported wanting to be more
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masculine. . . . Statistically normal behavior is not necessarily effective. (Blechman, 1980, pp. 225-226)

Certain behaviors have been labelled as "feminine" or "masculine" and appropriation of such behaviors across gender lines may be construed as deviant.

Summary. Behavioral and cognitive-behavioral therapies value rationality and behavioral modification. While the importance of gender is denied in therapy, therapists and clients alike bring to therapy certain cultural biases on what is appropriate behavior. Behaviorism fails to allow for the engendered culture in which people live (Kaschak, 1992). The impact of sex-role socialization on therapists was highlighted in the work of Broverman and colleagues reported earlier (Broverman et al., 1970). Additionally, Gilligan (1982) reported that women tended to interpret behavior in terms of the consequences of the behavior on relationships; this is at odds with behaviorists who see behavior as consequences of reinforcers.

Humanistic Theories

Sometimes called the "third force" (Hillner, 1984; Lerman, 1992; Nichols & Schwartz, 1991), humanistic
psychotherapies are based on the works of Carl Rogers and Abraham Maslow. These two men provided the foundation for the theory and practice of humanistic psychotherapy. Rogers focused on "becoming" while Maslow studied people whom he perceived to be healthy and whole adults. Each will be reviewed independently.

**Carl Rogers.** Rogers (1961) believed in "man's tendency to actualize himself, to become his potentialities" (p. 351). This could be achieved through therapy by a therapist modeling unconditional positive regard, genuineness, and empathy. Central to Rogers' theory is the "organismic valuing process" (Raskin & Rogers, 1989; Rogers, 1955/1983, 1959, 1967) in which the individual inherently has the ability to choose those things which enhance growth and reject the things which do not.

Rogers heavily relied on the power of the individual as an isolated and autonomous unit. In describing how he arrived at his conclusions about psychotherapy, he noted that it occurred during a "period of relative professional isolation" (1961, p. 10). Acknowledging that his perception is based on his "interpretation of the current meaning of my experience" [italics original] (p. 27), Rogers wrote,
"Simply describing these experiences makes me realize how stubbornly I have followed my own course, being relatively unconcerned with the question of whether I was going with my group or not" (p. 12). Further, according to Rogers,

Each person is an island unto himself, in a very real sense; and he can only build bridges to other islands if he is first of all willing to be himself and permitted to be himself. So I find that when I can accept another person, which means specifically accepting the feelings and attitudes and beliefs that he has as a real and vital part of him, then I am assisting him to become a person: and there seems to me great value in this. (p. 21)

Rogers viewed the self-actualizing individual as one who is first and foremost an "island unto himself."

From this isolated position, the individual connects with others secondarily. Rogers believed that therapists could aid the process of self-acceptance and then connection by accepting the other as he or she is. For Rogers, the connection between the individual and relationship was uni-directional and true relationship
could only be established by an autonomous, individuate person.

Abraham Maslow. Maslow (1962) based his theories on the study of people he perceived as healthy examples of humanity. He postulated that humans naturally moved toward self-actualization by traversing a hierarchical needs pyramid. Among his characteristics for the self-actualized individual are independence from the environment, spontaneity, appreciation of the basic givens of life with continued freshness and pleasure, and nonconformity (Hillner, 1984).

Maslow (1962) understood the impact of the culture on the individual: "Sick people are made by a sick culture; healthy people are made possible by a healthy culture" (p. 5). Yet, despite the negative impact of culture on women, he focused on the problem as the client’s issue:

Many brilliant women are caught up in the problem of making an unconscious identification between intelligence and masculinity. To probe, to search, to be curious, to affirm, to discover, all these she may feel as defeminizing. . . . Many cultures and many religions have kept women from knowing and studying, and I feel that one dynamic
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root of this action is the desire to keep them "feminine" (in a sado-masochistic sense). . . . At an unconscious level, knowing as an intrusive, penetrating into, as a kind of masculine sexual equivalent can help us to understand the archaic complex of conflicting emotions that may cluster around . . . some women's feeling of a contradiction between femininity and boldly knowing. (p. 59-60)

Although acknowledging cultural gender bias, Maslow, nonetheless, identifies "knowing" as masculine. He placed greater emphasis on the role of the individual than on the culture.

He does not recognize a gender difference in his definition of an "authentic person" which is one who not only transcends himself in various ways; he also transcends his culture. He resists enculturation. He becomes more detached from his culture and from his society. He becomes a little more a member of his species and a little less a member of his local group. (p. 11)

For Maslow, the epitome for the individual was independence and autonomy from the influences of the culture. As with Rogers, Maslow's perception was that
healthy individuals establish relationships from an autonomous position.

The focus for both men was the individual and the way the self experiences events in life. The individual was imbued with the power to change and control their environment by the choices they made and by changing themselves (Greenspan, 1993; Kaplan & Yasinski, 1980; Lerman, 1992). For Maslow self-actualization is an end-product; for Rogers it was a process (Hillner, 1984).

**Humanistic orienting belief regarding female development.** Humanistic psychotherapy is egalitarian in its view of human development. As with behaviorism, it does not propose differences in either the process of development nor the experiences of life according to gender. For the humanistic therapist, growth and self-awareness are the natural outcomes of a healthy therapeutic alliance.

**Summary.** Originally, the humanistic school of Rogers and Maslow was hailed by feminists as compatible with the egalitarian views of the movement (Lerman, 1992). However, this orientation emphasizes an individual’s experiences while neglecting the impact of external reality on the individual (Greenspan, 1993;
Lerman, 1992). The humanist orientation emphasized the free choice of an individual to self-actualize. However, Root (1992) argued that "traumas wound deeply in a way that challenges the meaning of life" (p. 229); if her position is correct, external forces may impinge on an individual’s ability to self-actualize (regardless of gender).

Family Systems

Family systems therapy moved therapeutic focus from the individual to the family. According to Jones and Butman (1991), seven major family systems models exist:

1. Structural family therapy based on the works of Minuchin.
2. Strategic family therapy based on the works of Haley.
3. Communication model based on the works of Satir.
4. Family systems model based on the works of Bowen.
5. Behavioral social exchange model based on behavioral and social-learning principles.
6. Psychodynamic/object-relations model using the work of Ackerman and Boszoremenyi-Nagy.
7. Experiential model based on humanistic ideas and the work of Whitaker.

Of these seven, several subsume categories already covered. The obvious three are behavioral, psychodynamic, and experiential/humanistic. Another, Bowen's family systems model, was heavily influenced by Freud and psychoanalysis (Foley, 1989; Nichols & Schwarz, 1991). Haley (1963) portrayed family systems as building on Freud's work. Minuchin's (1982) theories were a reaction against his psychoanalytic training. By her own report, Satir was heavily influenced by the humanists (Satir, 1983; Satir & Baldwin, 1983; Woods & Martin, 1984).

Family theorists attempt to hold the individual and the family in balance and in tension. For example, Minuchin wrote, "The sense of separateness and individuation occurs through participation in different family subsystems in different family contexts" (1974, p. 47). Individual autonomy and independence in the context of the family is valued by this system (Bograd, 1987; Green & Holevzon, 1984; Haley, 1984; Matorin & Greenberg, 1992; Satir, Bitter, & Krestensen, 1988).

According to family systems theory, the family functions to maintain a homeostasis. The "identified
patient" or I.P. is simply acting out the dysfunction of a family (Gross, 1994; Matorin & Greenberg, 1992; Minuchin, 1982; Nichols & Schwartz, 1991). "As a result, the locus of the pathology is shifted from the individual to the system" (Foley, 1989, p. 455). By correcting the balance of interpersonal relationships between members of the family, the whole system will function in a manner healthy for the system and for the individual. This was done, according to early theorists, by a value-free therapist assessing and adjusting family values, which played a role in the functioning of the family (Nichols & Schwartz, 1991).

Haley (1963), Minuchin (1974, 1982), and Satir (1983), in particular, focus on familial interactions. Haley, a communications analyst, placed "particular emphasis . . . upon what are generally agreed as symptoms, although these symptoms will be seen from a communication rather than an intrapsychic point of view" (1963, p. 3). For Satir (1983), dysfunction is the result of faulty communication within the family. Healthy families openly and directly communicate their wants and needs to other family members. In dysfunctional families, communication is vague and obtuse, often with hidden meanings and agendas.
Minuchin (1974) proposed that "three assumptions—that the context affects inner processes, that changes in context produce changes in the individual, and that the therapist’s behavior is significant in change—have always been part of the common sense basis of therapy" (p. 9). Minuchin centered on the family structure and its types of interactions. For him, the individual and the context could not be separated and, in order for change to occur, the context had to change.

**Family systems orientation regarding female development.** Individual development is not negligible in family systems. The emphasis is on the development of the system which evolves into either a functional or dysfunctional unit. Marecek and Johnson (1980) noted that "surprisingly, there is only a small amount of literature concerning gender influences on the process of marital and family therapy" (p. 69). Later, feminist theorists accused family system therapists of maintaining the hierarchical, patriarchal structure prevalent in society (Bograd, 1987; Caplan, 1989; Nichols & Schwartz, 1991). Caplan (1985) noted that family therapists have traditionally focused on preserving the nuclear family, ignoring the
harmful effects that traditional cultural practices can have on the family members. . . . Many therapists sincerely believe that a woman who has an equal share of the power in the family is the cause of a troubled family's "dysfunction," because her power makes the family non-traditional, and automatically flawed. (p. 208)

Gurman and Klein (1980) supported this assessment by noting that Minuchin saw "himself as modeling the male executive functions, forming alliances, most typically with the father, and . . . demanding that the father resume control of the family" (p. 172).

Additionally, Bograd (1987) asserted that language utilized by family systems tended to pathologize "the normative structure of family relations" (p. 70) and of women. She wrote, "There is theoretical evidence that suggests, however, that this model is not appropriate for understanding women's development, specifically their experience of self and relationships" (p. 73-74). Bograd maintained that the family systems view of enmeshment, a basic family systems term, was gender-neutral 'in theory, only; in practice, it ignored female
Therapists' Values

Development literature in favor of a male-based view of
development and healthy functioning.¹

Summary. Family systems therapy views pathology
in terms of the family system rather than in terms of
an individual "identified patient." The goal of this
type of therapy is to help the family achieve a
homeostatic balance that spawns healthy individuals.
Unfortunately, prior to the feminist critique of the
orientation, the theory assumed equal power-sharing
between the parents while continuing to promote a
traditional family system that was patriarchal in
structure.

Summary

Therapy is not value-free. Instead, therapists
bring values to the therapeutic arena. Utilizing those
values, therapists define what is healthy and what is
pathology, what is a successful therapeutic outcome and
what is an unsuccessful therapeutic outcome. While

¹Bograd also addressed "disengagement," noting
that reactions to it are less critical than to
enmeshment. Additionally, "disengagement" has
different connotations for men than for women.
research has been not been able to examine individual values in isolation, one value has been widely held by therapists--namely, individual autonomy.

Additionally, values are intricately tied to theoretical orientations which delineate the type of interaction therapists have with clients, including questions asked, avenues pursued, and assessment of outcome. Theoretical orientations not only have general values; they also have specific values on such topics as female development.

Four theoretical orientations were examined. The goal of psychodynamic theory is insight. This theory has the fullest definition of female development of the four orientations reviewed. Behavior theory maintains behavioral change as its goal. While this theory does not explicitly acknowledge gender as a variable, societal values clearly hold differing expectations for male and female behavior. The humanistic school focuses on self-actualization of the individual. Again, this orientation does not explicitly acknowledge differences in gender and, therefore, does not address the issue of societal expectation. Finally, family systems therapy views the family as dysfunctional and in need of gaining a healthy balance. However, it
fails to address the differential of power in some marital relationships, nor does it address the detrimental impact some traditional definitions of the functional family have on women.

In summary, therapists' values play an orienting and process-setting role in the therapeutic arena. These values relate to therapists' personal and professional beliefs and assumptions as to what is "good." Values are used to evaluate clients and process outcome.

Having surveyed the research regarding the role of therapists' values in the therapy process and of the values inherent in four traditional theoretical orientations, the next chapter highlights the literature pertaining to the client based on a feminist view of female development. This view values connection and empathy as healthy aspects of female development. Another component of this view addresses the cultural tendency to devalue women.
CHAPTER 2

FEMALE DEVELOPMENT

The therapist and his or her values are not alone in the therapeutic arena. The other participant in the therapeutic alliance is the client. Her development and experiences have traditionally been interpreted by male observers rather than by a jury of her peers (Ballou & Gabalac, 1985; Chesler, 1989; Erikson, 1974; Greenspan, 1993.) As such, traditional developmental theories have been inadequate in describing female development in terms other than as inferior or pathological. In contrast, female development discerned from the perspective of some feminists provides a foundation for understanding and appreciating the client’s experience as a woman (Chodorow, 1989; Jordan et al., 1991). This developmental theory incorporates a female model which values relationship and empathy while acknowledging the negative impact of societal gender bias.
Gender bias is pervasive (Schur, 1984). Cultural gender bias determines appropriate sex-role behaviors and aspirations. Women are often expected to fit impossible sex-role stereotypes while being denied access to wider areas dominated by men.

Gender bias is seen in the literature on domestic abuse. On a societal level, women are the most frequently abused victims as well as the most readily blamed or ignored victims (Thorne-Finch, 1992). Academically, advocates\(^5\) (Avis, 1994; Jacobson, 1994a, 1994b) complain that female perspectives tend to be ignored by the predominantly male research community.

To appropriately address issues experienced by female victims of domestic abuse, therapists need an appreciation of healthy female development and an understanding of matters unique to domestic violence. In this chapter I will address the first of these two aspects. Female development will be based on feminist developmental theory as proposed by Chodorow (1989) and Jordan et al. (1991). This position values the continuity of the mother-daughter relationship as one affording the individual a foundation for connected

\(^5\)For a working definition of advocate as used here refer to page 12.
relationship and empathy. This position is distinct from the larger society which devalues women and women's experiences.

In regard to the second issue, domestic abuse occurs in a social relationship. It has implications for society, academia, and families. Society lacks clear guidelines regarding domestic violence. Academia frequently ignores the voices of predominantly female advocates in favor of predominantly male researchers. The familial context of this type of violence is often ignored by those who focus on the actions of the victim. These avenues will be examined in the next chapter. Included in the familial context will be literature on the client's domestic relationship, her partner, her children, and herself.

I will begin by briefly assessing the inadequacies of traditional developmental theories. This will be followed by a review of the literature on female development. Finally, gender bias in society and its impact on women will be examined.

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6Violence against partners occurs in both opposite-sex and same-sex relationships. However, I will address only opposite-sex relationships.
Developmental theories generated in the early years of psychological research were primarily based on male observations of males, as Freud (1974a/1925) freely admitted. Subsequently, female development was interpreted within a male framework (Benton, Czechanski, Pavy, & Sweeney, 1993; Chesler, 1989; Greenspan, 1993; Horney, 1974/1926; Kaschak, 1992; Lerner, 1988). Since the male model was cited as the epitome of development, female aspects of development differing from the male model were construed as inferior (Ballou & Gabalac, 1985). The tendency to think in hierarchical terms left women (who make up the majority of clients) in a deficient or inferior position to men (who made up the majority of clinicians and theorists) (Ballou & Gabalac, 1985; Chesler, 1989; Greenspan, 1993).

For example, Erikson (1974), best known for his stages of psychosocial development, acknowledged gender differences (see Table 2). He noted that young girls and young boys used space differently in their play (Erikson, 1974; Lax, 1994). Based on this observation, he surmised that "inner space" (Erikson, 1974, p. 349)
Table 2

Erikson’s Stages of Development

<table>
<thead>
<tr>
<th>Age</th>
<th>Male Stage</th>
<th>Female Stage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birth</td>
<td>Basic Trust</td>
<td>Basic Trust</td>
</tr>
<tr>
<td>2 yrs</td>
<td>Autonomy</td>
<td>Autonomy</td>
</tr>
<tr>
<td>4 yrs</td>
<td>Initiative</td>
<td>Initiative</td>
</tr>
<tr>
<td>6 yrs</td>
<td>Industry</td>
<td>Industry</td>
</tr>
<tr>
<td>12 yrs</td>
<td>Identity</td>
<td>Psychosocial Moratorium*</td>
</tr>
<tr>
<td>22 yrs</td>
<td>Intimacy</td>
<td></td>
</tr>
<tr>
<td>34 yrs</td>
<td>Generativity</td>
<td></td>
</tr>
<tr>
<td>60 yrs</td>
<td>Ego Integrity</td>
<td></td>
</tr>
</tbody>
</table>

*According to Erikson, Psychosocial Moratorium ends when a female finds a male with whom she can connect; he does not address further development.

played an important role throughout female development. This was noticeably different from what he had observed in males, yet he did not incorporate this gender difference into his theory of psychosocial development.

While Erikson’s adolescent developmental stage has been characterized as one of identity "or the
individual’s attempt to define himself or herself as a unique person" (Berger, 1986, p. 516), Erikson (1974) believed that the adolescent stage was different for females than for males. Despite texts on human development which merge male and female development at all stages of development (Berger, 1986; Newman & Newman, 1991), Erikson did not believe that males and females traversed the adolescent stage in the same manner. For the male, adolescence was a period of increased autonomy and individuation; for the female, adolescence was a period of "psychosocial moratorium" (Erikson, 1974, p. 353) which ended when she "succeeded in selecting what is to be admitted to the welcome of the inner space 'for keeps'" (p. 354)--i.e., a man. Erikson did not incorporate this gender difference into his psychosocial stage (Gilligan, 1982). In effect, Erikson’s stages trace only male development while it is presented in most textbooks as reflective of both genders.

Some female theorists suggested alternative explanations for traditional views of female development. Horney (1974/1926) wrote that "the psychology of women hitherto actually represents a deposit of the desires and disappointments of men" and,
as such, forced women to adapt their "true natures. . . to the suggestion of masculine thought" (p. 201).
Thompson (1974c/1941) suggested that culture played a significant role in female development by utilizing only the experience of males to define and explain the shaping of both sexes. In her classic work, *Against Our Will*, Brownmiller (1975) documented the prominence of male perspectives in defining and explaining women's experiences (particularly violent experiences) and how, historically, these perspectives have exonerated men and vilified women. Sadker and Sadker (1994) wrote, "when the male becomes the norm, the female does not fit the theory" (p. 227).

While earlier feminist works appear to focus on external forces that impinged upon female development, later work shows a shift to internal factors of female development. For example, Katz and Ksansnak found that different innate "developmental patterns [are] associated with how gender-related behaviors are acquired with regard to the self and to others" (1994, p. 281). This latter line of thought detailed healthy aspects of female development such as connection and empathy. Noting that these aspects are generally de-valued in society and in psychology, this later
developmental theory submitted that the deficits were in society rather than in female development as insinuated by traditional developmental theories.

Therapists' lack of understanding of healthy female development, in part, was due to their training, which in the past frequently ignored literature focusing on women's experience. Often, the literature reviewed was limited and presented a male point of view or emphasized pathology rather than a female view emphasizing unique female "normalcy." Recently, feminist writers have begun to develop a model for females that is built on connection and relationship rather than the male model of separation and autonomy.

