SOCIAL WORK INTERVENTION WITH DEPRESSED WOMEN: A FEMINIST PERSPECTIVE

BY

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SHEILA JEAN RAINONEN

A practicum submitted to the Faculty of Graduate Studies of the University of Manitoba in partial fulfillment of the requirements of the degree of

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TABLE OF CONTENTS

PAGE

INTRODUCTION 1

SECTION I: LITERATURE REVIEW

Chapter 1. The Oppression of Women
Introduction........................... 3
Historical Background.................. 4
Sex-Role Stereotyping.................. 8
The Facts about Oppression............. 12
Chapter 2. Mental Health Issues for Women
Introduction........................... 15
Depression in Women.................... 15
Marriage............................... 17
Motherhood............................. 26
Employment in the Labour Force......... 33
Chapter 3. Mental Health Systems
Introduction........................... 39
Sexism in Social Work.................. 41
Sexism in Practice..................... 45
Chapter 4. Feminist Counselling
Introduction........................... 54
Emergence of Feminist Counselling...... 56
Definition of Feminist Counselling..... 58
The Personal is Political.............. 63
Egalitarian Counsellor-Client Relationship............ 66
Other Considerations................... 70
Chapter 5. Summary and Conclusions................ 74

SECTION II: INTERVENTION

Introduction.................................. 78
Chapter 1. The Setting........................ 80
The Counselling Process................ 82
Chapter 2. The Women.......................... 87
Demographic Characteristics............ 88
Assessment Measures.................... 90
Chapter 3. Themes and Case Examples
Common Themes.......................... 96
Case Examples
Case 1............................. 99
Case 2............................. 108
Case 3............................. 119
Case 4............................. 136

Chapter 4. Evaluation......................... 148
The Post-Test Measures................. 149
The Consumer Feedback Form............. 152
Summary and Conclusions................ 163
Personal Comments...................... 167

BIBLIOGRAPHY 172

APPENDICES 182
Appendix A...................................183
Appendix B...................................185
Appendix C...................................189
Appendix D...................................191
Appendix E...................................193
Appendix F...................................196
Appendix G...................................200

"Thus humanity is male and man defines woman not in herself but as relative to him; she is not regarded as an autonomous being." (Simone De Beauvoir, 1952).

"The problem that has no name - which is simply the fact that American women are kept from growing to their full human capacities - is taking a far greater toll on the physical and mental health of our country than any known disease". (Betty Friedan, 1963).

"The name of 'the problem that has no name' is chronic depression". (Miriam Greenspan, 1983).

"We are part of the longest and deepest kind of revolution: a revolution that will humanize us and will do away with the sexual and racial caste systems that have divided us. Never again, whatever social systems we may develop, will anyone be born into a particular role because of sex or race or class. Finally, we will begin to understand the unique and human and irreplaceable individual that each of us could be." (Gloria Steinem, 1983).

INTRODUCTION

For approximately six years I have been referring to myself as a feminist. I have been employed as a social worker for the same length of time. I had thought that if I was a feminist and a counsellor, then I must be practicing feminist counselling. However, in my work as a counsellor, I worked with many women clients trying to be empathic, nonjudgmental and caring, but I found that these attributes were often not enough to help the women make positive changes in their lives. I realized that I was not fully applying my feminist beliefs to social work, and decided to take the opportunity of pursuing the Master of Social Work degree in order to remedy this gap in counselling practice. My interest in learning about a feminist approach to counselling women has arisen out of a desire to combine my experience and skills as a social worker with my awareness and life experience as a woman.

This practicum is a beginning attempt to integrate feminist and social work beliefs into a practice framework that can effectively help women clients. The report consists of two sections: first, a review of literature related to women's issues, women's mental health issues, the mental health system, and feminist counselling; and second, a description and discussion of the practicum itself, and an evaluation of the feminist counselling approach used in the practicum.

When referring to women as a whole, I have used the pronoun "we" rather than "they" because I consider myself to be part of the collective I am writing about rather than a professional outsider.

"Most Canadian women will, like me, go through marriage, motherhood, and paid employment. I hope that some of them through seeing their own joys and trials mirrored here, will come to share my conviction that until we all enjoy a perfect social, cultural, legal, and financial equality with men, none of us - however privileged we may be individually or temporarily - is really anything more than a second class citizen. (Michele Landsberg, 1983).

SECTION I: LITERATURE REVIEW

Chapter 1. OVERVIEW OF THE OPPRESSION OF WOMEN

INTRODUCTION

Feminism is an ideological commitment to the legal, economic, and social equality of the sexes. Modern feminist thought describes the world as one defined by men and for men, with women seen primarily as property, modern servants inside and outside the home, and as marginal to fundamental issues of historical struggle and change (Levine, 1979).