Female Development

Based on the early works previously mentioned, some feminists' proposals emphasize the experience of women and normalize women's development and life experiences (Brown, 1992b). Without a clear understanding and valuing of normal female development, a therapist may be oriented to look for pathology where none exists or to assume pathology exists separated from context. For example, a therapist observes that a
client is hypervigilant and has paranoid ideation. The therapist oriented to detect pathology may focus on the paranoia and diagnose the client as having Paranoid Personality Disorder. However, if the therapist gives due weight to the fact that the client had been a recent rape victim, the paranoia would be viewed as a normal response to a traumatic event and warrant a clinical diagnosis rather than a personality disorder diagnosis. To ignore the context is to declare the client's experience invalid.

Though female developmental theory is still in its early stages, precursory research provides a patchwork for a preliminary understanding of the process. Early findings appear to support the feminist developmental theory that development for women is done in connection. Although to date no clear, comprehensive developmental life-span theory for women has been developed, research and theories provide a beginning for understanding development at different stages of a woman's life, beginning at birth and progressing to adulthood.
Childhood Development

Gender assignment starts at the very beginning of life and continues throughout the life cycle. It begins with the first question ever asked about the child: Is it a boy or a girl? Society has expectations and norms built on the answer to that basic question (Ballou & Gabalan, 1985; Brownmiller, 1975; Campbell, 1993; Faludi, 1991; Gilbert, 1984; Kaschak, 1992; Lyddon, 1991).

The child acquires an awareness of gender very early. Contrary to Freud's hypothesis that gender awareness occurs during the Oedipal stage (about 5 years of age), current research points to a much younger age for gender awareness in children. Poulin-Dubois, Serbin, Kenyon, and Derbyshire (1994) discovered that an "infant's gender categories [which] include[s] intermodal knowledge about female faces and voices" (p. 439) may occur as early as the age of 9 months but is securely established by 1 year of age. A child forms some understanding of gender differences by 15 to 18 months of age (Bernstein, 1990).

Around 3 years of age, gender becomes pivotal for children. At this age children begin to categorize according to gender stereotypes (Poulin-Dubois et. al,
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1994; Powlishta, Serbin, Doyle, & White, 1994). Three-year-old children show increasingly greater affinity for interacting with same-sex peers (Bracken & Crain, 1994; Poulin-Dubois et al., 1994; Powlishta et al., 1994). Thus, gender awareness occurs at a much earlier age than originally conceived in traditional theories.

In addition to gender awareness, gender bias also appears to occur early in the developmental process. In researching prejudice in children (ages 5 to 13 years old), Powlishta and her colleagues (1994) discovered that children not only attributed positive traits to their own sex and nominated same-sex peers as "most liked," but they also attributed negative traits to the other sex and nominated cross-sex peers as "least liked." . . . In contrast to the general pattern of declining prejudice noted earlier, one measure of bias actually increased with age: Older children were more likely than their younger counterparts to nominate same-sex classmates on the positive sociometric measure. (p. 533)

While same-sex and cross-sex attributions appear to coincide regardless of gender, another component was
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not gender-neutral: "boys are resistant to influence attempts by girls and frequently dominate cross-sex interactions" (p. 534). A study of children ages 12 to 16 months found that when girls acted in an aggressive manner, their behavior was typically ignored; when boys acted in like manner, their behavior typically was attended to by parents (Birns et al., 1994). Girls tend to use verbal persuasion; boys tend to use "commands and physically aggressive tactics" (Birns et al., 1994, p. 53). Gender, gender awareness, and gender bias are basic in development.

Feminist theorists suggest that gender influences development throughout the life span. Dujovne (1991) wrote, "The feminine line of development becomes strengthened with gender assignment at birth which labels the infant as male or female and cultural influences that shape the infant to its assigned sex" (emphasis original, p. 318). Gender forms a basic building block of development and of identity. Katz and Ksansnak (1994) defined gender as "based in part on biological differences but is also a social construct that is highly correlated with differences in socialization practices" (p. 273). Separating the biological aspects from the social aspects of gender is
an impossible task; the two are too deeply intertwined to allow one or the other to be isolated (Katz & Ksansnak, 1994, Van Leeuwen, 1990). Therefore, both are assumed to play a role in gender development but the weight of each part is beyond the scope of this dissertation.

For the female child, development is predicated on the idea of the "self-in-relation" (Kaplan, 1991; Lerner, 1988; Miller, 1991a; Randour, 1987; Stiver, 1991a; Surrey, 1991). While the male infant must acknowledge "I am not like mother" as his awareness of gender develops, the female infant develops a sense of self increasingly based on the idea "I am like mother." This continuity of connected identity with the mother establishes for the female child a foundation not disrupted by dramatic separation experienced by the male child (Chodorow, 1989; Dujovne, 1991; Freed, 1985; Giannandrea, 1985). In other words, the male traverses a period of psychological trauma in which he disconnects from the mother and arrives at the notion "I am male and not like mother"; the female does not.

This continuity develops within the female child an increased capacity for empathy and relationship. Sagan (1988) pointed to identification with early
mothering as the source for empathy, compassion, and nurturance. "Mothering behavior is part of the socialization of little girls" (Tam, 1994). The mother-daughter dyad is experienced as one of mutual empathy and sets the foundation for intersubjectivity as the cornerstone of female development and a cognitive map for her experiences (Surrey, 1991). The continuity of identification with mother experienced by females promotes the development of empathy and provides a forum to experiment with self as a relational, connected being.

Empathy, as described by Jordan (1991a, 1991b), incorporates affect and cognition in a developmental progression. Initially, empathy is a means for human relatedness whereby one emotionally experiences an event by identifying with the emotional state of another. A resolution period follows the identification period, during which the empathic person is able to separate from the other person while maintaining an understanding of the experience as it exists for the other. As the female child grows, this resolution period matures and allows her to balance connection with others with a sense of self. Jordan (1991b) further developed this view of empathy:
In order to empathize, one must have a well-differentiated sense of self in addition to an appreciation of and sensitivity to the differentness as well as sameness of the other. Empathy always involves surrender to feelings and active cognitive structuring; in order for empathy to occur, self boundaries must be flexible. Experientially, empathy begins with some general motivation for interpersonal relatedness that allows the perception of the other's affective cues (both verbal and nonverbal) followed by surrender to affective arousal in oneself. This involves temporary identification with the other's state, during which one is aware that the source of the affect is in the other. In the final resolution period, the affect subsides and one's self feels more separate. (p. 69)

In this way, empathy becomes self-perpetuating. Empathy fulfills the desire to be connected to another. This connection leads to greater empathic ability, which, in turn, nurtures the desire to be in relationship.

Research has supported the hypotheses that females are more empathic and relational at an earlier age and
to a greater intensity. Adams, Summers, and Christopherson (1993) reported "significant interaction between gender and age. . . . Girls were more efficient when they were three years of age. But by age five, boys scored higher on the empathy measure" (p. 104). Researching attachment between fathers and their children, experimenters noted that girls attached "earlier and more intensely than boys did" (Bernstein, 1990, p. 161). Jordan (1991a) noted that while males and females were equally able to label affect, "females typically are more motivated to attend to affect in others" (p. 33). Another study found that, among children age 9 to 19, "females experience more positive interpersonal relations than do males, whether as the person who rates the relationship or as the ones who are being rated" (Bracken & Crain, 1994, p. 27). Koenig, Isaacs, and Schwartz (1994) discovered paradoxical "empirical findings that indicate greater perceived social support among female adolescents despite the consistent finding that they also feel more depressed" (p. 40). Based on empirical research, girls appear to be more interactively relational than boys.

Female development appears to entail incorporating empathy, relationship, and gender awareness into one's
identity (Birns et al., 1994; Campbell, 1993). This process begins very early in the life of a female child and continues throughout the life span. These components consistently emerge both in feminist developmental theory and in gender research.

**Adolescent and Adult Development**

Relationship remains an important component of development as adolescence gives way to adulthood. Gleason (1991) found that late adolescent females anticipated maintaining close relationships with their mothers. Most of Gleason’s subjects expected the nature of these relationships to change in terms of mutuality but not in terms of closeness. Subjects who did express wanting to change in the relationship expressed a desire for more closeness with their mothers, not less.

A woman’s sense of connection does not end when she leaves home. Schultheiss and Blustein (1994) examined college students’ relationships with their parents as related to the level of college adjustment. They found a correlation between “psychological separation and parental attachment” (p. 251) for women. The closeness of women’s relationships with their
families correlated with their favorable adjustment to college life. This appears to be gender-specific as the findings did not hold true for male adjustment to college.

Our findings suggest that women who have access to emotionally and intellectually close relationships with both parents are more likely to be further developed than are women who do not have access to this type of parental closeness. These results lend empirical support to new models of women's development . . . and to women's self-in-relation theory . . . which emphasizes relatedness as the basis for development. (p. 254)

These findings, if replicated, may provide empirical support for the self-in-relation theory.

Gilligan (1982) discussed women's relational tendencies within the context of her studies on moral development and an "ethic of care."

Thus in the transition from adolescence to adulthood, the dilemma of the self is the same for both sexes, a conflict between integrity and care. But approached from different perspectives, this dilemma generates the recognition of opposite truths. These different perspectives are
reflected in two different moral ideologies, since separation is justified by an ethic of rights while attachment is supported by an ethic of care. (p. 164)

Male development, focused on separation and individuation, builds on an ethics of rights while female development, focused on attachment, emphasizes an ethic of care.

Researchers have attempted to empirically verify Gilligan's assertion that female development is predicated on an ethic of care to a different degree than male development. Skoe and Diessner (1994) found that an ethic of care (based on the Ethics of Care Interview [ECI]) was significantly related to identity for both sexes; however, the relationship was stronger for females than for males. Although "care-based moral thought was more highly related to identity than was justice-based moral thought" (p. 284) for women, the reverse was not true for men.

Female development as a process of the self-in-relation influenced by societal constraints constitutes a high percentage of the literature. However, other areas pertaining to female development are also frequently explored. These areas include gender bias,
dichotomous stereotyped sex-roles, women as physical bodies, and female expression of anger. These will be examined before leaving the issue of female development.

**Gender Bias**

While the importance of relationship and an ethic of care appears to be constant in the literature on female development, gender bias is also a constant. In discussing gender bias, two primary areas will be reviewed: society and the educational system.

**Gender bias in society**

Society has had a vested interest in devaluing women (Baber & Allen, 1992; Ballou & Gabalac, 1985; Bem, 1970; Campbell, 1993; Gilbert, 1984; Thompson, 1974a, 1974b). Noting "our society’s pervasive devaluation of the female sex" (p. 18), sociologist Schur (1984) wrote

Diverse studies of the gender system have irrefutably shown how the subordination of women is sustained through their being socialized for, and restricted to, limited aspirations, options, roles, and rewards. . . . social stigmatization must be recognized as a key mechanism that backs
up and "enforces" many of the restrictions and limitations placed on women. (p. 11)

Women do not choose to be devalued; they are bestowed this dubious honor by virtue of their sex in order to maintain the status quo of society. This quite easily becomes self-perpetuating not only by limiting avenues of success for women but also by stigmatizing women who attempt to gain access to those avenues outside the norm.

Additionally, gender bias is subtly perpetrated over a long period of time; according to Bem (1970), society . . . has spent twenty years carefully marking the woman's ballot for her, [it] has nothing to lose in the twenty-first year by pretending that she may cast it for the alternative of her choice. Society has controlled not her alternatives, but her motivation to choose any but one of those alternatives. The so-called freedom to choose is illusory and cannot be invoked when the society controls the motivation to choose. (p. 93)

Typically, by the time a woman reaches adulthood, social bias has sufficiently indoctrinated her so that her "choice" is not a threat to the status quo. Both
the limitations and the stigmas impact women's self-concept.

**Gender bias in the educational system**

Reviewing 20 years of research on sexism in schools, Sadker and Sadker (1994) subtitled their book "How America's Schools Cheat Girls." They reported that, while progress has been made in some areas, many schools continue to promote sexist ideas, often in ways that are subtle and detrimental to female's self-esteem.

Sadker and Sadker (1994) documented that girls received less time and attention from teachers than did boys. Girls were less likely to be called on to answer questions or to contribute to class discussions. They were more likely to be reprimanded for speaking out without being called on than were boys. They were more likely to receive an ambiguous "OK" from teachers while boys were more likely to receive direct praise such as "Good" or "Nice thinking." In short, girls were encouraged to be as observers of the educational process while boys were encouraged to be active participants.

Despite the frequency of female teachers, girls have limited role models. A survey of texts revealed
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that males greatly outnumber females. Additionally, when females are portrayed, it is generally in stereotypic terms. This has been found to be true for a multitude of disciplines: history, math, science, literature, economic, and children's programs (Feiner, 1993; Sadker & Sadker, 1994) and psychology.

This form of gender bias impacts boys as well as girls by adding "to the male's emerging sense of entitlement, power, and influence" (Birns et al., 1994) Boys learn that they are the dominant group and, as a result,

Two anecdotes from my own experience. The first occurred during a class on family systems. I counted the number of times a male or a female was used as an example of a client in the first 50 pages of a text: the ratio was 10:16 (males:females). The second occurred while writing the family systems portion of this dissertation in chapter 1. Although Virginia Satir was credited with founding a major area within family systems by Jones & Butman (1991), Foley (1989) mentions her name only once in his chapter while giving others noted by Jones and Butman considerable attention.
from their earliest days at school, boys learn a destructive form of division—how to separate themselves from girls. Once the school world is divided, boys can strive to climb to the top of the male domain, thinking that even if they fall short, they still are ahead of the game because they are not girls. Boys learn in the classroom that they can demean girls at will. Schools that do not permit racist, ethnic, or religious slights still tolerate sexism as a harmless bigotry.

(Sadker & Sadker, 1994, p. 225)

By being given preferential treatment in elementary school and an abundance of role models, boys may begin to view themselves as superior⁸. Their behaviors are condoned and the responsibility for their inappropriate actions placed on others.

By the time a female reaches college, gender bias has had a profound effect which is further compounded in higher education. Bem (1970) wrote:

⁸Erikson (1983/1959) also addressed gender and education: "The fact that the majority of teachers in the elementary school are women must be considered here in passing, because it often leads to a conflict with the 'ordinary' boy's masculine identification" (p. 151)
as long as a woman’s socialization does not nurture her uniqueness, but treats her only as a member of a group on the basis of some assumed average characteristic, she will not be prepared to realize her own potential in the way that the values of today’s college students imply she should. (p. 93)

In the first place, female socialization may preclude a woman from being prepared to explore areas outside of her comfort zone. Additionally, "some researchers and educators believe . . . that sexism remains common in higher education and that its continued presence allows both overt and covert barriers to educational equity to survive" (Fischer & Good, 1994, p. 343). Women perceived greater sex bias and discrimination than did men. Male instructors were perceived as more sexist than their female counterparts; in fact, "college students perceived female instructors as displaying more behaviors conducive to a positive climate than male instructors and concluded that 'female faculty seem better at making all their students feel known and their participation valued'" (p. 345). These perceptions, the lack of female role models in the curriculum, and the disparate ratio of male to female
instructors (Fischer, & Good, 1994; Gilbert, 1984) combine to leave many college women feeling invisible and devalued.

**Dichotomous Stereotyped Sex-Roles**

Dichotomous stereotyped sex-roles apply to two aspects of the female experience. First, a dichotomy exists between men and women in regard to appropriate gender-related behaviors. Splitting of traits into "feminine" or "masculine" allows an either/or dichotomy. In a culture that tends to describe things as "good" or "bad," the dominant group (males) attributes "good" to members of their own group while labeling "bad" or "not as good" as traits of the "other" group (Powlishta et al., 1994). As with the Broverman studies (1970) noted earlier, this leaves women with a dilemma--to be either "bad" but feminine or "unfeminine" (which is also labelled "bad").

Independent behavior is one example of sex-role stereotyping. Muller (1992) wrote

Much Western psychological literature speaks of the need to develop an identity, an "I," that is separate and distinct from our mother, our father, our siblings, and our peers. This critical
process of "individuation" is considered to be of paramount importance in healthy psychological development, so that we may evolve a strong sense of self and an ability to perform as individuals in society. (p. 155)

Culturally we view men as being independent and autonomous, while independent, autonomous women are treated with disdain.

This divergence was illustrated in a political cartoon by Mike Thompson printed in a local newspaper, The Oregonian, on January 11, 1995. The cartoon contained two frames positioned side-by-side; across the top of the left frame was the statement "THIS IS AN INTELLIGENT, EDUCATED, HARD WORKING, PRINCIPLED AND HIGHLY DRIVEN MALE IN A POSITION OF POWER . . . " Underneath a caricature of Newt Gingrich was a lower caption reading, "... SO HE GETS CALLED 'SIR.'" The second frame read, "THIS IS AN INTELLIGENT, EDUCATED, HARD WORKING, PRINCIPLED AND HIGHLY DRIVEN FEMALE IN A POSITION OF POWER . . . " Under a caricature of Hillary Rodham Clinton were the words, "... SO SHE GETS CALLED 'BITCH.'"

This dichotomy is especially relevant in regard to assertive, self-protecting behaviors. Studies show
when women act with equal assertiveness as that of men, women will be labeled "aggressive" while men will be labeled "assertive" (Blechman, 1980; Kantrowitz & Ballou, 1992). This will be further explored under the section entitled Female Expressions of Anger.

The second dichotomy magnifies extremes of female behavior and is summarized in the words of Marina Warner, "There is no place in the conceptual architecture of Christian society for a single woman who is neither a virgin nor a whore" (1986, p. 235). This facet overlaps the first in many ways since women who do not behave according to culturally-approved gender roles are often depicted as acting "unfeminine" or "masculine." However, the second is distinct in that women frequently are caught in a black-and-white division between virgin and whore. Since no woman can meet the lofty standards set by a deified Virgin Mary, the only category left open to her is the vilified Mary Magdalene.

Women as Physical Bodies

Freud once wrote that "Anatomy is Destiny" (Erikson, 1974; Young-Bruehl, 1990). Anatomy determines the sex of a child (male or female); gender
is determined by a combination of biological attributes and social constructs (Katz & Ksansnak, 1994). The destiny of an individual is heavily influenced by societal norms (Kaschak, 1992). For women, those norms frequently are determined based on the objectification of their bodies—"woman in contemporary patriarchal society is fundamentally identified with her body. Her body is her power. Men are their brains; women are their bodies" (Greenspan, 1983, p. 164).

Historically, a woman's body has not belonged to her; she had merely been property of a man. Brownmiller (1975) traced women's place as property of either their fathers or their husbands. Historically, if a woman was defiled (i.e., raped), she may or may not have been held responsible. However, in some cultures the offense was not considered to be against the woman but against her owner, the man who deserved restitution for his damaged property.

Though less flagrant than in times past, culture continues to define feminine physical attributes as well as behavior. Currently the male-dominated fashion industry appears to play the role of cultural standard-bearer for women's physiques. Documenting the industry's attitude toward women, Faludi (1992) quoted
one designer: "Fashion determines the shape of my girls" (p. 200). The perfect woman is young, petite, thin, and buxom with "three sets of eyelashes" (p. 200).