An analysis of society from a feminist perspective has been an essential part of the present women's movement which gained momentum after the publication of Betty Friedan's book The Feminine Mystique in 1963. According to a feminist critique, the traditional view of men and women that prevails in society is one which sees women's biological differences as legitimizing different and inferior social functions and social roles than those available to men (Thomas, 1977). Advocates of feminism reject this view, believing that the assumption of segregated roles according to sex is a throwback to primitive times, and the result of social conditioning and an institutionalized sexual class system rather than biological determinism. This critique has placed particular emphasis on psychological oppression of women, pointing to the damage women have suffered with respect to

self-concept, identity formation, intellectual development and aspirations, and overall emotional well-being as a result of the socialization we have undergone and the lower sociopolitical status assigned to us.

The current women's liberation movement has taken a broad approach to feminism demanding equality for women in all areas of life. This includes not only economic and political equality but also the equalization of personal and social power in relationships between women and men (Sturdivant, 1980). This movement has forged a new and important link for women between personal pain and political oppression. Helen Levine (1979, p.76) describes it thus: "The women's movement asserts that the ways in which women and men share their labour, money, and decision making power at the domestic level are intimately linked with our lack of power in shaping the societal structure, institutions, and goals that affect each and every one of us." It is beyond the scope of this paper to explore extensively the anthropological explanation for the oppression of women but some historical background leading to this present day oppression will be briefly outlined.

HISTORICAL BACKGROUND

Long ago when people lived in caves, forests, and on the plains, women were thought to be magical because of their power to create new life. Many ancient people

thought that a female god created the world because of women's ability to produce babies (Epstein, 1984). At that time no one knew how conception occured. In this primitive society, pregnancy, childbirth, and lactation consumed a great deal of women's time and energy. Because women were usually either pregnant or nursing babies, and caring for young children, they stayed close to home. The females gathered because a female could pick berries or dig roots while pregnant or carrying a nursing child but she could not chase or carry game. Men did the hunting that required roaming far from home for unpredictable lengths of time. In a society whose main function was to survive, whose women had no control over their childbearing and no alternative to breastfeeding, whose meat supply was unreliable, and whose vegetable foods provided only subsistence, hunting was a valued activity and a division of labour based on biology made sense (Pogrebin, 1980).

After a long time nomads settled down and became farmers, and owning land brought with it the notion of private property and inheritance. Men began to understand that women created babies with their help. Fathers began to think of children as their property, and since legitimacy was important in terms of passing land on to heirs, they also began to think of their wives as property. Little by little wives came to be ruled by husbands. By the time North American society reached the

stage of written law, patriarchy was established.

Before the Industrial Revolution, the husband was the uncontested head of the household according to the law, but his survival depended a great deal on his wife's work, including her production of all the food and clothing from basic ingredients, and her ability to produce children to help on the farm. With the Industrial Revolution of the 19th century, the world of work became increasingly separated from the home. Men went to work outside the home and were paid wages. Important changes took place in women's roles. New industries started to provide many of the products women used to make in their homes; clothes, canned foods, bread, and soap were now commonly sold. The role of children changed from asset to liability; they were forced to attend school, prevented from working until certain ages, and came to be seen as a strain on family resources. As housework and motherhood were no longer related to the production of visible goods and services, women's roles became devalued. They became much more vulnerable and many were totally dependent on their breadwinner husbands.

During the Second World War, this situation changed dramatically. Women joined the paid labour force in record numbers because the men were away at war, and public child care services were provided for those "working mothers". However, when the war ended, the men returned and demanded their jobs back. Women were again

relegated to the home (Levine, 1983).

After the war, emerging ideas about childrearing and maternal deprivation, usually written by male experts, held women responsible for the outcome of family life, and led to marriage and motherhood becoming full time careers for many women. All women were perceived to be potential wives and mothers to the exclusion of other roles. More importantly, the image of what an ideal wife and mother is supposed to be has come to define what women in general are supposed to be (Bardwick, 1979).

Today, while there have been some improvements in the power structures of families through equal rights legislation, family law changes, and the entry of women into the labour force in everincreasing numbers, most women are still "choosing" marriage and motherhood. These two institutions still incorporate oppression and male dominance in ways which will be detailed later in this paper.

The traditional family structure, seen as central in today's society, is one institution that is a particularly effective vehicle for the containment and oppression of women (Levine, 1979). Women as a group have kept the thread of human society going through the feminine work of raising and nurturing children, and loving and sustaining families, but this very work has been devalued and exploited by patriarchal society (Greenspan, 1983). The sexual division of labour has

developed so that the productive sphere of providing for people's material needs has become mainly the prerogative of men, while the reproductive sphere of bearing and rearing children has become the responsibility of women. In other words, the greatest difference between the sexes is the identification of women with the family and housework, and of men with paid labour (Eichler, 1983). Reproductive labour is socially necessary but has no exchange value in a money economy, and the women engaged in it are not seen as contributing to the economy (Cummings, 1981). For example, the value of housework and childrearing is not included in the country's Gross National Product (GNP). Estimates of the value of housework (which includes caring for children) performed within private households usually place it at one third of the GNP in Canada (Eichler, 1983). The toll this unpaid work and nurturing takes in terms of women's mental health will be discussed in a later section.

A major function of the family is the socialization of children, whereby they learn what society expects of them. It is through this process that the prescribed roles and statuses of the sexes are perpetuated. This process is called sex role stereotyping and will be examined next.