To match this description women have engaged in the use of cosmetics, cosmetic surgery, and dieting. In 1986, women spent $1.9 billion on antiwrinkle skin cream (Faludi, 1992). By 1988, 2 million women had breast implants. (Later research discovered flaws in the original safety claims of breast implant manufacturers.) "Cultural standards ... clearly have a greater impact on women than on men" (Wooley & Wooley, 1980, p. 138) concerning weight control. Dieting has provided a source of job security for therapists as caseloads of eating-disordered (primarily female) clients can attest.

Much of this physical self-focus is aimed at avoiding the despicable cultural label of "spinster." Yet, women have been socialized to think of their bodies as it is viewed by others. (Hamilton & Jensvold, 1992). When one is identified as only a body, to remain acceptable demands having that body conform to the norms set by the culture. The impact of cultural requirements on women may well explain what is
consistently found in the literature: women have greater negative images of their bodies than do men (Faludi, 1992; Greenspan, 1983; Kaschak 1992).

Women have been objectified into being "bodies." Traditionally, they have not been free to think of their bodies as their own. Additionally, they have been socialized to think of their bodies in terms of how it pleases others, namely men.

Female Expression of Anger

Anger is typically thought of as an unfeminine attribute (Lerner, 1985; Miller, 1991b). Women are given prohibitions against expressing anger both on a cultural level and a psychotherapeutic level, even if the anger is justified. Thorne-Finch noted

Our society generally deems any anger exhibited by women as unacceptable or invalid. What contains the incredible levels of anger experienced by victims . . . are the numerous individual and social mores which tell a woman that she has no right to be angry at men, and that if anyone is to be blamed, it is herself. . . . Our society's tradition of blaming female victims for male violence perpetuates the silence of women because
it restricts their ease of connecting with, and their willingness to externalize, the anger that is a normal and healthy response to having been violated and victimized. (1992, p. 32)

The societal focus of anger in women is the prohibition against such expression with little consideration of the contextual validity of the anger.

Societal interdictions on female anger are internalized. Campbell (1993) argued that anger and aggression (which she uses almost interchangeably) is experienced internally different for women than it is for men. Three contentions of her work are important here. First, she wrote that "women’s anger often erupts from being manipulated or humiliated by their superiors, men’s usually arises when inferiors challenge or even question their authority" (p. 56). Women’s anger tends to go up the hierarchical chain.

Second, for women, expressing anger is a sign that one has lost self-control (Campbell, 1993). Women tend to allow anger to build up internally until finally reaching a boiling point at which it explodes. Women are frequently in positions both at work and in the home, where restraint is necessary (whether dealing with a boss or a child). However, women still
experience frustrating events but have limited avenues for expressing this feelings. This is different than for men who experience anger as a means for regaining control and for whom society accepts their expression of anger as proper.

Third, since women tend to feel more empathy, they also experience more guilt when they express anger (Campbell, 1993). Empathy allows women to understand another person’s position and feel the other’s feelings. This ability is operative whether women are on the giving or receiving end of the anger. When they are on the giving side, they feel guilt with the awareness of the hurt experienced by the other person. When on the receiving side, they view expressed anger as an overflow of frustration (their experience of it) and look to themselves to alleviate the added burden.

Similar to cultural and internalized restrictions on female expression of anger are the psychological community’s response to female anger. "Both psychotherapy and marriage enable women to express and defuse their anger by experiencing it as a form of emotional illness, by translating it into hysterical symptoms" (Chesler, 1989, p. 108). Therapeutic orientations which do not consider the societal context
in which women exist have no framework for understanding anger in women as healthy. Clients and therapists are heavily influenced by cultural norms prohibiting expression of female anger.

Summary of Female Development

In summary, according to feminist developmental theory presented above, connection and empathy are foundational for female development. These relational aspects of female development are healthy and normative and should be valued as such. Rather than forcing female development to fit into a male model or else be considered pathological, this feminist model presents female development in a positive light. It allows for validation and appreciation of women and their experiences.

However, as development also incorporates societal norms and values, gender, gender role stereotypes, and gender biases enter early into the developmental process. Societal norms include dichotomous stereotyped sex-roles, assumptions regarding women’s physical bodies, and gender-appropriate expressions of anger. Since societal norms and values tend to devalue
women and their experiences, these also impinge on development.

Having presented a female developmental model which affirms women while acknowledging societal biases and devaluation, I will next narrow the focus to a portion of women whose unique experience is often ignored in the traditional therapeutic literature--the victim of domestic abuse.
Women comprise the majority of clients seen in therapy (Ballou & Gabalac, 1985; Chesler, 1989; Greenspan, 1993) and are frequently the victims of violence or intimidation. One-third of all females are believed to have been molested as children by a family member or family friend. Eighty-five percent of working women will experience sexual harassment at work. A rape is committed every 6 minutes and one of every two women will be a target sometime in their lives. One-third of all murdered women were killed by their partners. More women seek medical treatment for injuries inflicted on them by their partners than from rapes, muggings, and car accidents combined (Kaschak, 1992; Straus & Gelles, 1988; Thorne-Finch, 1992).

Despite these facts, victimization of women goes largely unaddressed in traditional therapeutic orientations and is frequently missed by mental health professionals (Brown et al., 1993; Goodman et al.,
Traditionally, the psychotherapist has ignored the objective facts of female oppression" (p. 110). Jordan and Walker (1994) discovered that the number of patients disclosing domestic violence doubled when the intake interview specifically included questions about victimization, something not typically done in the standard intake interview. Additionally, they found "that 68 percent had experienced major physical or sexual assault or both, but that 71 percent of those patients had never before disclosed the experience of abuse to a clinician" (p. 147). As a result, victims of spousal abuse frequently are undetected by mental health professionals (Goodman et al., 1993).

Lack of detection may be attributed to several reasons. Since therapists' values or orienting beliefs guide questions asked during intake and the direction of therapy, therapists may not be oriented to assess the issue or aware of the magnitude of the problem. Societal values impact the significance given to violence against women. Clients may fail to disclose due to shame or minimization of the problem and its impact. Therapists and clients may be uncomfortable with the issue for personal, interpersonal, and
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cultural reasons (Randal, 1994). Therapists may not have a framework to fit women's experiences either therapeutically or developmentally. However, the question is not whether or not such a client will present herself, but whether the therapist will be aware enough to detect the context of her life and/or the client will understand the impact of her abuse (Kroll, 1993).

A client may experience domestic abuse in many different forms (Goodman et al., 1993). Since physical and sexual domestic abuse are behaviorally defined, they are more easily identifiable types. Physical abuse includes pushing, shoving, kicking, hitting, throwing objects at a person, or throwing them down stairs or against a wall. Sexual abuse includes derogatory language of a sexual nature and any form of coerced sex.

More difficult to assess is psychological or emotional domestic abuse. Psychological abuse includes verbal assaults that attack a person's sense of self or self-worth and any form of intimidation. Goodman and her colleagues (1993) included coercion, degradation, intimidation, and humiliation as types of psychological abuse. Emotional abuse is any "behavior sufficiently
threatening to the woman so that she believes her
capacity to work, to interact in the family or society,
or to enjoy good physical or mental health, has been or
might be threatened" (Thorne-Finch, 1992, p. 13). The
victim feels devalued and fearful (Bicehouse & Hawker,
1993; Fortune, 1993). As Thorne-Finch (1992) noted,
this type of abuse is often subtle and covert, leaving
the victim defenseless and unsure of the intent.

In all of its forms, abuse has an intended
negative affect on the victim. The intent of the
abuser is to "dominate, control, or intimidate another,
lower another’s self-esteem, and take away freedom of
choice" (Bicehouse & Hawker, 1993, p. 195).

By using the term "domestic abuse," I do not wish
to imply that gender is irrelevant. In fact, experts
estimate that 95% of domestic abuse victims are women
and that 95% of domestic abuse perpetrators are men
(Dobash & Dobash, 1984; Fortune, 1993; Schur, 1984;
Thorne-Finch, 1992). (See following section entitled
"Controversies in the Literature."

Nor is domestic abuse a problem for a few
isolated, socially maladjusted families. It is a
societal problem (Lempert, 1994; Schur, 1984; Thorne-
Finch, 1992). "It is generally agreed that one of the
reasons men batter is because of societal norms that legitimate family violence and permit men's domination over women" (Margolin & Burman, 1993, p. 62). Hillier and Foddy (1993) reported that those who hold traditional sex role attitudes tended to blame the victims of spousal abuse. Additionally, men were more likely than women to attribute blame to provocation. These researchers found that "those with more traditional attitudes may not only perceive more behaviors to be out of role, provocative, and deserving of retribution, but also that a husband has a duty to ensure that his partner is punished for inappropriate actions" (p. 642). Thus, beliefs of those outside the family may tolerate, perpetuate, and advocate male-to-female violence as the husband's duty and the wife's just punishment. Societal denial permits domestic violence; societal tolerance allows its continuance.

Many cultural institutions have no clear policies or procedures to deal with the issue of violence against a woman, particularly violence perpetrated in the home by the person with whom she is most intimate. Clergy struggle with traditional views of the husband as head of his home versus protecting battered women (Wood & McHugh, 1994). Courts and police are often
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reluctant to deal with domestic abuse in a manner that provides healing for the victim (Hart, 1993). Members of the medical profession often do not know how to help or what resources are available (Brown et al., 1993; Quimby, 1994; Robinson, Wright, & Watson, 1994).

Additionally, services offered to victims of domestic abuse by these diverse segments are frequently uncoordinated and disjointed, leaving the victim confused and overwhelmed (Nurius & Asplund, 1994).

The psychological community is not exempt from this dilemma. Community mental health clinics often do not consider treatment of domestic abuse victims as part of their mandate (Jordan & Walker, 1994). Mental health professionals typically do not address domestic abuse in traditional theoretical orientations. If domestic abuse is acknowledged, the tendency is to blame the victim (Fortune, 1993; Gard, 1993; Randal, 1994; Walker, 1980, 1985). By focusing on the individual client without due consideration of her social context, therapists have tended to ignore or minimize the impact of the abuse while blaming the victim.

This ambivalence regarding how to deal with domestic abuse is at the heart of two research-related
controversies. The first controversy is over the social responsibilities of the researcher and the advocate; the second relates to an issue in which research contradicts the experience of the advocate.

Controversies in the Literature

Domestic abuse research frequently lacks a theoretical foundation. The result has been two main controversies in the literature on domestic abuse. The first controversy centers around the writings of Neil Jacobson (1994a; 1994b) who proposed that researchers collaborate with advocates. He acknowledged the inability of research to be value-free (Jacobson, 1994b) but maintained that rigorous scientific standards used by researchers was fundamental to gathering quality data. Jacobson suggested that researchers dialogue with advocates in order to access their experiential expertise in interpreting empirical studies on domestic violence.

Gelles (1994) pondered whether Jacobson was too optimistic about the scientific community’s ability to maneuver between research and advocacy. Like Jacobson, Gelles acknowledged the potential harm done by
misinterpreted data. However, Gelles failed to voice the concern expressed by Jacobson, choosing to dismiss the issue: "the nomothetic paradigm used by researchers is rarely of much value in the ideographic world of clinical practice or the political world of advocacy" (p. 95).

In response to Gelles, Avis (1994) pointed to researchers' failure to incorporate the expertise of domestic abuse advocates into the research. Since advocates are almost entirely female and researchers mostly male, it is women's knowledge that becomes subjugated by the dominant scientific (male) discourse. ... it is not surprising that [advocates] find researchers' findings suspect, especially when research interpretations conflict with advocates' own lived experience. (p. 89)

Failure of researchers to avail themselves to the opinion of advocates is conceded by Jacobson (1994b) and is a concern of others as well. Nurius and Asplund (1994) wrote, "Some feminists, for example, view traditional research methodologies as inherently sexist, failing to capture validly women's experiences, and believe such methods are inappropriate to the study
of partner abuse" (p. 21). Therefore, interpretation of the data is left open to dispute.

The debate between Jacobson (1994a, 1994b), Avis (1994), and Gelles (1994), is depicted clearly in the disagreement between Dobash et al. (1992) and Straus and Gelles (1988). Maintaining that they were merely presenting research, Straus and Gelles (1988) reported that family violence was equally perpetrated by both husbands and wives, a finding that fueled the division between researchers and advocates.

Advocates were not without supporters in the research community. Dobash et al. (1992) maintained that "claims of sexual symmetry in marital violence are exaggerated, and that wives' and husbands' uses of violence differ greatly, both quantitatively and qualitatively. . . . violence is gendered" (p. 72). Additionally, they suggested that researchers in this field often are without a fundamental understanding of how interpersonal relationships function, the impact of marital conflict, or the role of societally-approved gender biases. Holtzworth-Munroe and Hutchinson noted "research that simply applies measures and ideas from other clinical areas (e.g., marital distress) to the problem of marital violence may fail to consider what
is unique about marital violence" (1993, p. 209)

In response to Straus and Gelles (1988), Dobash et al. (1992) based their argument on two factors. First, police and court records throughout America consistently reveal that women constitute 95% of the victims of partner abuse. Dobash et al. (1992) documented that females were more likely to be victims, less likely to leave or prosecute their abusers, and less likely to view their abuse as abnormal. Dobash et al. disputed charges that male victims were less likely to come forward. They noted that when male victims of domestic abuse are reported to authorities, male victims prosecuted their abuser statistically more frequently than did their female counterparts. Additionally, no data exists to support the contention that violence is gender-symmetrical (with the exception of studies using the Conflict Tactics Scale [CTS] which will be discussed presently). Additionally, according to Dobash et al., cross-sex violence was disproportionately male-to-female in the public sector and no evidence to the contrary has been presented to suggest this ratio would be different in the private sector.
Second, Dobash et al. (1992) noted that Straus and Gelles’ (1988) use of the Conflict Tactics Scale (CTS) flawed their experimental design. The CTS is a self-report instrument and does not differentiate between types of behaviors based on intent. For example, according to the CTS, the wife who slaps her husband’s hand as he reaches into the salad she is preparing is equivalent to the husband who slaps his wife because his dinner is cold. Dobash and Dobash (1984) found that when women reciprocated more severe forms of violence, it was often in self-defense. This position is maintained by others as well (Kasian, Spanos, Terrance, & Peebles, 1993; Ptacek, 1988; Schur, 1984; Thorne-Finch, 1992).  

Resolution of these controversies is unlikely—supporters of each position are apt to maintain their stance. However, my position is that the knowledge gained by advocates must be valued and incorporated in order to give voice to the female victims of domestic violence.

\[9\text{Female-to-male violence does occur and is not always simply an attempt at self-defense. However, it is rare (Ptacek, 1988) and to use it as a counter to male-to-female violence is to minimize the experience of many women.}\]
abuse. Advocates’ positions are compatible with the empirically solid work of Dobash and Dobash (1984; Dobash et al., 1992) who are among the most highly respected in the field. As such, I maintain that the majority of domestic abuse victims are women, that violence is gendered, and that attempts to excuse perpetrators of violence against their partners is rooted in societal gender bias.

Literature on the Familial Context of Domestic Abuse

Controversies aside, 20 years of domestic abuse literature (Browne, 1993; Walker, 1980) provides a foundation for understanding the phenomena. As noted previously, emphasis will be on male-to-female domestic abuse. The client functions in the social context of the family. Therefore, aspects of this context will be reviewed. These aspects are the client’s marital relationship, her partner, her children, and herself.

The Client’s Marital Relationship

To the outsider, a family experiencing domestic violence may appear to be quite normal (Kaser-Boyd &
Mosten, 1993; Stout, 1993). Yet significant differences are seen in therapy between couples who engage in violence and those who do not. Typically when a couple presents for therapy in marital distress, conflict is handled by the couple in a wife demand/husband withdraw scenario. However, husbands who battered their wives more frequently reported that conflict patterns in these relationships was one of husband demand/wife withdraw (Babcock, Waltz, Jacobson, & Gottman, 1993). Additionally, demand/withdraw patterns were more likely to be perceived as equally split with either partner taking either role by couples who experienced domestic abuse (DA). Cordova, Jacobson, Gottman, Rushe, and Cox (1993) found that DA couples showed a distinct tendency to negative reciprocity\(^{10}\) in their interactions to a greater degree than non-DA couples. Yet, DA couples tend to minimize the impact of negative, non-physical interactions (O’Leary, Malone, & Tyree, 1994). This would seem to

\(^{10}\)Negative reciprocity refers to the tendency to respond to a partner’s negative communication in a manner which is also negative in fashion. For example, to respond to biting sarcasm with biting sarcasm or to a verbal slur with a verbal slur.
suggest that in DA relationships, couples engage in negative interactions more frequently than do non-DA couples without being aware of the repercussions.

Gender symmetry in this research may be explained in numerous ways. As abusive relationships progress, some women choose to fight back. However, over time women in domestic abuse relationships also show a tendency to accept the projections of their partner. In doing so, they often accept the blame for the "fight" and their perceptions may be distorted by years of being told "If you hadn't ... I wouldn't have had to ..." Interpretation of this research will vary depending on experimenters' foundational theories of the developmental impact of abuse (Dobash et. al, 1992; Holtzworth-Munroe & Hutchinson, 1993) as well as the developmental stage of the relationship.

Clinicians and researchers have attempted to explain the progressive development of domestic abuse relationships. Two theories dominate the literature regarding the relational interactions of domestic abuse couples. First, Walker (1980) proposed a three phase cycle. In the first stage, tension builds and minor abuse occurs. During stage two, violence erupts and the most severe abuse occurs. Stage three has been
called the honeymoon stage during which the abusive partner's repentant attitude frequently is accompanied by showering his victim with gifts and promises that this will never happen again. Walker suggested that this cycle escalates with increased frequency and violence.

Walker's theory has come under scrutiny. Research shows that many abusive couples do not progress through the proposed stages. Dutton and Painter (1993) suggested an alternative development in the abusive relationship. Noting that abused women become increasingly isolated from social support networks, Dutton and Painter suggested that the isolation of victims commonly noted in DA situations combined with the intermittency of abuse to form a trauma bond in the relationship. They defined intermittency as when "extreme positive behavior and extreme negative behavior occur with temporal contiguity" (p. 620). Trauma bond refers to the an emotional connection between a victim and an abuser.

For example, the victim experiences the post-trauma symptoms (increased anxiety and de-personalization) as a result of the violence. Her only support is from her abuser who, after the
incident, is more than willing to atone for the damage while denying responsibility: "if you hadn’t . . . I wouldn’t have had to . . . " The victim, relieved at the cessation of abuse and convinced by his attentive, loving behavior, believes she is at fault and feels grateful that he is willing to stay in relationship with her after what she’s done. The relationship is thus maintained.

The Client’s Partner

Batterers are not easily identifiable. Researchers have attempted to find markers to recognize batterers as a way to explain domestic abuse. However, results have been contradictory. Holtzworth-Munroe and Stuart (1994) did not find significant difference between the assumptions about relationships of maritally distressed, non-abusive husbands and maritally distressed, abusive husbands. They did find considerable differences between distressed and non-distressed husbands but could not account for why some distressed men battered while others did not. In another study, maritally violent men attributed negative intentions to women in a series of vignettes
to a greater degree than did nonviolent men (Holtzworth-Munroe & Hutchinson, 1993).

Batterers commonly blame external factors for their violence (Margolin & Burman, 1993; Thorne-Finch, 1992). Cantos, Neidig, and O’Leary (1993) found that violent men blamed their partners unless the men had been drinking, in which case the alcohol was blamed (also see Rynerson & Fishel, 1993; Sirles, Lipchik, & Kowalski, 1993); alcohol has not been found to be causally related to domestic abuse (Collins, 1989; Kaser-Boyd & Mosten, 1993; Stout, 1993). Although Dutton (1995) found family of origin factors (particularly paternal rejection) to be discriminative for abusers, other studies have not found a high correlation between experiencing childhood abuse (either as a witness or a victim) and becoming abusers (Saunders, 1994). In fact many men raised in abusive homes do not become abusers.

Other researchers queried whether personality traits explain violence on the part of men. Using the Millon Clinical Multiaxial Inventory (MCMI), one study suggested that batterers met the criteria for several personality disorders: borderline-schizoid, narcissistic-antisocial, and passive-dependent—
passive-aggressive (Else, Wonderlich, Beatty, Christie, & Staton, 1993). Hastings and Hamberger (1994) reported that while psychosocial variables influenced personality characteristics of batterers, batterers continued to score lower on the Conforming scale of the MCMI. Post-traumatic Stress Disorder (PTSD) has been proposed as a cause of violence perpetrated by war veterans (Miller & Veltkamp, 1993); however, PTSD subjects were found to have more anxiety and dysthymia while men who batter showed more antisocial traits (Dutton, 1995). Others report no "outstanding pathology is suggested" by standard psychological tests (Kaser-Boyd & Mosten, 1993). Actually, men who batter frequently appear to "function well while their partners appear pathological" (Saunders, 1994, p. 54).

Dutton (1995) proposed that borderline personality organization (BPO), a milder form of borderline personality disorder, typified men who batter. BPO, according to Dutton, resulted from poor attachment in childhood. In adulthood, attachment is desired but intimacy is not achieved due to fear, anxiety, and anger experienced by the male partner. This personality type tends "to split women into ideal and devalued objects and to project angry impulses onto the
devalued woman-object" (p. 215). Additionally, Dutton emphasized, BPO males cycle through moods based on self-generated internal cues.

Therapists working with batterers suggest that socialization and shame are primary components of male violence (Dutton, 1995; Ryan, 1993; Thorne-Finch, 1992; Wallace & Nosko, 1993). Batterers reported more acting out of hostility and self-criticism than control subjects (Else et al., 1993). Low self-esteem has been correlated with battering behavior in research (Margolin & Burman, 1993; Thorne-Finch, 1992). Abusive partners appear to have fewer problem-solving skills than non-violent partners and resort to physical violence out of frustration (Babcock et al., 1993). Figueredo and McCloskey (1993) suggested that battering was a "selfish effort on the part of certain disadvantaged individuals to selectively enhance their otherwise failing competitive sexual struggle against other men. The men apply various means of physical intimidation to keep their spouses home" (p. 374). The typical batterer was egocentric, had a low frustration tolerance, had a sense of entitlement, and frequently lacked the ability to feel empathy for others (Kaser-Boyd & Mosten, 1993).
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While socialization plays a primary role in the tolerance of violence against women, socialization does not provide justification for the actions chosen by batterers. Batterers make choices and are responsible for their actions. Batterers admitted to using "violence to control and intimidate their wives, and minimized any suffering caused by their aggression" (Birns et al., 1994, p. 54). Abusers appear to be incapable of feeling empathy. Thorne-Finch summarized:

All too frequently, when attempting to explain why violence occurs in a specific family, theorists label the family ‘dysfunctional.’ Yet, it is the violent male, not the family, who is malfunctioning. To deny his sole responsibility for his violence works to implicate the other family members—the victims of the violence—as causes of the dysfunction. . . . he is able to choose when, where, and how—and if—he will be violent. He does have other options. . . . other family members must not be implicated as co-conspirators to the violence. (1992, p. 62)

This is not to say that the violent male does not have stressors, nor that his partner is never acting inappropriately. However, he is responsible for his
violence. Provocation is not justification; provocation is a "retrospective rationalization" (Schur, 1984, p. 159).

The Client's Children

Children living in homes with domestic abuse are victims as well, though, often, this fact is neglected (Burman & Allen-Meares, 1994: Lehmann, Rabenstein, Duff, & Van Meyel, 1994). Research on spousal-abuse has shown a high correlation with child abuse (Afolayan, 1993; Magana & Taylor, 1993; Saunders, 1994). Women who have been battered frequently refrain from reporting their own abuse out of fear that child abuse will be exposed and their child(ren) will be taken away from them. One study revealed that "almost two-thirds of abused children were being parented by battered women" (McKay, 1994, p. 30). Battered women have been found to overdiscipline their children in an effort to avert greater abuse by their partner (McKay, 1994) and as a displacement of their own anger (Saunders, 1994). More commonly, however, battered women neglect their children because they "simply did not have the emotional energy necessary to handle their children's demands" (Henderson, 1993, p. 9).
Frequently, women who would not seek protection for themselves requested aid when their partners turned violent with the children.

Children are often witnesses to their mothers abuse. Some researchers have asked whether these children are merely witnesses or are themselves victims. Children who have witnessed domestic abuse are more likely to report depressive symptoms than other children. Sternberg and her colleagues (1993) discovered that "being a victim or an abused witness thus appeared to tax the children's psychological resources beyond the effects of the stressful life ecologies in which they and the comparison children lived" (p. 50). These effects seem to be missed by their abused mothers (who tended to be more attuned to external behaviors) and by their abusive fathers (who failed to be attuned to either external or internal affects).

Other findings also point to deleterious results for children who have witnessed violence. Children from abusive homes were more cautious in dealing with

\[11\] Interestingly, boys appear to be more adversely impacted by marital discord than girls. See Wolfe, Jaffe, Wilson, & Zak (1988).
adults than other children (Lehmann et al., 1994). A significant relationship between parental use of violence to resolve interspousal conflict and sibling violence has been found (Graham-Bermann, Cutler, Litzenberger, & Schwartz, 1994; Widom, 1989). A study of adults diagnosed as Borderline Personality Disorder (BPD) found that these adults reported witnessing domestic abuse to a greater degree than did non-BPD subjects (Weaver & Clum, 1993). Parental violence may lead to a greater likelihood of depression as an adult for the child witness (Kessler & Magee, 1994).

Children who witness domestic abuse are also victims of the abuse. When they are not victims of direct abuse or neglect, they suffer vicarious trauma from witnessing the abuse. They appear to have more behavioral problems in childhood and the trauma seems to follow them into adulthood.

**The Client**

Victims of domestic abuse typically minimize their abuse (Hart, 1993; Kaser-Boyd & Mosten, 1993; Serra, 1993). In fact, victims tend to maintain cultural beliefs that: (a) violence against women is normal, (b) a rational explanation exists for the violence, (c)
the victim deserved the violence or provoked it, and
(d) women can control the violence if they are good or
submissive enough (Caplan, 1985). Early in abusive
relationships, women deny abuse; later in abusive
relationships, women minimize abuse (Cantos et al.,
1993; Kaser-Boyd & Mosten, 1993; Margolin & Burman,
1993). These women typically attempt to protect their
violent abusers and their violent relationships.

Victims connect with the inner turmoil of their
abuser. Serra found that "most of the women we
interviewed who were still living with their partners
interpreted their partners' violent behavior as a sign
of distress" (1993, p. 25). Further, when their
abusive partners were in counseling, battered women
tended to return to them (Margolin & Burman, 1993).
Trauma bonding (see the section entitled The Client's
Marital Relationship) connects the victim with the
victimizer as she identifies with his pain;
additionally, "[f]or many women, attention to their
own inner experience often feels incompatible with
attention to other (it is 'selfish,' 'egocentric,'
'hurtful'); an ethic of caring for others carries the
connotation of self-sacrifice or putting oneself last"
(Jordan, 1991c, p. 283).
Contrary to popular opinion, battered women attempt to defuse rather than provoke violence, a difficult task given the randomness of the violence (Walker, 1980). This was done through compliance with the abusers wishes (Birns et al., 1994) or by attempting to escape. Few women struck back because most had come to believe that resistance to violence generated increased violence from their partner. When women did become violent, they typically did so as an angered response to the abuse they received (Dobash & Dobash, 1984). Choosing not to reciprocate violence has societal implications---"while a man’s nonaggression toward a woman expresses a norm inscribed in our morals and in our culture, a woman’s nonviolence toward a man appears to be a form of nonpower" (Serra, 1993, p. 24).

Many have suggested reasons battered women do not leave these relationships. Women who do attempt to end the violence by leaving the scene or the relationship often find that threats and acts of violence increased. They were often blamed for leaving (Lehmann et al., 1994). Often battered victims have been isolated by their abusers and do not know what aid is available to leave their situation (Schur, 1984).
Many do not have the economic resources to leave (Margolin & Burman, 1993). One study found that 89% of poor and homeless mothers had suffered some form of victimization (Browne, 1993). In fact, "recent studies have suggested that violence against women may also be a critical subtext of homelessness, based on documentation of the extremely high prevalence of current abuse and battering among this [homeless] group" (Bassuk, 1993, p. 345). Lack of financial resources was a chief concern of women who returned to abusive relationships (Newman, 1993). Economic dependency keeps women in abusive relationships.

When victims of domestic abuse contact mental health professionals, their symptoms are diverse. Presenting symptoms include: anxiety, dissociation, depression, self-blame, guilt, shame, fear, social isolation, hopelessness, blunted affect, flashbacks, hypervigilance, memory loss, paranoia, self-hatred, and feelings of worthlessness (Browne, 1993; Dutton & Painter, 1993; Goodman et al., 1993; Serra, 1993). Rhodes (1992) found that battered women "tend to score higher on [the Minnesota Multiphasic Personality Inventory (MMPI)] scale 4 [Psychopathic Deviate scale] than the nonbattered" (p. 304) women. MMPI scales 2
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(Depression), 6 (Paranoia), and 8 (Schizophrenia) have also been found to be elevated for battered women (Rosewater, 1985).

Yet, perhaps these are simply a woman's response to the all-to-common traumatic episodes of abuse. Victimization impacts women (as it does men) in a negative way and may result in pathology (rather than pathology as the cause of victimization). According to Root, "judgment is passed on the normative, defensive behaviors of those who have not been guaranteed the safety and privileges of those in power" (1992, p. 255). Pathological symptoms may be normal responses to trauma and must be assessed in light shed by the context.

Victims are often diagnosed as pathological (Browne, 1993; Goodman et al., 1993; Kaser-Boyd & Mosten, 1993). According to Walker (1980), these women suffer from battered women syndrome, a form of post-traumatic stress disorder (PTSD). Others have noted that victims of domestic abuse have been diagnosed as borderline, PTSD, and schizophrenic (Goodman et al., 1993; Kaser-Boyd & Mosten, 1993; Rosewater, 1985; Saunders, 1994). This raises the question whether pathology was the result or the cause of the abuse
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(Randal, 1994; Rosewater, 1985; Schur, 1984; Walker, 1985). Browne warned that "a diagnostic structure that ignores etiology as well as extrinsic realities is problematic for cases in which a trauma history is present, particularly if that history is not known to the clinician" (1993, p. 378). Diagnosing of battered women is often based on symptoms presented without regard to their abusive environment.

Summary of the Domestic Abuse Literature

Domestic abuse is a prominent, and common, event in our society. Yet society often ignores the victim while academia frequently blames the victim. Women are the predominant victims of domestic violence. As such, when women present for therapy, the surrounding circumstances of their predicament are frequently missed. Since psychology tends to focus on the client in the therapist's office, external factors such as domestic abuse may go undetected. Abuse impacts relationships and children. Victims get blamed; victimizers get excused. This is played out in the abusive situation, in society, and, as the result of
ignorance or willful neglect, in the therapist's office.

Summary

Women have a developmental pathway distinct from the course suggested by traditional developmental theorists. This pathway is grounded in relationship and has empathy as a cornerstone. Her relational tendency connects her with others—her spouse, her children, her family, and her friends. With connection comes empathy which empowers her to not only identify with the emotions of those with whom she has a relationship but also encourages her to strive to meet the need which accompanies the emotion. Empathy, in turns, allows her to feel connected (an important aspect in her development). This provides stability for her and her relationships.

Connection and empathy also explains the domestic abuse client. Societal norms emphasizing relationships (marriage) in order for women to have identity connects the victim to her partner. Empathy cements her in the relationship. Continued violation of both the desire
to connect and her empathy produces pathology which therapists find because they are oriented to it.

Despite the positive aspects of female development, women's ways of developing and of interacting have been devalued in society which has elevated the male model of autonomy and individuation. Yet, society has only elevated the male model for males; cultural gender norms discourage women from acting masculine (i.e., independent, assertive, angry). In fact, these norms tolerate and justify violence against women who ignore the sanctions. As a result, our society has allowed domestic violence against women to reign virtually unchecked.

Psychologists have aided and abetted in this domestic victimization of women. Therapists have done this by failing to examine their own gender biases and those of their orientation, despite professional mandates to do so. The profession has failed to address the issue, despite its prominence in society. By focusing too narrowly on the client and diligently searching for pathology within her, therapists have missed the larger societal pathology which tolerates violence.
I have explored three main aspects of this dissertation: therapists' values (chapter 1) and the client variables of female development (chapter 2) and domestic abuse (chapter 3). In chapter 4, I will synthesize these facets, exploring commonalities, strengths, and weakness. In chapter 5, I will propose that a paradigm shift is needed. A shift from traditional therapeutic orientations to a more feminist orientation of female development as a "self-in-relationship" is needed when dealing with clients who are victims of domestic abuse. This enables therapists to value and affirm clients and clients' choices. As such, therapists are able to provide empowerment by valuing clients' strengths and developmental tendencies.
In the confines of the therapy room, two components interact to form a therapeutic alliance: the therapist and the client. Both bring their unique life experiences, biases, and values to this setting. Experiences and biases are acquired from one's society and one's unique interactions with that society. Additionally, the therapist brings his or her training, which include graduate classes, mentoring, and clinical training experiences, as well as values gained through these vehicles. As noted previously, therapists' values are defined as "orienting beliefs about what is good or bad for clients and how that good can best be achieved" (Bergin, 1985, p. 290). As an applied science, psychology is not value free. It is influenced by the philosophy of the theoretical school followed and by the values of the society. When the APA (1979) mandated ethical guidelines to address the
issue of gender bias, it acknowledged the potential for misuse of the therapeutic process.

The therapist and his or her values, orientations, and goals were covered in chapter 1. Research appears to support the contention that therapy is not a value-free endeavor. In fact, theoretical orientations hold certain values and individuals who practice psychotherapy hold certain values. Not only do therapists have their own set of values, they also hold power in the therapeutic alliance, and, therefore, must be attentive to any biased tendencies so as not to perpetuate the "devaluation of the female sex" (Schur, 1984, p. 18). However, rarely do traditional orientations address gender as a factor in therapy. When gender differences have been addressed, as in psychodynamic theory, women have traditionally been relegated to inferior status due to their dissimilarity to the male norm.

The main focus of chapter 2 was the client's development as interpreted by women's experiences and the research literature. Shortcomings of traditional views of women were expounded. Societal sex role stereotypes and gender biases were addressed. Literature attempting to understand women's experiences
from a female vantage point appears to support the
notion of some feminist writers who maintain that women
develop in relationship rather than in separation and
autonomy.

In chapter 3, domestic violence as reported by
researchers and advocates was reviewed. The lack of
clear guidelines by cultural institutions was noted.
Controversies in the literature were analyzed; flaws in
the gender-symmetrical theories were examined and the
lack of input from advocates to researchers was noted.
Research on the client and her immediate family was
presented.

The convergence of these three foci (therapist
values, women’s development, and domestic violence) as
experienced by the client in the therapeutic arena is
the focus of this chapter. This chapter will review
the impact of traditional orientations on female
victims of domestic violence. Many of the orienting
beliefs of traditional therapies were proposed before
research on female development was expanded. As such,
these theories may lack vital components found in the
feminist literature on female development, components
that shed an illuminating light on the experience of
women, especially female victims of domestic abuse.
Two facets are primary for the client who has experienced domestic abuse. First, the clinician may not be aware that domestic violence is part of the client’s experience. Clinicians traditionally have not incorporated the issue of domestic abuse into intake interviews. Additionally, the client may not report the abuse regardless of whether or not she is directly asked. Several reasons can explain this: she does not recognize it as abuse; she is embarrassed; she feels stupid for allowing the abuse; she feels responsible for the abuse or for maintaining the facade; she minimizes the abuse; she is afraid of having it reported, having her children taken away, or being blamed. She may need to feel safe before reporting.

Second, the client is aware of gender bias, regardless of whether she is able to pinpoint or label it. If she has told anyone about the abuse she has probably been asked, "What did you do to provoke it?" She is aware that women are not supposed to get angry and that they are responsible for maintaining harmony in the home. She is aware that mothers bear a greater societal responsibility for how their children turn out and that her primary concern should be her home rather than a job. She is aware that in court, a rape victim
is most likely to be re-victimized, while many will believe a man accused of murdering his ex-wife is not guilty despite overwhelming evidence. Whatever she calls it, or even if she doesn’t, she is aware of it.

Traditional Orientations and the Client

Four traditional orientations were previously discussed: psychodynamic, behavioral, humanistic, and family systems. These will be compared to feminist developmental theory and the literature on domestic violence. Traditional theoretical orientations will be compared and contrasted with the newer theories that are based on a female model of development to find guiding principles that may aid in interpreting the literature regarding domestic violence.

Psychodynamic

The first orientation addressed was psychodynamic based on the work of Freud (chapter 1 and Appendix B). Freud provided the most in-depth discussion of female development of any theoretician other than the feminist writers. His work was applauded and added to by those who followed him. While many non-feminist writers took
issue with some of his ideas, few openly disagreed with Freud’s position on female development.

Comparison of Psychodynamic and Feminist Developmental Theory

Freud’s work was foundational for much of psychology. Feminist writings are not immune from his writings. Like Skinner, most feminists writing on female development are responding to Freud’s position. As such, striking similarities are not surprising. However, the similarities are superficial, at best, since the underlying values of each is widely divergent.

Both views emphasize early development, the importance of the mother-child relationship, and differences in development based on gender. Freud stressed the damage done to the child by faulty mothering, particularly during the pre-Oedipal stage. In fact, for Freud, identification with the mother by the young child was unhealthy because the child was identifying with someone who was inferior.

Conversely, the feminist developmental theory highlighted development in the reciprocal relationship between the child and the mother. Unlike Freud who believed that healthy growth was predicated on the
child understanding "I am not like mom," the feminist view of development necessitated that "not like mom" is part of a normal and healthy development for the boy-child while "like mom" is part of a normal and healthy development for the girl-child.

Freud's emphasis on the Oedipal stage and the inability of the female gender to traverse it due to their anatomical structure successfully placed women in an inferior position. His belief that normal female development produced narcissistic, masochistic, and passive beings did not allow for a healthy view of development in women. In fact, for Freud, normal female development led to pathology while abnormal development also led to pathology.

This absence of any hope for healthy female development became a catalyst for the writings of many female developmentalists. They explain female development in terms that imply gender differences rather than in dichotomous terms of good or bad. Healthy development for males is through separation, individuation, and autonomy; healthy development for females is through connectedness, relatedness, and empathy. The feminist view normalized female development as being gender appropriate and affirms the
beneficial quality of both self-in-separation as well as self-in-relationship. This position also acknowledges the likelihood of pathology should either position be taken to its extreme.