SEX ROLE STEREOTYPING

Sexism determines which attributes are defined as

masculine and valued above those defined as feminine with the result that men are valued more than women. Sex role socialization helps generate the psychic structures necessary for women to accept their specific societal position (Greenspan, 1983). Directing women into narrowly confined roles is a long socialization process that begins with toys and books given to young children to encourage instrumental behaviour for boys and expressive behaviour for girls. By the time they are in high school, girls realize that women are not allowed to make a significant impact on the world, and that our role in life is not only different from that of our brothers, but quantitatively inferior (Brodsky, 1981).

The primary values and behavioural norms of a society become part of the core personality of almost every individual in that society. Among the earliest learned and most strictly enforced of these values and norms are those that relate to sexual identity, to being a boy or a girl. These gender based values and norms influence people's life actions and choices from birth to death. Feminist authors believe that these are not innate, inherited, instinctual, or hormonally linked, but culturally derived (Norman, 1980).

In a review of the literature about sex roles, Larry Feldman (1982) outlines two major types of male and female sex roles - sociological and psychological. The sociological aspect involves the normal expectations for

the allocation of work and family responsibilities. Men are generally expected to assume the major share of the responsibility for providing economically for their families, while housework and child care are considered to be primarily the responsibilities of women. Both men and women are judged mainly by their performance in these roles. Men are evaluated in terms of their productive role, specifically, their work, while women are evaluated primarily by their sexual and productive role, or by how well they perform the functions of wife and mother, and how smoothly they keep their homes and families running (Brickman, 1984).

The psychological aspect defines a number of categories of traits expected of each sex. Since women are taught to view their place as in the home taking care of the children and the house, they learn to be nurturing, expressive, submissive, and dependent. Men learn that their place is in the world of paid work, thus they learn to be ambitious, competitive, calm, logical, aggressive, and independent. Neither sex is encouraged to acquire the traits of the other and in fact this is often discouraged.

Sex role stereotypes tell children that boys are better and girls are meant to be mothers. These two messages of male supremacy and compulsory motherhood are the raw essentials of the patriarchal system according to Letty Cottin Pogrebin (1980). There is little question that stereotypic notions of masculinity and femininity

have a constricting and inhibiting effect on human development. Children are encouraged to conform to idealized generalizations of what males and females should be, rather than being allowed to develop their own unique potentials, interests, and skills (Lerner, 1981). Aside from menstruation, pregnancy, and lactation, few behaviours have been proven to be exclusively male or female. Yet, both men and women have grown up believing in the restrictions placed on their behaviour and lives by a sexist society. Sex-role socialization is only one part of the total picture of the oppression of women; it sets the stage for women to accept the specific second class status assigned to females in a patriarchal society (Greenspan, 1983). Women in our society have been defined and therefore define themselves as reflections of their roles in the family: as wives and mothers, nurturers and homemakers. These roles and behaviours and the institution of the family have been given precedence over all other options. The idea that women are persons, with legitimate individual needs which may involve spheres outside the family or which may conflict with the family, has only just begun to surface as acceptable (Norman and Mancuso, 1980). Indeed, women became recognized legally as "persons" only within this century, and were first allowed to vote in the 1920s.

The narrow roles conferred on women, along with a subordinate status, lead inevitably to oppression. This

oppression is both external and internal. External oppression often takes the form of reinforcement of narrow stereotypic roles for women and the prescription of rigid behavioural expectations by society as a whole (Donadello, 1980) as well as the more obvious oppression that occurs in women's exclusion from society's privileges. Internalization is the process by which what was an externally imposed dictate is transformed into an internally imposed command (Greenspan, 1983). Internal oppression occurs as women internalize the norms, values, and prescriptions of this society and thus experience doubts, anxieties, and oppression when any behaviours ouside the norms are enacted. Thus, the social message that women are worth less than men is converted through internalization into women's feelings of worthlessness. Oppression of women is a fact and will be detailed in the next section.

THE FACTS ABOUT OPPRESSION

The oppression of women is reflected in many shapes and forms in Canada today. Women are the targets of male violence; we are beaten in our homes, and sexually harassed in our workplaces. It is estimated that every year one in ten Canadian women who is married or in a live in relationship with a partner is battered (MacLeod, 1980). As adults and children, we are raped and sexually abused. Violent pornography contributes to the belief

that women are appropriate objects of violence and degradation. Legal sanctions against this violence are largely unenforced, and the few existing services for women who are victims of this violence are poorly and unreliably funded (Canadian Advisory Council on the Status of Women, 1984). Specifically, females experience a higher rate of child sexual abuse than males, with estimates as high as one in four (Rush, 1980). Statistics show that one in every 17 Canadian women is raped at some point in her life, and one in every five is sexually assaulted. Rape victims have ranged in age from six months to 90 years old (CACSW, 1981).

Economically, women are oppressed. Over two-thirds of the single people in Canada who are poor are women, and while 10% of male-headed families live in poverty, almost half of all female-headed families do (CACSW, 1981a). In the workplace, women are underrepresented in the professions, and overrepresented in female job ghettos. The CACSW (1981b) notes that the jobs that most women have are low paying jobs. Over 62% of all employed women, compared to 29% of employed men hold clerical, sales, and service jobs. Also women are paid less for their work in the labour force, earning on average 62% of what men earn and two-thirds of all minimum wage earners are women. Of all part time workers, 72% are women, and part time workers earn only 79% of the hourly wage of full time workers. They also receive fewer

benefits, including pensions, and many of those working less than 15 hours per week are not eligible for unemployment insurance. Canada's public pension plans pay 25% of pre-retirement earnings so that women, with lower pay than men throughout their lives, continue to receive less in retirement. Most employed women have no private pensions, and few widows receive any benefits from their husbands' pensions. Full time homemakers are entitled only to benefits under the Old Age Security and Guaranteed Income Supplement programs (CACSW, 1982).

Women in the labour force are penalized for becoming mothers. Maternity benefits under the unemployment insurance program replace only 60% of a woman's earnings for 15 weeks, and a new mother must wait two weeks without any income before receiving these benefits. Availability of day care for children is minimal. Only 14.4% of children under 6 whose mothers are employed are in spaces in approved day care settings. For infants under 2, the situation is even worse: only 3.8% are in any form of licensed or supervised day care (CACSW, 1982b).

These facts have a powerful and detrimental effect on women's mental health and the connections between oppression and depression will be considered in the next section.

Chapter 2. MENTAL HEALTH ISSUES FOR WOMEN

INTRODUCTION

Phyllis Chesler (1972) calls women the most "treated" category in our society. She notes that many women display "female" psychiatric symptoms, such as depression, frigidity, paranoia, psychoneurosis, and suicide attempts. Men typically display "male" symptoms, such as alcoholism, drug addiction, personality disorders, and brain diseases. Of all the female mental illness diagnoses, depression is the most prevalent. This practicum will focus primarily on depression in women and explore the relationship between depression and women's traditional roles of wife and mother.

DEPRESSION IN WOMEN

Helen Lewis (1981) defines depression as an illness when the person cannot throw off a state of deep sadness that paralyzes the self. She found that middle class women as well as poor women are more prone to depression than men, in both hospitals and outpatient clinics. Miriam Greenspan (1983) defines the major ingredients of depression as a sense of powerlessness and self-hatred. In documenting sex differences in the utilization of mental health services in the U.S., Myrna Weissman and Gerald Klerman (1981) found that women consistently presented higher rates of depression than men, usually at a ratio of two to one. More significant findings are the rates per population group adjusted for

age: at every age group rates of depression are higher for women. These researchers also found that not only are women more likely than men to enter treatment for depression, but studies that randomly surveyed communities found more depressed women than men in the general population.

Differences in mental disturbances between men and women first appear in childhood. Chesler (1981) found that little boys are often referred to child guidance clinics for aggressiveness, and destructive, anti-social, and competitive behaviour, while little girls are sent for excessive fears, shyness, lack of self-confidence, and feelings of inferiority. These symptoms are the precursors of the types of mental disorders found in adult men and women.

Embedded in much of the speculation about women's greater vulnerability to depression is the conviction of feminists that sex differences in mental disturbance reflect differences in the social experience of men and women (Pearlin, 1975). A sociocultural approach emphasizes that certain variables associated with women's sex roles and traditional ways of relating to others have an impact on the development of mental illness. These include: women's socialization, low social status, and legal and economic sex discrimination (Bernardez, 1984). Annette Brodsky and Rachel Hare-Mustin (1980) consider difficulty in expressing negative emotions, taking roles

that satisfy a male partner, passivity, learned helplessness, exaggerated femininity, and "otherdirectedness" as factors. Esther Rothblum (1982) postulates several environmental conditions to account for the high rates of depression among women. Women's roles are often more restricted than men's and allow for less financial, social, and occupational gratification. Also, women are socialized to be unassertive, dependent, and passive, all of which can lead to depression rather than action under stress. She notes that women are taught to be helpless. We experience a lack of control over our environment thus perceiving little relationship between our efforts and any significant results. These factors can contribute to depression.

These authors tend to agree that depression among women is significantly affected by sex role expectations which are reflected in the institutions of marriage, motherhood, and the world of paid employment. Each of these will be looked at more closely.

MARRIAGE

With soaring divorce rates today, marriage is viewed by those contemplating it with trepidation. However, most women with long range needs for security, companionship, and children feel that available alternative lifestyles will not satisfy those needs. Heterosexual monogamous marriage is generally considered

to be the only "normal" choice for everyone and alternative lifestyles are subject to some degree of social sanction and disapproval. Nowadays, it is not necessary to be married in order to have a sexual relationship, live with a partner, or have children, but 90% of Canadians still marry (Dulude, 1984). Currently, although the rate of marriage is beginning to drop, the age of people marrying for the first time is rising, fertility rates are dropping, and divorce rates are rising, marriage in Canada continues to be associated with love and legitimized sex (Eichler, 1983).