Diverging from Freud’s position that gender differences were solely the result of inherent biological differences, the feminist writers incorporated the impact of culturally determined mores as well as biological factors into developmental theories. In practice, psychodynamic therapy focuses on the individual and internal conflicts arising out of early childhood experiences. It narrowly interprets conflict and external turmoil as manifestations of residual internal turmoil of the client’s past. Feminist developmental theory acknowledges the global influences of society in its explanation of pathology. It includes in its interpretation external factors such as societal gender bias.

**Domestic Abuse From a Psychodynamic Perspective**

For the client who has experienced domestic abuse, foundational premises of the psychodynamic perspective perpetuates a blaming-the-victim stance held by much of society. If women are naturally passive, narcissistic, and masochistic, as Freud maintained, the battered wife
is easy prey for a pathological label while her situation goes unattended. In fact, research exists which may support such a diagnoses since the battered wife often looks pathological while the battering husband does not (Saunders, 1994).

Likewise, if clinicians view the physical violence as merely the misguided perception of a woman struggling with internal conflict, the client may be left in mortal danger. Her fear of leaving the situation may be viewed by the therapist as avoidance rather than as a survival choice. By failing to address external constraints on these clients, the myth that women "ask for" their abuse is preserved.

Additionally, psychodynamic theory does not address the literature which clearly shows gender bias at all levels of the social structure. This bias is decisively against women while holding women responsible for that over which they do not have power. This is maintained in psychodynamic theory where the client is asked to resolve inner conflicts resulting from childhood trauma in order to understand her perception that she the victim of domestic abuse. This leaves the client attempting to understand her predicament as an internal affair over which she is to
gain control while ignoring the part of her external reality over which she does not have control: namely, her abuser’s internal workings.

Behavioral Theory

The second theory reviewed was behavioral theory based on the work of B. F. Skinner. Skinner did not acknowledge gender differences in development nor did he address social mores about the appropriateness of different behaviors for different genders. He conceded, however, Freud’s influence on the beliefs of his day in his (Skinner’s) writings (Appendix B).

Comparison of Behavioral and Feminist Developmental Theory

Like feminist developmental theory, behavioral therapy recognizes the impact of socialization on the individual. Socialization provides the framework for individuals to assimilate cultural mores and standards. It is the vehicle for individuals to learn what behaviors and standards are acceptable and appropriate for them given their particular society.

Feminists and behaviorists support the belief that behavior is socially determined and that one’s environment interacts with the individual to shape
behavior. In short, rewarded behavior will tend to increase, while behavior that is not rewarded will tend to decrease. For example, using the literature on female development, little girls are praised/rewarded for dressing "pretty." This increases the likelihood that the child will dress to please and elicit another praise/reward.

Although behavior therapy accepts this cause-and-effect scenario, it fails to acknowledge that society has gender-labeled behavior. This is particularly salient when attempting to define such things as assertive behavior or self-sufficiency, areas where women have traditionally been expected to be deficient. Behaviorism does not address the detrimental effect that a gender-biased culture may have on the less-valued gender.

Furthermore, this orientation's emphasis on behavior and "rationality" (Bart, 1971) may tend to dismiss, minimize, or devalue women's proclivity toward emotional expressiveness. Rationality when viewed from a position that values autonomy differs from one that values relationship. From an autonomous viewpoint, it prizes objectivity and separation from the event; from a relational viewpoint, it esteems the opinions of
Therapists' Values

those effected by the decision. However, rationality from a relationship perspective, if not appreciated, may appear to lack the necessary detached cognitive style of the former perspective. The feminists give credence to both relational styles.

Behavioral theory has two major flaws in respect to female clients. First, it does not acknowledge developmental gender differences, despite the fact that society expects different behaviors depending on gender. Second, in claiming to be scientific and value free, behavior therapy does not address gender-bias in society. Since it claims not to make value judgments regarding behavior, behaviors are viewed simply as responses elicited by a stimulus. The object is to change the stimulus in order to change the behavior-response.

Domestic Abuse From a Behavioral Perspective

Since the behavioral perspective explains all behavior as the result of cause-and-effect, changing one's behavior is expected to change another's response. For example, changing her behavioral pattern, the battered wife may choose to leave the relationship. Since the abusive behavior did not result in a reward (power and/or control over the
victim), abusive behavior would be expected to diminish. However, studies show that abusive behavior tends to increase when the battered partner leaves or threatens to leave (Campbell, 1993; Lehmann et al., 1994). In fact, domestic abuse literature explains the increased abuse when the wife attempts to leave in terms that are internal for her partner and his fear of abandonment (Dutton, 1995) rather than within the wife’s control.

If domestic abuse is seen solely as a cause-and-effect interaction, the victim may again bear the brunt of the blame. Again, battered women I have worked with have almost universally been asked, "What did you do to make him hit you?" While therapists are expected to be more sensitive to the plight of their clients, expecting that a batterer will stop his abusive behaviors if the victim changes her behavior places responsibility for the abuse on the victim.

Although provocation is not justification, as noted earlier, behavior theory is accurate in addressing the reciprocal effect of behaviors, particularly in intimate relationships. Some abusive behaviors are responses to perceived threats which may or may not have been intentional on the part of the
victim. In other words, the victim may or may not have acted appropriately, but the one who chooses the response is responsible for the interpreting and responding in an appropriate manner.

Cause-and-effect does occur in domestic violence situations. Abuse (the cause) adversely impacts (the effect) the victim. To its credit, behavioral therapy has acknowledged this connection and has suggested learned-helplessness as an explanation for the behavior of the victim.

However, learned-helplessness falls short in explaining the impact of domestic abuse. First, this hypothesis does not adequately address the emotional aspects of the trauma bond. It does not recognize the impact of positive reinforcers in the relationship such as the honeymoon period described by Walker (1980; 1985) or the intermittency effect suggested by Dutton and Painter (1993). Second, it fails to explain how some women eventually get the courage to fight back or to leave despite increased threats. Third, classical learned-helplessness suggests a sort of numb automaton and does not address the issue of (appropriate) fear experienced by victims of domestic abuse.
Finally, behavioral theory fails to address the tolerance of society in regard to violence against women. By maintaining the facade of a value free therapy and avoiding this issue, this orientation supports and perpetuates the status quo.

**Humanistic Theory**

Carl Rogers and Abraham Maslow provided the foundation and framework for humanistic theory. They emphasized the power inherent in the individual toward growth and self-actualization. Although both believed in the importance of relationships, they maintained that relationships were a logical goal of healthy, autonomous individuals. Maslow acknowledged the impact of society on individuals in general (and on women, in particular); however, for him, healthy, self-actualizing individuals could transcend their societies while sustaining a detached relationship with their societies.

**Comparison of Humanistic and Feminist Developmental Theory**

As noted earlier in the text, many feminist writers initially applauded humanistic theory for its consideration of the unique experiences of the
individually. Each individual was to be respected and valued. Humanists (and early feminists) maintained that individuals were innately imbued with the power and the ability to transcend their environment and simply needed an arena to explore this power in order to live responsibly in the world. That arena was the therapist’s office and the method was the therapeutic relationship.

Like feminists, humanists value relationships. Both view relationships as natural and necessary for a healthy life. For the humanist, however, relationships are the result of mature, autonomous individuals choosing to be in connection with other humans, a sort of ebb and flow of life which progresses from the necessary dependence of infancy, through the increasing individuation of childhood and adolescence, before returning to relationship by choice as an adult. The feminists view this as one venue for relationships—a male venue. For females, relationship and connection are a continuous way of life from early childhood. The form of relationship develops and expands.

Transcendence as viewed by humanists and feminists also has this alike-but-different quality. Humanistic transcendence is premised on the idea that the
individual transcends the environment in search of the self. Again, feminists concur that this is one avenue—a more typically male avenue. Another form of transcendence is a female type: the transcendence of the self for the benefit of the relationship.

Some humanists may argue that their theory addresses this latter form of transcendence in underscoring the responsibility of the individual to the community. For the humanist, responsibility is part of the normal progression for the self-actualized, independent human, not an increasing understanding of a basic, internalized awareness. Again, the question becomes, is relationship the result of the individual viewed as an independent self or as a self-in-relationship or both?

The humanistic position is somewhat paradoxical. It values the unique experiences of the individual as valid, yet it also supports a framework that is more closely aligned with the male model of development. Put more succinctly, humanist theory is built on the foundation of the self-as-uniquely-autonomous. In doing so, it invalidates the experience of many women: the self-in-relationship.
While humanist theorists (mainly, Maslow) recognized gender bias in society, they minimized it, emphasizing instead the ability of the individual to transcend. Humanists do not actively address gender differences, socially-sanctioned gender bias, nor its impact on the individual. Additionally, another aspect of responsibility may be addressed here. While humanism clings to the issue of individual responsibility, it neglects the issue of corporate responsibility.

**Domestic Abuse From a Humanistic Perspective**

By accentuating the role of the individual, the humanistic perspective fails to adequately access the reverberations of familial and social constraints on the client to stay in the situation rather than to "self-actualize." Additionally, if women tend to gain their identity from their relationships, as suggested, then for the victims of domestic violence, this may mean they gain their identify from the relationship (but not from the abuse). Humanistic theory cannot conceptualize a healthy relationship apart from the joining of two self-actualized individuals. This may place on the client an autonomy with which she is not familiar, which minimizes her real and valid fear of
external pressures and dangers, and which does not value her as first and foremost a relational being.

Genuineness as promoted by Rogers may be tricky for the therapist dealing with a domestic abuse client. If the therapist holds egalitarian views, as admittedly did Maslow, he or she may promote autonomy for the client without understanding the aspects of the client’s identity that are entwined in relationship and empowered by being in relationship.

If the therapist holds traditional views of women and/or the family, these will be communicated to the client. Historically, traditional views have held that the family is to be maintained at any cost and that wives are to be subservient to their husbands. The therapist may have to struggle between valuing the individual’s autonomy and maintaining the marital relationship. Either orienting belief (autonomy or remaining in an abusive marital relationship) excludes alternatives that are complementary to female developmental patterns of relatedness, empathy, and connection. Therefore, they may be unhelpful in dealing with the client.
Family Systems Theory

Several writers comprise family systems theorists. Some, such as Ackerman, Boszoremenyi-Nagy, Bowen, and, possibly, Haley, directly acknowledge the importance of Freud’s work (Jones & Butman, 1991). Others (Satir and Whitaker) follow the lead of the humanists, while still others adhere to behavioral principals. Minuchin (1974), Satir (1983), and Haley (1963, 1984) stressed the importance of familial interactions. Since psychodynamic, behavioral, and humanistic theories have already been covered, family systems adherents to these schools will be set aside for the moment, and the following section will focus on the work of Minuchin, Satir, and Haley.

Comparison of Family Systems and Feminist Developmental Theory

Family systems, like behavioral theory and feminist developmental theory, concede the importance of the social context of the family as a source of socialization. In the context of the family, children learn their roles by watching their parents as models. The goal of this social learning is for healthy, autonomous, and individuated individuals which healthy
family systems promote according to family systems theorists.

Family systems theory promoted several "firsts" for therapists. It was among the first to emphasize the importance of both parents for childhood development and family stability. Parental interactions, in addition to being role models for interpersonal relationships, serve as role models for the child's self-identity.

Family systems theorists were among the first to suggest that the context of the family was dynamic. Rather than one-way learning, family members' interactions impact each other in reciprocal fashion. Healthy families change over time and proceed through stages in a fashion similar to that heretofore reserved for individuals.

Family systems was the first of the therapies reviewed to suggest that the identified patient may be a facade, diverting attention from other troubles in the system. This is consistent with the feminist position that women are given a pathological label when, in fact, their symptoms are the result of dealing with unhealthy systems.
However, in spite of these positive aspects of family systems, this orientation fails to acknowledge gender differences in childhood development. It does not address the impact of socially sanctioned gender expectations on individuals or on the system. By ignoring this aspect, it fails to address a major portion of women’s experience.

As a corollary, family systems does not confront inequities in traditional family systems. This inequality is particularly salient for women, especially women who have experienced abuse by their partners. If the assumption is that partners are equal (and this is frequently given lip-service), then inequities accepted by both partners and the therapist as inconsequential will not be addressed although they may deeply impact the partner who has the lower status in the relationship. As an illustration, studies continue to show that working women perform the majority of the household tasks (Campbell, 1993). If this is assumed by those involved to be the natural order of things, the wife may feel overwhelmed but unable to pinpoint specifics. Her communication, for example, may be vague and labeled unhealthy. Since
women tend to feel guilty rather than express anger, she may decide not to mention her nebulous feelings.

Family systems therapists may assume that power within the system is more equally shared than is true. As noted in a previous chapter, both partners in the domestic abuse situation may concede equal responsibility for disputes or a sharing of family power. Partners may believe that separation of duties represents equal power. For example, the wife may be responsible for choices regarding groceries, household decorating, and clothing of the children. The couple feels that by having separate spheres of responsibility they are sharing power. However, when decisions are to be made outside of these specific realms but which impact the entire family, such as a family move, a vacation, or a night out, he alone has the power to make such decisions. Separation of powers does not automatically mean equity of powers.

With the possible exception of Satir (1983), family systems has tended to focus on the family while overlooking the larger picture of the community or

12In the final chapter of her book Conjoint Family Therapy, Satir (1983) discusses preliminary research into the role of the community.
society. While expanding the focus of other traditional therapies from the individual to the family, family systems does not go far enough in addressing the role of society on the family.

Where other orientations lack balance by failing to address the contextual setting of the client, family systems may lack balance by failing to acknowledge that an individual within the family system may have an indiscriminate amount of power over the rest of the family. In this sense, family systems may go too far in relinquishing the responsibility of the individual. It may perpetuate the myth that women in domestic abuse situations hold more power than they do in reality.

*Domestic Abuse From a Family Systems Perspective*

Family systems perspective of the identified patient is a helpful concept for domestic abuse victims. Studies have shown that the battered wife frequently appears pathological while the batterer presents as normal. In this case, the wife is the identified patient but not necessarily the problem.

Yet, as Thorne-Finch (1992) noted, the family is not dysfunctional in domestic abuse cases, the batterer is. If a therapist concentrates too heavily on the system, he or she may fail to recognize the signs that
the client is in danger. Where both partners attend therapy, the tendency is that both will minimize the use of force in their relationship. She may do so because she assumes it is a normal part of marital relationships, she feels responsible as a result of trauma bonding, or her identity is so deeply ingrained in relationship that she needs to maintain the secret to protect her sense of self. He may do so out of a sense shame, because he sees it as part of his rights to control his wife, or he sees it as irrelevant. As a result the therapist may be guilty of collusion.

People make the best choice from the options they feel are available to them. If the victim fears she may lose her children or that violence will increase if she speaks up or if she leaves (and, based on the research, these are valid fears), she will remain and remain silent. Here collusion is not only done by the therapist but by society and an orientation that does not address this larger issue that impacts women.

Summary

Each of the theories offers something valuable to the therapist working with the victim of domestic
abuse. Likewise, each falls short in areas vital to the female victim of domestic abuse. While some of these orientations acknowledge gender differences, only feminist developmental theory incorporates gender bias in society into its perspective (see Table 3).

Freud led the way in acknowledging that developmental differences based on gender exist. However, he provided a view of female development that only allowed a pathological diagnosis by the clinician and hopelessness for the female. His writings disregard the external realities of this particular type of client, while labelling her passive, narcissistic, and/or masochistic. Followers have tended to fail to address the impact of a sexist society on the view towards women, women’s development, and on the women themselves.

Behavioral theory provides insight into the reactions displayed by the victim of domestic abuse. This orientation addresses the importance socialization plays in developing identity and gender-roles. Paradoxically, it does not speak to the detrimental aspect of sexism in society. Nor does it confront the issue of different meaning given to behaviors when practiced by the different sexes.
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*This category is only relevant for those addressing gender development in the original format of the theory.**

**Addresses gender bias in society.

Humanistic theory's value for the individual and his or her experience is important in dealing with any client. In the context given here, it provides an avenue for exploring the here-and-now of the client's external reality. Nevertheless, the emphasis of this
orientation on the individuality and isolation of the individual (i.e., individual as an island), neglects the aspect of female development which is founded as a self-in-relationship.

In contrast, family systems theories do concede the importance of familial context for the individual. It recognized that the client in the therapist's office may simply be manifesting dysfunctional symptoms of the family system. Yet, this orientation may fail to balance the responsibility of the individual within the system while valuing the autonomy and power of the individual. In so doing, it denies the experience of many women who gain their identity from relationship and are refused equal power by both the system and the society.\(^\text{13}\)

These four theories are a beginning, but they do not go far enough in incorporating the experience and expertise of women into their orientations. Where women are addressed as differing from the dominant male standard, they are often minimized, devalued, or denigrated. This does not provide a foundation for

\(^{13}\)Schneider & Schneider (1991) make a good argument that gender bias in society, if not addressed, precludes mutuality in marital relationships.
valuing or understanding the female victim of domestic abuse, her circumstances, nor her internal processes. In fact, this may be a set up to continue the status quo. A positive outcome by the therapist's standards may be deadly for the client.

Conclusion

A new paradigm needs to be implemented by therapists who work with female victims of domestic abuse: a paradigm in which female development as experienced by women is understood, acknowledged, and valued. The emphasis on separation, individuation, and autonomy must be balanced with consideration for the importance of relatedness, connectedness, and empathy.

Additionally, acceptance of the status quo must be addressed. Societally accepted gender bias can no longer be ignored. Its impact on people is detrimental to both genders and therapists need to explore which myths they have held on to.

These issues, as they relate to the victim of domestic violence, will be the focus of the next chapter. As with other theorists, I build on the old in order to provide a new perspective in the literature.
Therapists' Values

for women who have been victimized by domestic violence
and by the mental health community.
Viktor Frankl wrote that "there is no such thing as psychotherapy unconcerned with values, only one that is blind to values" (1986, p. xvii). His observation has been empirically verified. Therapy is a process in which values are brought to the therapeutic arena by both the therapist and the client, but the assimilation of values appears to move primarily unidirectionally—from therapist to client (chapter 1).

Virginia Satir (1987) took this one step further when she wrote,

the basic ingredient remains the relationship between the therapist and the patient. Since the latter comes to the former in a state of need, the therapist holds enormous power, which can be used negatively for exploitation and manipulation, or positively for healing and growth. The potential for abuse of such
power makes the value system and beliefs of
the therapist vitally important. (p. 17)
The orienting beliefs and guiding principles used by
therapists is pivotal. Therapists bear an immense
burden to be aware of their values and to assess the
impact of those values on clients of either gender.

For female clients who have been the victims of
domestic violence, this issue is particularly salient.
These clients are often misunderstood, minimized, and
blamed for their victimization. For clinicians working
with this population, orienting beliefs in two domains
need to be examined: (a) gender and gender-bias
(chapter 2) and (b) domestic violence (chapter 3).