Jessie Bernard (1973) found that married men live longer, and are happier and healthier than unmarried men. Married women, by contrast, are more likely to suffer from feelings of depression, to be unhappy, and generally to be bothered by pains and ailments than unmarried women. She concluded that this was the result of different conditions of marriage for men and women. Gove and Tudor (1973, cited in Howell, 1981) found that married women had higher rates of "mental disorder" than married men, while the reverse was true of unmarried men and women. They concluded that being married has a protective effect on males but a detrimental effect on females. Pogrebin (1983) notes that when a marriage ceremony pronounces a couple "man and wife", the man is pronounced a person and the woman a role. This can have a significant effect on women's mental health.

Linda MacLeod (1980) delineates several societal beliefs about marriage that have historically affected women: men were considered to own their wives; men had complete authority over their wives that was unquestioned within their own homes; women were expected to obey their husbands and conform to an ideal of self-denial; and women's place was in the home. Further support of these beliefs was found by Gurman and Klein (1980) in studying criteria for marital success. They found that concepts of marital stability and happiness were the main criteria, and these often involved a value system shared by the couple, usually requiring the wife to conform to the husband's values and needs, and a division of labour with task specialization along sex role lines.

Women often experience conflict and stress in marriage, likely related to lower status relative to men, the limited rewards inherent in the traditionally defined wife role, and the psychological effects of lack of personal choice and individuality that women experience (Gurman and Klein, 1980). Married women still enjoy the social prestige of their husband's occupation. Monique Proulx (1979) found that, for instance, being married to a physician gives a woman more social status than being married to a plumber. Married women often experience a lack of personal identity and have a tendency to live "by proxy". For example, women have customarily changed their surnames to those of their husbands upon marriage

and therefore have been socially defined with the husbands (Eichler, 1983).

The success of the family unit is more often judged by the husband's achievements than by the wife's, while at the same time women's work within the household is often devalued or overlooked, so that the instrumental contributions of her role are minimized (Gurman and Klein, 1980). Recently there has been a refinement in terminology regarding women and work, and we now speak with increasing care of women's work "inside the home" as opposed to work "outside the home".

Even before a couple has children, the woman is still likely to be responsible for running the household and for maintaining the emotional relationships in the family. Women's domestic labour maintains the household and because it is unpaid work it is often referred to as a "labour of love" (Luxton, 1980). Part of a woman's work involves taking care of her husband and creating a well-ordered home. Men depend on their wives for both the physical aspect of their labour as well as the important psychosocial support. On some level all women's work takes into account their husbands' preferences.

Housework is defined by feminists as both physical and mental, personal and political (Pogrebin, 1983). It involves all those activities that maintain the house and service its members - planning and preparing meals, cleaning and maintaining the house and its contents, and

obtaining the materials and supplies needed for that work (Luxton, 1980). Contrary to widespread belief, there has been no real reduction in the number of hours spent on work in the home with the advent of domestic technology, because the requirements of quality and quantity of household services have increased as technology developed, and our standards of living have increased (De Koninck, 1984). For example, automatic washers and dryers make doing laundry less time consuming but clothes are washed much more often than they were thirty years ago. This "industrialization of housework" has led to a further devaluation of the housekeeping function traditionally performed by wives (Eichler, 1983). Other than childbearing, housework has been found to be the one shared phenomenon of the female condition, not only in this country but around the world (Pogrebin, 1983). This unpaid labour of housework is seen as one factor in creating stress that can lead to depression in women.

Marriage also brings to women the risk of being abused by their partner. Wife abuse is one of the hidden crimes of this society and refers to violent acts by an assailant, usually male, against a partner, usually female, in an intimate relationship. This may take the form of psychological, sexual, and/or physical assault. All forms of abuse are used with the intent of controlling the victim through fear, intimidation, and inflicting pain. The physical assaults can range from a slap to

homicide and wife abuse is a phenomenon that occurs with equal frequency among families of all socio-economic classes (Luxton, 1980). Pogrebin (1983) defines violence as the ultimate act of inequality; in marriage it is the male-female power struggle acted out in muscle and blood. MacLeod (1980) makes connections between wife battering and wives' economic dependence on husbands, the general social acceptance of a man's authority over his wife, and the immunity of the family from many of the rules and laws of the wider society. Until the 1970s, "family" violence was one of society's best kept secrets. In fact, such terms as "domestic abuse" and "interspousal violence" obscured the fact that the majority of abuse is perpetrated by men against women. Historically, society has held a rosy picture of families that largely ignored the ugly aspects of family interaction such as abuse, violence, and neglect (Eichler, 1983).

The woman's role in the home is to preserve for the outside world an image of the family as peaceful and self-contained. This role is primarily one of helping others, not ourselves. Women are faced with the normal daily stresses of any family situation and frequently explain away at least initial bouts of violence as just another normal part of family life. The woman who is battered normalizes the violence not because she enjoys it but because it is her "job" to normalize it. Women are taught to hold the major responsibility for the success or

failure of a marriage so cope with the situation frequently by accepting the guilt (MacLeod,1980). This reflects how women have incorporated the societal myths about wife battering and marriage.

Many battering incidents occur during the first year of the relationship at a time when the woman is still experiencing the novelty and optimism of the new relationship. At that point, the violence appears to be an anomaly, out of keeping with the partner's character. This, coupled with the relative lack of severity which often characterizes the first violent incident, and the man's post-abuse contrition and promise that it will not happen again reinforce the belief that the violence was an isolated incident (Dutton and Painter, undated).

In Lenore Walker's 1979 study of battered women, most women stated that they were taken unaware by the violence demonstrated by their partners. They said they could not have predicted that these men would have been so violent until after the initial incident occurred. Walker describes a cycle theory of violence that contains three distinct phases. The first is the tension building phase which is characterized by minor battering incidents and the woman's attempts to prevent the batterer's anger from escalating. She tries to be more nurturing and compliant, denies her own anger at being abused, and rationalizes that she somehow deserves the abuse. The second phase is the acute battering incident which is usually triggered by

an external event or the internal state of the man. It is impossible for the woman to predict the kind of violence that will occur during this time and it is usually futile for her to try to prevent her husband from abusing her. This is followed by the third phase characterized by contrite, loving behaviour on the part of the batterer. He tries to make up to her, says he is sorry and cannot live without her, plays on her guilt, and begs her forgiveness. Both the man and the woman experience this as the honeymoon phase. This is the phase which provides the "glue" holding the relationship together. Soon, however, the tension starts to build again and the cycle repeats itself. Having struck a woman once seems to make it easier for a man to do it again.

Richard Gelles (1974) found that one fifth of all Americans approved of slapping one's spouse on appropriate occasions, and that numerous incidents were considered normal, routine, and needing little justification. Some wives tend to believe they are struck because they deserve it, feeling that they precipitated the attack by badgering or nagging their spouse. Personal experiences with violence and societal pressure to be submissive make battered women less apt to escape their situations. Furthermore, many women withdraw under stress, a response which reflects the learned sex-role stereotype of passivity, as well as fear, and increases her dependence on her partner (Weitzman and Dreen, 1982). As a logical

extension of their role as wives, women as the victims blame themselves and feel guilty for having induced male hostility and aggression (Luxton, 1980). The combination of fear of their husbands, isolation from potential supportive persons, and guilt result in the victims becoming more dependent on the attacker. As their self-esteem lowers, the process of victimization for women is complete.

Women do not remain in battering relationships because they like being beaten (Walker, 1979). They have difficulty leaving because of complex psychosocial reasons. Many stay because of economic, legal, emotional, and social dependence. Others are afraid to leave because they have no safe place to go. Police, courts, hospitals, and social service agencies often do not offer them adequate protection. Psychologists, psychiatrists, and social workers tend to counsel them to keep the family together at any cost, and the price often turns out to be their mental health and sometimes their lives. While in recent years, primarily because of pressures from the women's liberation movement, wife battering has gradually come to be considered deviant, it is still not recognized as a social problem (Luxton, 1980). Public monies are beginning to be allocated to services for battered women but very little is being done to prevent the abuse of women.

Sandra Smith (1984) describes the battered

condition as a normal outgrowth of female development. Feminine identity is defined through attachment and threatened by separation. Women are socialized to cultivate and nurture feelings related to attachment, and to become caretakers and caregivers. This sets up a relationship between men and women based on inequality. Because women feel that we need our mates, we blame ourselves for abuse, rather than blaming the oppressor. Reducing male violence is not a matter of learning self-control alone but of undoing power relations (Pogrebin, 1983). The effects of battering on a woman's mental health can be devastating. Wife abuse is the most extreme form of women's oppression within the family (Luxton, 1980). The combination of fear, isolation, devaluation, and subordination can lead to depression.

Thus the role of wife, and abused wife specifically can create stress for women. Fundamental to marriage is an assumption that the couple will have children (Luxton, 1980). What happens to women if an additional role is assumed - that of mother?

MOTHERHOOD

The decision to have children has a more profound effect on women than on men because it is women who become pregnant and give birth, who have primary responsibility for child care, and who will have to make decisions about trying to combine the roles of wife, mother, and worker in

the wage sector (Gluck et al, 1980). There is a powerful societal belief that having children is "natural" for women, that the essential responsibility for bearing and rearing children is located within the nuclear family, and that mothers make the best rearers of their children (Luxton, 1980). Having a child adds the role of mother to a woman's life.

"Motherwork" is the emotional work and investment involved in having and raising children. Several authors (Pearlin, 1975; Rauch, 1978; Parlee,1976; Bernard,1974; Rosenberg, 1981) delineate social and cultural factors that can lead to depression in women after becoming mothers. These factors are usually discussed as contributing to postpartum depression, when shortly after the birth of a child approximately 20% of new mothers experience symptoms of depression. However, while these factors first emerge at the birth of a child, they tend to remain a part of a mother's life and can contribute to depression throughout her "career" as a mother.