The literature and my own experiences in graduate
school lead me to believe that values regarding gender,
gender-bias, and domestic violence are rarely addressed
(or confronted) by therapists. Doherty (1995) noted
"when therapists have no clearly formulated value
system regarding gender relations, they enforce
traditional gender norms in therapy" (p. 24). Of the
psychotherapeutic orientations reviewed in this
dissertation (chapters 1 and 2), only feminist
developmental theory (chapter 2) addressed the issue of
gender and gender-bias. Psychodynamic theory addressed
differences in gender development but not gender-bias (chapter 1 and chapter 4). However, its view of female development as predicated on the work by Freud, failed to provide a healthy view of female development. Behavioral, humanistic, and family systems theory neglect both issues (although Maslow did acknowledge gender-bias, he dismissed it). As such, they fail to address the issue of differential societal pressures based on gender and differences in developmental tendencies. Where gender differentiation is not addressed, male norms have been used to evaluate female experiences, often to the detriment of the female client.

Regarding the issue of domestic violence (chapter 3), traditional therapeutic orientations which focus exclusively on the individual (psychodynamic, behavioral, and humanistic) fail to address issues of familial and cultural context (chapter 4). While family systems does address faulty interpersonal dynamics within the spousal dyad, it perpetuates a blaming-the-victim position by making the family "dysfunctional" rather than the abuser. Feminist developmental theory acknowledges the prevalence of domestic violence, appreciates healthy female and male
development, and addresses gender bias in society. Still a relatively new theoretical orientation, feminist developmental theory has not yet made the transition from theory to application in the area of domestic violence. In this dissertation, I propose to further the feminist position by applying its premises to the therapeutic interaction between therapist and client--integrating research into an applicable orientation for therapists working with domestic abuse victims which has remained largely undone (Russo, 1990; Scarr, 1988). Feminist developmental theory provides therapists working with this population a framework for empathizing with the client in a way that appreciates and values her development, tendencies, and experiences. Adapting feminist developmental theory to work with domestic abuse victims addresses both the client as an unique individual and as a member of a gender-biased society.

On a personal level, graduate training further cemented (for me) the conclusion that self-examination by therapists regarding gender, gender-bias, and domestic violence is rare. For example, in my first year of graduate school, I overheard a married male student ask a single female student: "Well, you are
going to leave the program if you get married, aren't you?" Following a discussion of a clinician's responsibilities and constraints when student-clients disclosed sex-for-a-grade coercion by a male professor, another male student commented that "it wasn't a big deal, the girls weren't really hurt." I have sat in classes where male students suggested "these type of women [battered wives] were just normally passive because they wanted the guy to hit them." Fellow students have suggested that women whose husbands had hit them need to learn to "forgive" and to "be more submissive." In group supervision during internship, a colleague commented that I should address with a battered client the ways in which she "provokes" her husband to physically abuse her. While anecdotal, these occurrences illustrate a reality: attitudes continue to survive which are not in the best interest of this population and, in fact, do more to protect and continue the status quo in which women are victimized and then blamed for their own victimization.

\[14\] For the record, these all occurred in classes taught by male professors and this statement is the only time a male professor confronted the student.
I maintain that traditional orientations do not accurately assess or appropriately address the plight of female victims of domestic abuse because they pathologize the victim for no reason other than that she is female and may not fit a male template (chapter 4). Furthermore, these orientations, as originally formulated, preceded research on therapists' values, women's developmental literature, feminist's critique of the orientation, and the domestic abuse literature; as such, they have not benefitted from the added perspectives that this literature provides. By incorporating the newer literature, therapists can be empowered to aid their female clients in a fashion that is consistent with the clients' own inclination. For therapists working with female victims of domestic abuse, an orientation which values and appreciates women's relational development (including empathy, connection, and commitment within relationships), as well as acknowledges gender bias and its impact, will prepare therapists to view clients' choices within abusive relationships as natural sequela to their development and their identity. This takes the brunt of the burden for the violence off of the victim and enables the therapist to view the client in a positive
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and empathic light rather than through the filter of pathology of past orientations.

Theoretical Application of Feminist Developmental Theory

Therapists communicate their orienting beliefs during the therapy session through a myriad of mediums including body language, questions asked, and empathic responses. Traditionally, therapists have focused on encouraging behaviors and thought-processes which move the client to an individuated, autonomous sense of self. Relational aspects of clients have often been viewed as suspect—signs of co-dependency and/or immaturity—unless a strong sense of a separated self was present.

However, for female clients, a sense of self is attained and heightened through relationship. Female development embodies a growing sense of self ensuing from the unbroken identification with mother. This continuity promotes connectedness through empathy. As described by Jordan (1991a, 1991b, 1991c), empathy follows a developmental path that begins with identification. As the child matures and gains a sense
of personal identity, she incorporates the ability to identify with another as an important aspect of her emerging self. The adult experiences empathy as the ability to identify with another’s emotional self yet maintaining a boundaried sense of herself within a relationship. Throughout, relationship is perceived as primary and the self is seen as a contributing member of a relationship.

For the feminist therapist, self-as-relational and self-as-autonomous do not represent a hierarchy or an either/or dichotomy. Instead, both are viewed as tendencies: women tend to identify themselves (and behave) in terms that are relational and men tend to identify themselves (and behave) in terms that are autonomous. Both are valued (as is the struggle for balance between the two experienced by both genders).

Therapists transmit valuing of the relational self to clients in the same fashion that other values are transmitted. While therapists adhering to traditional orientations have tended to confront non-autonomous behaviors, feminist therapists encourage and support relational behaviors, confronting instead violation of the sense of self or unhealthy aspects of relationship rather than the client’s commitment to relationship.
In dealing with clients who have been victimized by domestic violence, therapists following feminist developmental theory value clients' ability to commit to a relationship, confronting unhealthy aspects of any particular relationship (such as abuse) and encouraging a healthy sense of empathy within a relationship. A client's self-perception as a self-in-relationship would be received positively by the therapist who would seek to enhance the sense of self-as-relational as healthy and normal. The client's sense of a valuable self with a unique voice would be explored and developed by the client. These two components (empathy and voice) as understood in feminist developmental theory provide the impetus for self understanding, awareness, and growth for the client.

For therapists working with this population (and using feminist thought), empathy and voice are major components and are deeply intertwined. These clients often explain their tendency to minimize their own victimization by sympathetically identifying the emotions of their abuser and "understanding" their abuser's position. The "voice" that is heard in the therapy session is often the voice of the abuser rather than of the client. I will address these separately,
with the understanding that they are not mutually exclusive.

For these clients, their ability to empathize is thoroughly embedded into their sense of self (as it is for many women). However, victims of domestic abuse confuse empathy with assimilation. By assimilating their abusers emotional states and justifications, victims believe they are empathizing with him and attempt to correct the situation in order to maintain the relationship.

Feminist therapists attempt to extract the baby from the bathwater before throwing it (the bathwater) out. They do this by understanding the client’s ability to understand her partner’s emotional state as an admirable trait. However, therapists also comprehend that the client has adopted her partner’s (and society’s) understanding of empathy which requires her to predict and prevent her abuser’s behavior, trapping her with the question: "What did you do to make him hit you?" This faulty understanding of empathy has frequently been used to blame her for the violence and to hold her responsible to make changes in order to stop the violence, despite overwhelming
evidence that she does not have control over her abuser.

In therapy, her adopted view of empathy can be challenged and healthy avenues for empathy can be explored. Therapists help their clients move through their "stuck" empathic position of identifying with the abuser by encouraging and supporting clients' struggle to balance sense of self-as-relational (the emphasis being on self) with empathy for another. In this manner, a therapist communicates a valuing of her as a relational, empathic being while separating her from the abuser and responsibility for the abuse.

This is closely related to the second issue— that of voice. Therapists encourage clients to have their own voice. This is a more difficult task. Women have frequently been socialized to not use their voice (prior to the domestic abuse situations) through socialization (chapter 2). Violence in the home, where the goal of the abuser is domination over another human being, further intimidates women into remaining silent. A danger exists in which clients simply switch the voice of their abuser for that of their therapists which will be addressed in more detail later.
Feminist therapists do not play the role of expert. Rather, they are compatriots and companions to clients as they explore their sense of self. This position encourages clients to search within themselves for answers. While similar to humanistic thought, feminist developmental theory allows for and values a healthy self-as-relational perspective without forcing the individual to be first and foremost self-actualized.

A therapist’s valuing of a client, including her developmental tendencies, provides an arena for her to begin to experiment using her voice. A therapist attends to the client’s inclination to use another’s voice. For example, clients frequently repeat what their abusers or others have told them. This can be refocused with the simple question, "What do you think (feel, believe)?" Therapists valuing of clients’ voices models behaviors that promote self-valuing in clients.

As noted earlier, a danger exists that a client will exchange the voice of her abuser for that of her therapist without developing a voice of her own. A therapist avoids this pitfall by understanding the therapeutic arena as a forum in which the client finds
and expresses her own voice. Additionally, the therapist recognizes that the client’s tendency to develop a voice using relational terms is consistent with healthy female development; therefore, do not enforce autonomy as the only true voice.

The most common area in which therapists unwittingly impose their voice on the client is in regard to whether or not she decides to stay in a relationship. Traditional theoretical thought (including feminist thought) has been that as a woman develops healthier skills: (a) she will be able to anticipate which men will be abusers and avoid them, or (b) she will mature to the point that she will no longer get in relationships that are unhealthy. Both of these positions label her at fault, should she again find herself involved with an abusive partner, and expect her to be clairvoyant—positions with which I disagree.

First, domestic violence is a prevalent societal problem and 50% of women will experience at least one incident of domestic violence. The feminist position acknowledges societal tolerance of the victimization of women, the constraints and pressures women face, and the prevalence of the problem. This issue is larger
than the individual and must be remedied on a higher level before domestic violence on the familial level will be alleviated. Even a healthy client may again find herself involved with an abusive male due to the sheer frequency of domestic abuse; a woman who values herself and her empathic abilities is empowered to disengage early from an abusive relationship.

Second, researchers are unable to differentiate between violent and non-violent men and are themselves unable to predict who will become an abuser. Therapists sensitive to women’s issues regarding domestic violence avoid giving messages that place clients in a double bind. To expect potential victims to predict what researchers and others cannot places on victims responsibility for not avoiding their abuse; furthermore, it ignores the perpetrator’s ability to mask his pathological behavioral tendencies, a deception which further haunts his victims.

Third, the reality is that many women return to their abusers several times before permanently leaving the relationship. The probability that she will return to the same partner increases if he seeks therapy. Traditional therapists may undermine progress made by clients if the message is, "If you are in an abusive
relationship then you have not grown or made progress."
This all-or-none thinking blames the victim if she again finds herself in an abusive relationship.
Therapists working with victims of domestic violence, understanding the prevalence of the problem and the ability of abusers to present a charming facade, encourage clients to develop a sense of self-as-relational that is aware of subtle abuse early in the development of the relationship. By promoting increased awareness which assists women in disengaging from harmful relationships earlier, therapists communicate respect for their client’s choices without blaming her for her partner’s behavior.

Feminist therapists value their clients relational tendencies and avoid blaming the victim; by modeling these views to the client, therapists support clients as they come to value themselves. As clients are able to feel secure in themselves and valued as relational, they can avoid becoming entrenched in relationships should they turn abusive. In this way, both clients’ external and internal realities are addressed.
Therapists desiring to achieve their goal of providing services that are in the best interest of their clients at a practical level will evaluate their position. They will assess, and, perhaps, continually reassess, their values: (a) regarding themselves, (b) regarding their attitudes about women's development, and (c) regarding domestic violence.

Each of these three sections builds on what has preceded it. Therapist values regarding the self incorporates ideas from chapters 1 through 4; values regarding female development incorporates values regarding the self. In the section entitled Regarding Domestic Violence, I propose orienting beliefs which consolidate therapists' values of self, values of female development, and values judging domestic violence.

Therapists' Values

Therapists' values impact therapy. The therapist undergirds the therapeutic arena; his or her values undergird him or her. As noted in chapter 1, the
The therapist communicates his or her values by the questions he or she asks, by the information from the client to which he or she attends, by body language, and in a myriad of other ways. Three areas of which therapists dealing with female victims of domestic abuse must be cognizant are: in regard to self, in regard to female development, and, especially when working with this population, in regard to domestic abuse.

Regarding Self

The therapist is first and foremost a gendered human being. She or he has been raised and socialized in a culture, has life experiences which impact her or his outlook, and, as a therapist, has extended training which provides theoretical foundations for behaviors done either in or out of the therapeutic context. Furthermore, as a human being, the therapist has limits on the extent of his or her knowledge, the validity of his or her assumptions, and the certainty of his or her assessments. All these areas impart values to therapists which they must address. Here the areas are separated into the socialized individual and the trained therapist.
The socialized individual. Being socialized in a particular culture influences the way one thinks, reasons, and acts. One of the prominent areas of socialization noted in the research is that of gender-specific behaviors and attitudes towards those who act either in accordance with or contrary to the specifications of cultural norms.

Responsible therapists are aware of the impact of the culture on themselves and on their clients. If a therapist holds stereotypic views of gender, whether as a theoretical orientation or as a personal belief, he or she may attempt to impose that belief on the client. Malleable clients who adapt may be labelled cooperative; independent clients who rebel may be labelled resistant. Clients' whose natural tendencies are compatible with cultural norms will be supported; those whose tendencies oppose the norms will be hindered from their fullest potential as unique individuals.

Further, therapists who hold traditional views of gender may fail to see the detrimental impact of sexism in society on both their male and female clients. When the voice of one gender is stifled, the society loses a great deal of wisdom available to it. This is
disadvantageous to both genders in that the dialogical discourses that may provide balance and fine-tuning of thought is stilted.

When males are constrained to live by a normative code for masculinity or be devalued as feminine, positive aspects of femininity such as compassion, nurturance, and empathy felt by men as well is cut off from them. The result leaves them being "less than all they can be"—to modify a prominent advertisement.

In similar manner, women are caught in the trap exposed by Broverman and her colleagues (1970). Women must opt for being healthy females but less than adequate adults or masculinized adults. This entraps therapists as well since they cannot hope for a positive outcome as one does not exist.

Therapists who do not hold stereotypical views of gender behavior are not free from evaluating their values. People do present in therapy who fit the stereotypical mold and therapists who insist on non-traditional behavior suffer the same delusion as the traditional therapist. Reactionary behaviors are just as pernicious as those that support an unhealthy status quo. The client as an unique individual needs to be the gold standard and valued.
An illustration may be helpful. A client presents who is the victim of domestic abuse. The traditional therapist may resist addressing issues of assertiveness since assertiveness may be viewed as an appropriate male behavior while passivity is the stereotypic behavior for women. Alternately, the non-traditional therapist may push assertiveness training for a woman who holds traditional views of behavior and feels that assertiveness as defined by the therapist compromises her self-image as a woman. The bottom line is that stereotypes while detrimental are accepted by some clients and the clients, if not the stereotype, need to be respected.

Another influence on therapists is their life experiences. They experience life as humans who are gendered. Gender of the therapist is a factor; a danger is to assume that gender has not impacted therapists. For male therapists, their experiences may more closely resemble what is culturally considered the norm than many of their clients. However, simply labelling an experience as normative does not make it so. For example, minority males experience events that are normative for their population but may not be considered normative by the dominant culture.
Additionally, male and female therapists may be mistakenly assuming they are using words and ideas in the same context. As an anecdotal illustration, a male colleague and I had been developing and conducting domestic abuse groups for women victims for a period of many months. During this time, we frequently discussed abuse in terms of power and control. Yet, 9 months into the process, while I was reading Anne Campbell’s (1993) *Men, Women, and Aggression*, I realized that we had differing definitions for the terms of power and control; a point that was confirmed by my colleague. My understanding was in terms of internal feelings of power and control (the female perspective); my colleague’s definition was having power and control over another human being or domination (the male perspective).

The therapist as a socialized individual brings biases, life experiences, and his or her gender to therapy. This needs to be assessed and reassessed to allow continued growth and awareness on the part of the therapist. The best hope, it seems to me, when dealing with assumptions, gender bias, and socialization is open communication between colleagues and between genders.
Although the therapist as a socialized individual has been acknowledged in some of the orientations, the therapist as a biased, socialized individual has not. This bias needs to be confronted when dealing with either sex, but particularly women who have experienced violence at the hands of their intimate partner.

The trained therapist. Therapists bring their training to the therapy hour. This includes experiences from their education, their chosen therapeutic orientation, and direct client interactions. Therapists' entire educational experience is an important aspect, particularly given the work by Sadker and Sadker (1992). If in fact bias against females exists in the educational process, this will have implications for therapists--male and female. The possibility exists that females who are able to attain higher levels of education may be more adept at thought patterns labelled "male." As a result thought patterns that are more stereotypically labelled "female" may be foreign or threatening to them.

Likewise, male therapists who have progressed through the educational system may face similar roadblocks. Having been given favored status, they may assume that since they have traditionally had "the
right answers" in school, they are equipped to understand the female experience when in fact they are not. Hidden biases must be addressed.

Second, research indicates that therapists choose orientations which fit their personality. While therapists may not read the works of the founding fathers of their orientation, they are still influenced by the originators whose works are filtered through later writers of a particular school. If the basic orienting beliefs of an original writer are merely assumed to be understood, followers (including therapists) may unwittingly adhere to methods of therapy based on misogynistic foundations.

For example, Sagan (1982) pointed out in his book, *Freud, Women, and Morality*, that many psychodynamic therapists believe that maturation is a process of separating and repressing the mother image established during the pre-Oedipal stage (not openly misogynistic on the surface). Sagan goes on to maintain that this position cuts off from the client such qualities as compassion, empathy, and nurturing. If therapists do not wrestle with the underlying assumptions which makes the repression of the pre-Oedipal mother image
neces sary, they become blind to the bias in their own
orientation.

Since many of the diverse schools are influenced
by Freud (Appendix B), if a therapist does not examine
his or her own attitudes and assumptions of Freud’s
work regarding women, he or she will follow guidelines
about development that do not provide for a healthy
view of women.\textsuperscript{15} Although an individual may not agree
with Freud’s work or has even taken positions opposed
to Freud in other areas, unless he or she wrestles with
Freud’s view of women, he or she will be unable to
modify later writers in order to best serve female
clients. If values or orienting beliefs underlay
everything done by the therapist, as I have asserted,
then those values need to be openly acknowledged and
addressed—this holds true for all theorists from Freud
to Skinner to Rogers and Maslow to the family systems
theorists.

Third, direct client contact, a vital part of
therapist training, impacts therapist. If “seeing is

\textsuperscript{15}I do not wish to minimize Freud’s great
contribution to psychiatry and psychology. My position
is that his work (particularly on female development)
is misogynistic.
believing," therapists are likely to believe they have adequate foundation and confirmation for their beliefs. However, seeing is influenced by society, by education, and by theoretical orientations. Unless therapists are willing to confront ingrained beliefs and struggle with the issues of gender bias, they very well may not be acting in the best interests of their clients.

Finally, therapists need to acknowledge their own limitations. Three main limitations for therapists are limits on the extent of his or her knowledge, the validity of his or her assumptions, and the certainty of his or her assessments. In light of these limits, therapists need a certain amount of humility and openness; for some therapists, this is counter to their self-perceived role as expert.

Therapists have limited knowledge. The vast amount of data available makes mastery of all of it virtually impossible. This data includes research and theoretical literature as well as the vastness of the client's whole life experience. Victims of domestic violence tend to hold back aspects of their abuse for numerous reasons; for a therapist to assume he or she has the whole picture would be presumptuous.
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With limited knowledge, the validity of assumptions must be challenged. Traditional orientations do not adequately answer questions regarding victims of domestic violence such as explaining (in a non-pathologizing way) why women stay. Assumptions based on the theoretical orientations reviewed here fall short.

Limited knowledge about the client restricts the certainty of assessments made by therapists about their clients. Therapists working with female clients, again, particularly victims of domestic violence, must resist the temptation to label their clients as pathological without understanding the context of their lives.

Summary. Therapists are people who have been socialized in a culture that is gendered and gender-biased. They must acknowledge and reflect on the impact of bias on their lives and understand the impact of bias on the lives of their clients. Although some theorists, such as Freud, recommended therapy for therapists, the narrowed focus of gender bias has not been delineated as an important issue. This leads to the faulty assumption that the status quo is right. Yet, the status quo does not appear to have a standard
policy that opposes violence against women. As long as this is true, the status quo is in error and the client is vulnerable to re-victimization in order to save face for the culture.

Therapists' self-awareness is essential for the health of the client and the vitality of the therapeutic arena. Therapists who are not cognizant of their biases will promote their values, biases and all, on clients who may innately perceive them as invalid for the clients' life experiences. This precludes connection--a major feature of the therapeutic alliance and the client's natural development.

Regarding Women's Development

The traditional orientations reviewed appear to fall into two camps: one places women's development in a category subordinate to that of men's development; the other fails to address any difference in gender development. I propose that, based on the research, therapists orienting beliefs, or values, would better serve their clients if their view of women's development incorporated the work of feminist theorists such as Chodorow and the Stone Center writers. Therapists who acknowledge the importance of gender in development concede the importance of understanding
cultural gender-bias in the life of the client, appreciate the importance of self-in-relationship as a valid context for development, and are better equipped to deal with female clients than those who have no framework for understanding healthy female development.

Few, if any, researchers studying development deny that gender is a major determinant in development. Erikson (1974; 1983) and Freud (1974a; 1974b) believed that gender differences existed. Freud's interpretation of gender differences placed women's development in a category inferior to that of men's development; Erikson (1974, 1983) left women's development to be investigated and deciphered by women. Chodorow (1989), Gilligan (1982), and several feminist writers focused on explaining female development from a women's perspective.

Gender carries with it societal expectations for aspirations, for life goals, and for behavior. Culture maintains assumptions regarding appropriate gender behavior. Therapists who address the pervasiveness of cultural mandates gain insight into an area traditionally ignored and open themselves to increased understanding of how cultural mandates impact clients.
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Not only is gender important on a global, theoretical plane, gender development and gender bias is a fact of life for the client to a larger or lesser degree. Societal parameters placed on the client are not always in her best interest, particularly if she is boxed into confines narrower than her own goals and aspirations. This is often true of victims of domestic violence. She generally wants to be a good partner and feels responsible for the abuse (societal message: "men don’t hit without a reason, what did you do that made him hit you?"). She frequently is isolated with limited work skills, regardless of her abilities (societal message: "women who are good mothers stay home to care for their children"; partner message: "no wife of mine is going to work; you think I can’t provide?"). Without work skills, she feels unemployable and unable to financially care for herself or her children (societal message: "welfare mothers are just lazy women"; partner message: "you can’t make it without me"). If therapists miss the gendered messages clients received and believed, therapists may mistakenly assume the constraints are merely internal. In fact, the messages began externally before being
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internalized and are continually reinforced by the society.

In addition to an awareness of the relevance of gender, feminist therapists appreciate diversity in development. They tend not to think of "normal" progression of development in hierarchical terms, which devalues and deprecates avenues other than the one which has traditionally valued only individuation and separation and has been the norm for development, to the detriment of female clients. Alternate paths of development are considered equally valid.

Since females do not appear to follow male paths of development (Erikson, 1974; Freud, 1974a), feminist therapists value women’s paths as distinct from those of men and equally as valid. These therapists maintain that women develop in relationship leading to enhanced qualities of empathy, caring, connection, and nurturing. These are inestimable characteristics for the individual and for society (although this society has not given them as prized a position as autonomy, ambition, and rugged individualism). A women’s ability to be related and to understand and connect with the feelings of others is precious and necessary for cohesiveness. She gains her sense of self from being
in connection and thrives not as an island but as an interlocking member of a greater whole.

Therapists who are able to incorporate the value of connectedness as a beginning point will have a framework for understanding healthy female development. This is a paradigm shift from the work of Rogers and Maslow who suggested that connectedness follows individuality. Feminist therapists understand that women are first connected and mature in continuing and ever-expanding identification with their mothers; connected relationships between mothers and daughters are healthy and normal. These therapists value a women’s desire to be in, and committed to, a relationship that is healthy and normal for women (and for families and for society).

In summary, therapists who fully understand the experience of the client acknowledge the impact of gender and gender-bias. Gender is a variable in the life of the client. It determines which roles and behaviors a culture will ascribe to her and expect from her. This obvious facet of the client carries with it a way of experiencing life, especially in a society that is not gender-blind.
In addition to attention to gender and gender-bias, therapists working with women need a paradigm for healthy female development or else face the possibility of subjecting the client to continued sexism. The feminist developmental theorists suggest that relatedness and connectedness are the essence of healthy female development. Developing in the context of relatedness and connectedness allows women to cultivate attributes of caring, empathy, and compassion; understanding and valuing this provides the therapist with a healthy, positive model by which to appraise the client.

Regarding Domestic Violence

Therapists’ appraisal of themselves and of their clients establishes a foundation upon which the issue of domestic violence can be addressed. Therapists aim to serve their clients to the best of their abilities for the benefit of the clients. Once clinicians understand the role of therapists’ values, gender, and gender bias and adopt a model of healthy female development predicated on empathy and connectedness, domestic violence can be viewed in a manner that appreciates the predicament of the victim from her perspective. Traditional orientations have lacked the
necessary foundation for this understanding. I propose three necessary steps: adequate assessment, adequate understanding of the clients predicament, and adequate valuing of her attributes.

**Assessment.** According to the literature, domestic violence is under-reported in the public sector as well as in the therapeutic arena. Although numerous reasons account for this, it is vital information for the therapist. Since domestic abuse victims are reticent to report and often minimize the issue when they do report, therapists aware of this possibility leave the door open for further disclosure on this topic as trust and safety issues are established in the therapeutic alliance. Recent awareness of trauma caused by childhood sexual abuse has led clinicians to be cognizant of the magnitude and frequency of this type of abuse and to assess this as a possibility at the intake interview; similar attentiveness may need to be paid to the issue of domestic abuse in the lives of clients.

In assessing this population, therapists understand the impact violence had on the victim. For example, although the client may report "only one" physically violent event, this single event did not
occur in a vacuum. Frequently, other types of abuse preceded the physical abuse, such as verbal, emotional, or sexual. Also, once the abuser has crossed the line and utilized physical violence, the victim is quite aware of his ability to do so again. Therefore, therapists are aware that intimidation and memory are sufficient reinforcers.

If therapists fail to recognize domestic violence as an issue for the client, internal factors rather than external realities may be misdiagnosed as the source of the client’s pathology. As a result, the self-blame common among this population is perpetuated with little relief for the client. Once the focus is established on internal factors and the external is excluded, the chances of further disclosure by the client is unlikely. Female victims of domestic abuse tend to believe the problem lies with them. As a result they readily attach to the theory of internal factors and minimize the external.

Although proper assessment is critical, this is not to imply that the client does not have internal issues to work on. Rather, the abuse is not her fault; she is not responsible for nor in control of the violence. The batterer is to be held responsible for
his actions. A colleague tells her domestic abuse clients, "Don't you think that if you really had control, you would have stopped the violence by now?"

Understanding. In order for therapists to empathize (a basic component of positive therapy outcome), they must understand the thought processes and perceptions of the client. Gender difference and gender bias come into play here. Three emotions (anger, empathy, and fear) interact and explain why women stay in domestic violence situations.

As Campbell (1993) pointed out, men and women experience and express anger differently. For women, expression of anger is often the result of stressors overtaking internal controls. So they experience anger as losing control in the face of overwhelming pressure. Since they interpret anger in this fashion, they also interpret the anger of their partners in this fashion.

In order to aid their partners, women will look for things in themselves to relieve the stress they believe their partners are feeling. However, when they act on this impulse, the partner will interpret this as an attempt to usurp the authority and control (i.e., domination) he is striving to gain and may increase the violence. The result is that the women feels
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responsible for adding to the stress and, yet, are confused as to why and what to do.

Therapists may see the injustice and encourage the client to be angry regarding the situation. However, this may set up a double bind for clients since social taboos prohibit women from openly expressing anger. If anger is not reframed for clients as an appropriate expression in the face of violation, the client may feel that the expressing of anger is the loss of control she had worked so hard at gaining. At the same time clinicians can make the distinction between the emotion and the behavior, freeing the client from responsibility for the batterers actions.

Alternatively, some clients feel very angry and are able to assertively express it. The goal for clinicians in this scenario is to ascertain the focus of the anger. Often clients express anger at their own "stupidity" for staying, for putting up with it, etc. This perpetuates the blame-the-victim mentality. Clients may need help in reframing: their tendency to be relational is not "stupid" and worthy of wrath, rather their partner violated their commitment to the relationship.
Empathy is a valued part of the client's psyche. It allows for caring and compassion. It provides a doorway to understanding among humans and unity with the client; as such it is indispensable for a cohesive, civilized society. Danger exists in pathologizing an attribute that is fundamental to civilization. A women's tendency toward empathy is not enmeshment or dependency. It is valued in healthy relationships and exploited in unhealthy relationships.

Empathy plays a role in why women stay. As Dutton and Painter (1993) reported, the trauma bond established in the aftermath of a violent incident hinges on women's ability to empathize with her abuser's feelings of stress and remorse. Again, this is not to say that empathy is wrong, rather the manipulation of it by the abuser is to be denounced not the victim's compassion. This frees the victim from further obligation and allows her to make choices regarding the relationship. As noted in the theoretical section of this chapter, one therapeutic goal is to enable the client to have a healthy understanding of empathy.

Society and the psychological community must wrestle with this issue of empathy. If as a society,
we view empathy as a weakness, we are not going to find a remedy to many of our social ills such as racism, sexism, violence, etc. Similarly, the clinical psychological community has emphasized the importance of empathy in the healing process. In valuing our own empathic abilities while pathologizing that of our clients, we run the risk of becoming elitist and harming the very society we are attempting to help. On the other hand, if we value empathy as a mechanism for healing, we will value it in our clients as well. This latter position is the one held by the feminist theorists.

Finally, therapists who can fathom the client’s fears understand how it can trap her in the situation. Such a therapist acknowledges the validity of many of the client’s fears. If the client has been isolated, as is often the case, her limited work skills may prevent her from finding employment sufficient to adequately care for herself and her children. Fear of increased violence from her partner is also valid as studies show that the abuse increases when the victim makes an attempt to leave--either in actuality or in the mind of the abuser. Fear that their children will be taken away and custody given to their abuser keep
women from leaving. Leaving the situation does not always end the fear, women fear stalking or being blamed for the demise of the relationship.

Valuing. Aware of their own biases and having a model of healthy female development, clinicians build on adequate assessment and understanding to serve their client’s best interest. In all of this, therapists’ orienting beliefs still govern the direction of therapy. Therapists who understand and value the importance of relationship and empathy in women’s lives will help clients value these aspects of themselves.

Empathy as conceived by feminist therapists is a priceless gift given by the client to her partner. Valuable in and of itself, rejection and depreciation of it by the partner reflects on the partner, not the woman, and frees her from her obligation. She has not failed; he did.

As therapists aid the client in understanding and appreciating this, she will have issues of grief and loss with which to deal. However, she can deal with these issues in a context in which her tendencies toward relationship are deemed valuable and as strengths rather than as inferior or as a weakness.
Relationship as the core of her identity will aid in the establishment of the therapeutic alliance. Therapists can use this time to model appropriate relationship interactions either in individual or group therapy. The therapeutic relationship can incorporate education regarding abusive relationships, specifically, reassuring the client of the fact that therapists and researchers have been unable to satisfactorily distinguish between men who will become or have been abusive and those who will not or have not.

Conclusions

Therapists' values impact therapy. For a therapist to foster a positive therapeutic outcome, he or she must have some concept of healthy female development. The feminist proposal for female development provides a framework for understanding healthy, mature women. This context allows for an understanding of the experience of female domestic violence victims in a way which values and appreciates them and their relational tendencies while placing the
responsibility for violence on the one who chooses to use it.

Therapists striving to provide beneficial service to their clients assess their own values. They determine the degree to which they have assimilated certain biases as a result of their socialization and/or training, as well as the possible implications of this for their clients. Therapists review their orienting belief regarding women and women’s development, again, focusing on the impact of their position. Questions for therapists include: (a) to what degree do I understand the underlying assumptions of my theoretical orientation, (b) does my orientation acknowledge gender difference and gender bias in society, (c) what is healthy female development, and (d) what are the implications of my orientation for the client?

Therapists working with victims of domestic violence need to be sufficiently aware of the literature to determine which of their beliefs are based on cultural assumptions, which are based on the literature, and what are the possible shortcomings of the literature—namely, are the views of advocates given merit?
In working with clients who have experienced domestic abuse, clinicians are careful to adequately assess clients' history regarding domestic abuse. If a particular client has experienced this phenomena, understanding her experience from her perspective is imperative. For the client to successfully work through this issue, her positive attributes, such as empathy and relational orientation, must be valued and separated from responsibility for the violence.

The result of such self-examination is that therapists are better equipped to empathize with clients, to establish therapeutic relationships based on sufficient knowledge, and to explore clients' world from clients' point of reference. This enables therapists to empower their clients by using clients' resources and strengths which hitherto were untapped and unappreciated.

Future Research

This dissertation adds to the theoretical literature; as such it may provide a foundation for empirical research. As noted in the introduction, ethics prevents setting up an abusive domestic
situation in order to study it. However, future research is in order. As more data becomes available on female development, modification of this theory may be appropriate.

Further research focusing on the effectiveness of feminist developmental theory as it is applied in the therapeutic realm would be helpful. Outcome measures need to be developed to determine the significance for the client of using a model which may more closely represent her own experience.

As long as society condones and tolerates violence against women, measures aimed at assessing the reduction of domestic violence are bound to provide dismal data. However, the psychological community may better serve society by advocating for institutionally standardized policies regarding the handling of domestic violence. This would include: demanding that the one who opts to use violence is held responsible for his or her actions; financial and emotional support for those wanting to escape this form of violence; an awareness by society of the prevalence of domestic violence, as well as the culture’s role in this form of violence; and taking responsibility for intolerance toward it. Perhaps research aimed at the degree to
which the psychological community addresses this issue would be helpful.

If in fact 1.8 million women will experience domestic abuse this year, researchers, therapists, and society have a moral responsibility to address the issue. The underlying issues of sexism and cultural gender bias must be addressed. These women must be believed and valued for the attributes they bring to the society—a desire to maintain relationship and a profound ability to be empathic. Therapy can be a conduit for health and safety as these women come to appreciate their empathic abilities and find their own voice.
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Appendix A

DEFINITIONS FOR "VALUES"
**Definitions for "Values"**

<table>
<thead>
<tr>
<th>Source</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kluckhohn, 1951</td>
<td>A conception. . . . distinctive of an individual . . . of the desirable which influences the selection from available modes, means, and ends of behavior.</td>
</tr>
<tr>
<td>(cited in Weisskopf-Joelson, 1980, p 459)</td>
<td></td>
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<tr>
<td>Kluckhohn, 1952</td>
<td>Values are inferred motivational constructs associated with perceived differences in goal-directed behavior and indicated by the selection of action-alternative within social situations.</td>
</tr>
<tr>
<td>Smith, 1954, p. 513</td>
<td>A person’s implicit or explicit standard of choice, insofar as they are invested with obligation or requiredness.</td>
</tr>
</tbody>
</table>
A belief upon which one acts by preference

Values are inferred motivational constructs associated with perceived differences in goal-direction and indicated by the selection of action-alternatives within social situations.

Values are partly discovered by us within ourselves as I have said. But they are also partly created or chosen by the person himself.

Values are conceived of as inclusive evaluative attitudes.
value is a primitive preference for or a positive attitude toward certain end-states of existence . . . or certain broad modes of conduct. . . . Values are ends, not means, and their desirability is either nonconsciously taken for granted . . . or seen as a direct derivation from one's experience or from some external authority.

A value is an enduring belief that a specific mode of conduct or end state of existence is personally or socially preferable to an opposite or converse mode of conduct or end-state of existence.

We include under the term values not only the everyday meaning of cherished personal and sociocultural norms but also the shared assumptions that communities
of scientists make and use to guide their investigations.

Bergin, 1985, p. 99

Values . . . are orienting beliefs about what is good for clients and how that good should be achieved.


Values are convictions--highly prized, often tacitly held--that form the foundations for the actions to which one is committed.

. . . they are convictions that are chosen consistently, statements of the basic principles that guide the direction of choices. They answer the question, Why take these actions?
Appendix B

FREUD AS FOUNDATIONAL
FREUD AS FOUNDATIONAL

This dissertation gave considerable attention to Freud's theory on female development. That his work was greatly influential and had wide breadth of acceptance is indisputable. I would argue three points:

1. Freud's work is widely accepted as foundational, work upon which later theoreticians built. Whether writers identified themselves as "like Freud" or "not like Freud," in both cases Freud was the benchmark.

2. Many of the traditional writers commonly viewed as "not like Freud" acknowledge Freud's influence. In fact, many freely admit to Freud's brilliance in framing their own thinking.

3. Regardless of which camp ("like Freud" or "not like Freud") they claim to be, writers are often explicit on where they agree or disagree with Freud. As such, I would argue that where they are silent, these writers are either in agreement with Freud or else see disagreement with Freud as unnecessary and irrelevant.
Following are portions of works from diverse writers. The common theme is Freud's influence. Even when authors did not agree with Freud, they felt that addressing Freud's impact on contemporary thought was necessary. The works are presented in alphabetical order by author rather than chronologically or categorically. All italics are original.