Caring for children involves some of the most significant and potentially loving relationships whose warmth and intimacy women usually enjoy. However, when children are young, child care is also full time work which can be frustrating and overwhelming. As soon as a child is born, child care becomes compulsory and fulltime for the mother. Motherwork is generally unrecognized as work in our society, and little attention is paid to the

emotional and physical components of caring for children. The effect of this work on the mother is added stress on women's lives (Bernard, 1974). Pogrebin (1983) notes that although the average woman spends only a small portion of her lifespan either pregnant, nursing, or caring for preschool children, it is as mothers that all women are defined (Pogrebin, 1983).

One important factor that can lead to depression in mothers is loss. In modern society women often lose friends and kinship networks after becoming mothers. There is usually loss of an occupational role women have given up at least temporarily upon becoming mothers. More importantly, a woman may lose her personal identity as someone other than a mother. Gurman and Klein (1980) note that the marital relationship often becomes strained after the arrival of children, and there is recent evidence that childbearing, once thought of as a woman's "peak" experience, is instead a significant stressor and cause of conflict.

A second factor, relating to loss, is social isolation. Mothers often spend a great deal of time in private homes with few adult contacts. In a longitudinal study of 40 first time mothers, Kathryn Saulnier (in press) found that women's average network size decreased after the arrival of a baby. Our modern isolated households deprive mothers of extended family help, and children greatly limit our freedom of movement, making it

difficult to go out socially. Parlee (1976) found that women with few family or friends to see on a regular basis, and few outside contacts and activities with adults are more likely to become depressed than those who are involved in a more cohesive social network.

The third factor leading to depression in mothers is the vague and impossible job description associated with mothering (Bernard,1974). Pogrebin (1983) calls it "the-buck-stops-here" responsibility for children. Motherworkers sign on indefinitely and there are no fixed hours, sick leave, vacation, pension, or job security. Training is considered unneccessary because women are expected to know instinctively how to mother (Levine, 1981). Male authors, theoreticians, and philosophers abound as experts in the fields of parenting, child care, and the family, despite the fact that this is the single area, according to these same experts, in which women are "naturals" and irreplaceable (Levine, 1981). We are expected to provide tender loving care 24 hours a day, 7 days a week, 365 days a year but we are often tired, and have to contend with constant interruptions and noise. Even when children are sleeping or playing away from home, the mother is responsible for them (Luxton, 1980). We often feel inadequate, trying to meet impossibly high standards for work that is difficult to measure in terms of success, and our leisure time may be nonexistent. There is a lack of external structure to our lives as

mothers, and we often feel trapped inside our homes.

Children also increase the necessary time spent on housework, and in fact child care is largely incompatible with good housekeeping. Keeping the house clean with children is difficult to accomplish. Another reason why the number of hours spent on housework has not diminished in recent years is that the child care function has been upgraded. Margrit Eichler (1983) calls it the "professionalization of child care".

Starting in the 1950s, child care manuals encouraged mothers to become more attentive to their children's cogitive growth. In particular, the persuasive Freudian insight that the first five years of life are critical to the development of the child's character caused mothers to be assigned the task of being responsible for ensuring the success of their children by providing the "correct" type of emotional, social, intellectual, and physical environment for them (Luxton, 1980). This advice to women has created a cultural environment in which expectations concerning child care are very high, and likely to increase stress on mothers as a result of high performance standards. If as the children grow, they exhibit any signs of deviance, the full social blame for this "failure" falls on the mothers' shoulders.

This pressure is confirmed by social scientists who say that a child who grows up without a mother is

suffering maternal deprivation while life without a father is merely called father absence (Pogrebin, 1983). Overall, the role of the father is seen as fairly negligible, both by the child care experts, and society at large. However, feminists believe that the care of and responsibility for children should be shared equally between fathers and mothers.

Marital violence is also related to motherhood. Wife battering often begins during a pregnancy, when a woman is particularly vulnerable. Pogrebin (1983) theorizes that it may be that the husband is attacking the very symbol of biological womanhood. Incest is another issue that has become entangled with the institution of motherhood (Levine, 1981). When incest occurs, professional theory and practice routinely point to the mother as having been guilty in some way of deserting the family, or having withdrawn from vital aspects, sexual or otherwise, of her wifely role.

A shift in focus from depression as a postpartum phenomenon to depression as an accompaniment of the transition to the social role of mother represents a shift away from the medical model of depression as a "disease" (Parlee, 1976). Rosenberg (1981) calls depression in mothers a symptom of "on the job stress", with the job being motherwork and the work site being the home. She analyzes conflicts relating to the role of mother as stemming from the contradiction between the high status of

the role (mother as Madonna) and the low status (mother as servant) of the job. The structural and social problems of the job as noted previously create difficulties for mothers rather than any inherent personality flaws.

Women's reproductive functions are biological processes which take place within particular social and cultural settings (Parlee, 1976). Since very little that is unbiased, definitive, and based on solid, extensive data has been written about the links between hormonal and genetic causes of depression in women (Notman and Nadelson, 1980), feminists analyze motherhood from a sociopolitical perspective. The personal is political, and each mother's individual and personal experience inevitably reflects the collective experience of mothers within the wider political context of women's oppression (Levine, 1979).