Bem (1970)

... psychologists are likely to look to the psychoanalytic insights of Sigmund Freud first whenever an individual appears to hold certain beliefs and attitudes primarily to fulfill his own unconscious values, to satisfy his own unconscious needs, or to protect himself against unconscious threats to his own self-esteem. (p. 21)

The area of beliefs and attitudes is not the only area of social psychology which has been illuminated by Freudian thought. It is true that not all of psychoanalytic theory has been adequately validated, that parts of it clearly need further correction or modification, and that, in its present form at least, it cannot explain all of human behavior satisfactorily.
Nevertheless, it remains to this day our most comprehensive single theory of human thought and behavior. In a very real sense, we are all Freudians; Freudian concepts and insights have become so much a part of our thinking that their influence is now largely nonconscious. (p. 23)

Breger & McGaugh (1965/1983)
Dollard and Miller present an attempt to translate psychoanalytic concepts into the terminology of Hullians learning theory. While many recent behavior therapists reject Dollard and Miller because of their identification with psychoanalysis and their failure to provide techniques distinct from psychoanalytic therapy, the Dollard-Miller explanation of neurotic symptoms in terms of conditioning and secondary anxiety drive is utilized extensively by Wolpe and his followers. (p. 407)

Erikson (1959/1983)
Psychoanalysis has enriched our vocabulary with the word "anal". (p. 140)
[In expounding on Initiative versus Guilt]
This leads to the ascendance of that human specialty which Freud called the "latency" period. . . . The very deep emotional consequences of this insight and the magic fears associated with it make up what Freud has called the oedipus complex. Psychoanalysis verifies the simple conclusion that boys attach their first genital affection to the maternal adults who have otherwise given comfort to their bodies . . . Girls often have a difficult time at this stage, because they observe sooner or later that, although their locomotor, mental and social intrusiveness is increased equally with, and is as adequate as, that of the boys, thus permitting them to become perfect tomboys, they lack one item: the penis; and with it, important prerogatives in some cultures and classes. While the boy has this visible, erectable, and comprehensible organ to which he can attach dreams of adult bigness, the girl's clitoris only poorly sustains dreams of sexual equality. (p. 145)

Eysenck (1959/1983)
In practically all its manifestations, psychotherapy is based on Freudian theories. (p. 384)
It is sometimes said that the model offered here differs from the psychoanalytic model only in the terminology used and that in fact the two models are very similar. Such a statement would be both true and untrue. There undoubtedly are certain similarities as . . . Miller and Dollard have been at pains to point out. . . . indeed this writer would be the first to acknowledge the tremendous service that Freud has done in elucidating for the first time some of these dynamic relationships. (p. 391)

Foley (1989)
[writing about family systems theorists]
Many early pioneers in family therapy, such as Murray Bowen and Nathan Ackerman, were trained as psychoanalysts and, consequently, there are similarities between their ideas and those of psychoanalysis. There are many interfaces between family therapy and psychoanalytic thinking, and some family therapists, such as Ivan Boszormenyi-Nagy and Geraldine Spark, and Helm Stierlin in particular, work on these. The major difference between psychoanalysis and family therapy is that in psychoanalysis, parental involvement is excluded as a hindrance to the
development of the transference neurosis, which is seen as necessary to successful therapy, whereas in family therapy, all members of the family are brought into the therapy sessions. (p. 458)

A humanistic approach to the alleviation of suffering due to relationship problems began with the psychological discoveries of Freud. . . . There are two discernible threads in the thinking of Freud. The first, coming from his early training in the biological sciences, is this theory of instincts. The second, going beyond instinct to a more psychological explanation, culminated in the theory of the Oedipus complex. (p. 459)

Frankl (1986)
We cannot discuss psychotherapy without taking for our starting-points psychoanalysis and individual psychology, the two great psychotherapeutic systems created by Freud and Adler respectively. The history of psychotherapy cannot be dealt with apart from their work, which is in the best sense of the word "historic"--but historic also in the sense that Freud and Adler already belong to history, later developments
having left them far behind. So, though it may often be necessary to go beyond the premises of psychoanalysis or individual psychology, we find ourselves again and again drawn back to the doctrines of these two schools. Stekel put the matter very aptly when he remarked, clarifying his position on Freud, that a dwarf standing upon the shoulders of a giant can see farther than the giant himself. (p. 3)

Haley (1963)

[family systems]

After Sigmund Freud, man was looked upon as a far less rational being, but it was still thought that he could change through self-understanding. Freud accepted the idea that self-awareness causes change, but he added the idea that the distressed individual must become aware of how his present ways of thinking and perceiving are related to his past and to his unconscious ideas. . . . It is becoming more clear that Sigmund Freud developed psychoanalysis as a method of dealing with a specific class of people. He was faced with the general inability of the medicine men of his day to relieve that type of person who went from doctor to doctor and consistently failed to undergo a change.
At that time there was no systematic method for dealing with this class of difficult people, and Freud developed one. Since then, methods of psychotherapy have bred and fostered until it is an accepted idea that one should sit down and have a conversation with a person who has psychiatric symptoms. Although the benefits of drugs, shock treatment, and brain operations are also applauded, the idea that an individual can undergo major changes as the result of a conversation is generally accepted. (p. 1-3)

The emphasis upon thought processes and the development of fantasy would seem to be related to Freud's fascination with the processes of human thinking. One cannot read Freud without admiring his tenacity and skill as he traces a patient's ideas through all their symbolic ramifications. There is no intent in this chapter to disagree with Freud's formulations about individual personality development or his analysis of symbolic material. Rather, it will be suggested that the exploration of the human psyche may be irrelevant to the therapeutic change. Although Freud assumed that the patient's self-exploration produced change, it is argued here that change occurs as a product of the
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interpersonal context of exploration rather than the self-awareness which is brought about by the patient. Freud appeared during a period when it was assumed that man could change through self-understanding, and it seems more apparent today that the ability of a person to change because of self-knowledge is definitely limited. A description of psychoanalytic therapy which includes both analyst and patient, rather than only the subjective processes within the patient, makes apparent other possibilities besides self-understanding as the source of therapeutic change. (p. 69)

This emphasis upon only internal processes in a patient was not always so in the history of psychoanalysis. One of the more important moments in that history was Freud's courageous reversal of his position on hysteria. From asserting that hysterics had suffered an actual sexual assault in the past, as they reported, he shifted to the argument that their statements represented fantasies involving wish fulfillment. From this emphasis came the presentation of the Oedipal conflict. However, this shift also centered psychoanalysis upon the fantasy life of the patient rather than his behavior in relation to other people.
If Freud had emphasized the possibility of the hysteric's parents behaving in a particular way with the patient, he would have entered the field of family study and classification. If he had emphasized the way the hysteric was manipulating him by falsely telling him about such an assault, he would have examined psychotherapy in terms of tactics between patient and therapist. Instead, he centered upon the patient's misinterpretations of his past and so entered the field of symbolic process. (p. 70)

The central notion of Freudianism, the Oedipal conflict, represents a point of view which is typical of the individual approach--the child has sexual impulses toward his mother which conflict with his fear that his father will castrate him, resulting in a repression of ideas about these impulses and a continuing conflict between these impulses and the defenses against them. . . . The family point of view does not refute the typical portrait of intrapsychic conflict. Such a refutation is, perhaps, impossible. If one looks at the data the way Freud did, the Oedipal conflict is apparent in the individual's statements and in the fiction and drama he creates. Similarly, if one
records what a patient says and interprets those statements as symbolic expressions of a struggle between instinctual drives and repressing forces, the metaphors of intrapsychic conflict are appropriate. What the family point of view adds is a different way of looking at the same data as well as an emphasis upon collecting new kinds of data. (p. 155)

Maslow (1962)
This point of view in no way denies the usual Freudian picture. But it does add to it and supplement it. To over-simplify the matter somewhat, it is as if Freud supplied to us the sick half of psychology and we must now fill it out with the healthy half. (p. 5)

Freud supplied us with the most comprehensive systems of psychopathology and psychotherapy. (p. 13)

There is another reason why my systematizing side likes this notion of growth-through-delight. It is that then I find it possible to tie it in nicely with dynamic theory, with all the dynamic theories of Freud. (p. 46)
From our point of view, Freud's greatest discovery is that the great cause of much psychological illness is the fear of knowledge of oneself. (p. 57)

Classical Freudian theory is of little use for our purposes and is even partially contradicted by our data. (p. 133)

May (1960/1983)
[existential psychotherapist]
Binswanger [a leading existential psychiatrist] gave credit to Freud for having enlarged and deepened our insight into human nature more, perhaps, than anyone since Aristotle. . . . He held that Freud's great contribution was in the area of *homo natura*, man in relation to nature. (p. 270)

I maintained at the time that this missed the point: Freud had uncovered realms of human experience of tremendous importance, and if they did not fit our methods, so much the worse for our methods; the problem was to devise new ones. . . . There is at present a three-cornered liaison, in tendency and to some extent in actuality, between Freudianism, behaviorism in
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psychology, and positivism in philosophy. An example of the first side of the liaison is the great similarity between Hull's drive-reduction theory of learning and Freud's concept of pleasure. . . . I have tried elsewhere to show that Freud's tragic concept of the Oedipus complex is much closer to the truth than our tendency to interpret the Oedipus complex in terms of discrete sexual and hostile relationships in the family. (p. 271)

May (1969)
One of Sigmund Freud's greatest contributions--if not his greatest--lay in his cutting through the futility and self-deceit in Victorian "will power." That "will power" was conceived by our nineteenth-century forefathers as the faculty by which they made resolutions. . . . I say that was possibly Freud's greatest discovery because it was this exploration of the ill effects of Victorian will power which led him to what he called the "unconscious." He uncovered the vast areas in which motives and behavior--whether in bringing up children or making love or running a business or planning a war--are determined by
unconscious urges, anxieties, fears, and the endless host of bodily drives and instinctual forces. (p. 180)

Millon (1983)
Our presentation of the intrapsychic approach begins with a contribution by Sigmund Freud for two reasons. First, in recognition of the fact that his monumental works are the foundation upon which all other intrapsychic theories are based and, second, to demonstrate the bridge he attempted to build between the biophysical and the intrapsychic orientations. (p. 118)

Nichols & Schwarz (1991)
[family systems writers]
The two most influential approaches to psychotherapy in the middle of the twentieth century, Freud’s psychoanalysis and Rogers’s [sic] client-centered therapy. (p. 2)

Freudian concepts, extrapolated from the individual to the group, remain part of group dynamics theory, but most of the working concepts focus less on individuals than on the interactions among them. (p. 189)
It is appropriate to begin by acknowledging Freud's contribution to the psychoanalytic study of family life. (p. 227)

Thoroughly trained in psychoanalysis, including undergoing thirteen years of personal analysis, Bowen, not surprisingly, sought to apply psychoanalytic concepts to schizophrenia. He began by expanding his focus from the schizophrenic patient to the mother-child dyad. (p. 363)

Perls (1969/1983)
[founder gestalt therapy]
Great strides have been made since Freud's monumental discoveries. . . . We find the condensation of Freud's historic outlook in the concept of transference.
[footnote to this last line reads] According to Freud, a neurosis rests on three pillars; sex instinct, repression and transference. (p. 309)

Satir (1983)
[family systems]
[In chapter entitled: "Stresses Affecting the Modern Family"]
Psychoanalysis, also, profoundly affected concepts about "normal" human behavior, motivation, learning. It led people to reexamine and worry about all aspects of existence, especially about proper child-rearing practices.

a. The theory implicitly urged parents to give the child freedom to avoid injuring his psychic development.

b. Over-applied (or carried to a logical conclusion), such ideas immobilized and confused parents.

Satir (1987)

Freud's views also offered a new way of understanding human behavior. By 1940, psychoanalytic concepts underlay almost all psychological thinking and treatment.

Skinner (1956/1983)

I do not want to raise the question of the supposed nature of these inner entities. . . . If we come out flatly for the existence of instincts, needs, memories, and so on, on the one hand, and the mental process and functions of the personality on the other, then we must
accept the responsibility of devising methods of observing these inner events and of discovering dimensional systems according to which they can be measured. . . . It is possible, however, to argue that these inner events are merely ways of representing the outer. . . . The concepts which one encounters in current behavior theory represent the observable events in an extremely confusing way. Most of them have arisen from theoretical or practical considerations which have little reference to their validity or usefulness as scientific constructs, and they bear the scars of such a history. For example, Freud pointed to important relationships between the behavior of an adult and certain episodes in early childhood, but he chose to bridge the very considerable gap between cause and effect with activities or states of the mental apparatus. Conscious or unconscious wishes or emotions in the adult represent the earlier episodes and are said to be directly responsible for their effect upon behavior. (p. 366-367)
Freud was part of the landscape of my profession, more or less prominent depending on one's point of view but never out of sight entirely. (p. xvi)

In short the nature-nurture debate became quietly "Freudianized" as it also became politicized. (p. 59)

Benjamin Spock probably did more than any single individual to disseminate the theory of Sigmund Freud in America. (p. 128)

It is also important to realize that the Freudian child-rearing practices being promoted by Spock were consonant with public advice being given by Mead, Benedict, Erik Erikson, and leaders in progressive education circles. (p. 143)

The theory of Sigmund Freud was incorporated into America's jails and prisons much more quickly than it would be welcomed into its nurseries. (p. 147)
Karl Menninger became, in his own estimation, "more Freudian than Freud." (p. 160)

While Freud's ideas have been inculcated upon American thought and culture, these ideas have also been scientifically discredited. (p. 214)

Perhaps the most fundamental change in American culture wrought by Freud's legacy has been the popularization of counseling and psychotherapy. In no other nation in the world have these become so much a part of the culture as they have in America. While it is acknowledged that an increasing proportion of counseling and psychotherapy is not directly Freudian, most of it is indirectly Freudian insofar as it assumes that adult problems are a consequence of childhood experiences and that talking about or understanding the childhood experiences will help solve the adult problems. It seems likely that the immense popularity of counseling and psychotherapy in America is a direct consequence of Freud's greater popularity here compared to other countries. (p. 246)
Freudian theory is inherently misogynistic and patronizing. . . . A few of Freud's followers, most notably Karen Horney, disagreed with this denigration of women and publicly said so. The majority, however, accepted Freud's evaluation of women and conveyed this assessment, implicitly if not explicitly, to their patients. (p. 250)

Tournier (1957)
[philosopher]
Among the various schools which have come into being as a result of Freud's discoveries, it seems that it is that of Rank which has best understood the close connection between psychology and spiritual life. (p. 109)

Becoming adult is the whole program of the Freudsians, and their work has done much to help us to see its full significance. They stressed first the passage from infantile to adult sexuality and then the passage from captative to oblative love; and lastly the idea of autonomy, the courage to be oneself, in harmony with oneself, to break free from infantile dependence on others. (p. 205)
Watson & Rayner (1920/1983)
[behaviorists]
[closing his discussion on the Little Albert experiment]

While in general the results of our experiment offer no particular points of conflict with Freudian concepts, one fact out of harmony with them should be emphasized. According to proper Freudians, sex (or in our terminology, love) is the principal emotion in which conditioned responses arise which later limit and distort personality. We wish to take sharp issue with this view on the basis of the experimental evidence we have gathered.

The Freudians 20 years from now, unless their hypotheses change, when they come to analyze Albert's fear of a seal skin coat—assuming that he comes to analysis at that age—will probably tease from the recital of a dream which upon their analysis will show that Albert at 3 years of age attempted to play with the pubic hair of the mother and was scolded violently for it. (p. 342)

Wolpe (1958/1983)
[learning theory]
Like other neurotic reactions, hysterical reactions are acquired by learning. It is intriguing to note that Freud's very early observations on hysterical subjects could easily have led him to this conclusion had he not been sidetracked by a spurious deduction from observations on therapeutic effects. . . . That Freud did not see this was mainly because, having observed patients cured when they recalled and narrated the story of the precipitating experience, he concluded that the symptoms were due to the imprisonment of emotionally disturbing memories. . . . the mind-structure theory that is psychoanalytic theory would not have been born, if Freud could have known that memories do not exist in the form of thoughts or images in some kind of repository. (p. 344-345)

Writers from diverse schools adhere to and praise Freud's work, often time explicitly referring to his work on development and the Oedipal complex. Where authors disagree, they acknowledge Freud's great genius and influence.
Appendix C

VITA
Vita

Patricia A. Warford

2206 Thorne Street
Newberg, Oregon
(503) 538-9601 (home)

Personal:

Date of birth: May 19, 1957
Place of Birth: Vicenza, Italy
Marital status: Married
Date of Marriage: 8-27-77
Husband: Gary W. Warford (9-5-55)
Children: Candice (8-26-80)
Nathanael (1-23-84)

Internship:

September 1994-Present
Western Psychological & Counseling Services, Inc.
9725 S. W. Beaverton-Hillsdale Hwy.
Beaverton, OR
(503) 626-9494
Supervisors: Carol Dell’Oliver, Ph.D.
C. Wayne Yocky, Ph.D.

Work Experience:

July 1994-Present
Yamhill County Mental Health
Adult Mental Health
627 N. Evans
McMinnville, OR
(503) 434-7523
Duties: Counseling for the AFS/JOBS Program (includes individual and group)
Supervisor: Marie M. Bellasario, L.C.S.W.


**Practicum Experience:**

1993-1994
Yamhill County Mental Health
Family and Youth Division
Site Supervisor: Diane Roelandt, L.C.S.W.
412 N. Ford
McMinnville, OR
(503) 434-7528
Duties: Counseling: individual, family, and group
Clients: (Individual) Children ages 5-19, sexual abuse victims
(Family) Single-mother, adoptive
(Group) Children of Alcoholics, Adult Sexual Abuse Survivors Group, Problem-Solving for Mentally Handicapped Adults

1992-1993
George Fox College Counseling and Development Center
Site Supervisor: David Arnold, M.Ed., M.A.
Washington, Oregon
Duties: Counseling
Clients: Mainly woman; childhood physical, emotional and sexual abuse issues, developmental issues of college age women.

Newberg District School System
Site Supervisor: Ross Quackenbush, Ph.D.
District School Psychologist
Duties: Achievement Testing with the Woodcock-Johnson, Revised, to assess level of functioning.
Clients: School children grades K-12, most functioning well below age and grade level.

**Education:**

From 09/91
To 04/94
George Fox College
Graduate School of Clinical Psychology
Newberg, OR 97132
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MA Received: 5/1/93 G.P.A.: 4.0
Anticipated date for Psy.D.: 9/96
Served on following committees:
Graduate Student Council (1991 - 1994)
   - Chair for 1993-94 school year
   - Saturday Seminar coordinator
organized seminars:
   Fall 1993-
   Symposium on Homosexuality
   Spring 1994-
   James Fowler
   "Faith, Selfhood, and Shame"
   Spring 1995-
   Mary S. Van Leeuwen
   "Opposite Sexes or Neighboring Sexes"
Faculty Committee student rep. (1992-1994)
Administrative Committee student rep. (1992-1993)
Curriculum Review Committee (1992-1993)
Administrative Graduate Fellow
   Rodger Bufford, Ph.D. (1993-94)
   duties include editing dissertations, manuals, involved in the writing of the application for APA accreditation

Testing instruments:
Beck Depression Inventory
Beery
Bender Visual Motor Gestalt Test
Edwards Personal Preference Scale (EPPS)
House-Tree-Person Projective Drawing
Minnesota Multiphasic Personality Inventory (MMPI)
Rorschach Projective Test/Exner System
Sixteen Personality Factor Questionnaire (16 PF)
Stanford-Binet Intelligence Scale: Fourth Edition
Thematic Apperception Test (TAT)
Wechsler Adult Intelligence Scale-Revised (WAIS-R)
Wechsler Intelligence Scale for Children-III (WISC-III)
Wechsler Intelligence Scale for Children-Revised (WISC-R)
Wide Range Achievement Test-Revised (WRAT-R)
Woodcock Johnson Achievement Test
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From 05/90 To 05/91
South Dakota State University
Brooking, SD - B.S. in Psychology
Overall G.P.A.: 3.63
G.P.A. Last Two Years: 3.89

From 09/88 To 05/90
Mount Marty College - Harmony Hill Branch
Watertown, SD
G.P.A.: 4.0

From 01/76 To 05/77
Trinity Bible College
Ellendale, ND

From 09/75 To 12/75
University of Nebraska Medical Center
Omaha, NE

References: AVAILABLE UPON REQUEST