The myth of the happy family is disproven daily in newspaper accounts of family violence, in family courts, and in the despair of friends' confided secrets. For the wife and mother, home is not a happy place when she feels trapped in the role of cook, cleaning woman, and child-caregiver, and above all, taken for granted (Pogrebin, 1983). Many women who are already wives and mothers are employed in the labour force adding another role and stress to their lives. This "double work" will be the next focus.

EMPLOYMENT IN THE LABOUR FORCE

Many of us have a traditional conception of the "normal average" family as being one in which the father is in the labour market and provides economic support for the family, while the mother stays home to look after the children and do the housework. Today, the traditional two parent, one income family is on the decline, representing only 13% (U.S. statistics) of all households. Hartman and Laird (1983) note that there are increasing numbers of single parent (usually female) families (16%), married couples without children, or whose children are grown up (23%), and couples with children where both parents work outside the home (16%).

In Canada, the percentage of wives and mothers with full or part time employment outside the home is steadily increasing. In 1983, 53% of married women aged 20-64 held full or part time jobs, compared to 31% in 1969. There has been a 62% increase in the female labour force since 1969, compared to a 24% increase in the male labour force (Dulude, 1984). The greatest increase in the female labour force participation has been among mothers of young children. In 1983 51.8% of mothers with children under 16 were in the wage sector. For mothers with children under six, the increase has been particularly dramatic, from 16.7% in 1967 to 46% in 1983. The major reason for this in two parent families is economic need. In the past decade, increases in the cost of living have

overtaken the ability of a one income family to maintain its present standard of living. For single parent mothers, employment is the only alternative to welfare, while women from low income families have always been obliged to seek employment in the labour market. Also, because divorce rates are high, and women outlive men, three-quarters of the 90% of Canadian women who marry will eventually be forced to look after their own financial needs and those of their families (Dulude, 1984) because they will have no husband to take on that responsibility.

Increased female participation in the labour market does not mean that women enjoy a professional life in the same way that men do. The fact that half the female population has joined the ranks of the employed has not altered the fundamental market structure. Working outside the home does not reduce the expectation that women assume primary responsibility for domestic work and child care. As a result, women in the labour force experience cumulative stress. We have too many physical and emotional demands to meet, too many hours to work, and a continuous struggle to reconcile the demands of the two work settings (De Koninck, 1984). This cumulation of domestic labour and paid labour is now becoming a daily way of life for many women, and many working mothers meet the extra demands of job, house, and child care by cutting down on sleep and eliminating leisure activities (Pogrebin, 1983).

The move of married women into the labour force is taking place at a time when there is still a strong segregation of labour by sex (Armstrong and Armstrong, 1978). In the paid labour force, women are concentrated into a limited number of occupations, into sex-typed jobs, and on average paid less than men. According to the 1981 census, the top five occupations for women were: secretary, bookkeeper, salesclerk, teller, and waitress. 62% of women who work for pay are in sales, clerical, or service jobs (CACSW, 1981c). These typically female jobs are different expressions of the mothering function which women exercise in our society. The expected prerequisites for these jobs, like those for mothering, are regarded not as skills, but rather as attributes of feminine socialization (Proulx, 1979). There is a generally believed assumption on the part of both men and women that the "feminine" qualities that are acceptable in the home do not equip women to do the same jobs as men in the workplace (Jeffery and Wiebe, 1982). This contradiction in attitudes is addressed in the Charter of Rights recently passed in Canada but the impact of this Charter on the lives of women remains to be seen.

The lack of recognition of housework penalizes women who work outside the home because it conceals the fact that these women generally have two occupations, considering the unequal distribution of household duties within the home (Proulx, 1979). Both types of work

involve taking care of others and our availability is taken for granted as inherent in the "feminine" nature (De Koninck, 1984). The term "working mother" is a reflection of the double load experienced and expected of women; the term "working father" is not part of our vocabulary. Husbands' contributions to housework do not increase appreciably when their wives are in the labour force. Proulx (1979) found that in families with children, the husband does an extra hour a week of housework when his wife is doing paid work. While in recent years, the involvement of men in domestic affairs has increased, it is usually done in the context of "helping out" and not assuming equal responsibility (Luxton, 1980). More husbands than ever wash dishes and play with and care for their chidren, but women retain the primary responsibility for the family (Greenspan, 1983).

Women's movement in and out of the labour market still revolves around periods of childbearing. Our participation is defined and governed by the needs arising from our domestic responsibilities. Research has shown that mothers who work outside the home often experience guilt (Johnson and Johnson, 1977). Another problem is the overlapping of the two jobs. For example, paid holidays are often used to catch up on domestic tasks put aside during paid working hours, and lunch hours may be spent shopping for the family. Also, women workers feel the need to perform both jobs well, leading to problems of

concentration, stress over daycare, and a constant affective load. Work outside the home can cause stressful role conflict and overload (Gurman and Klein, 1980), and women's excessive number of working hours can be a source of tension, fatigue, stress, and emotional vulnerability (De Koninck, 1984).

Paid employment need not be regarded as negative in itself. Indeed, paid work for some women is a means of liberation, providing newfound financial independence and breaking the isolation experienced by many housewives (De Koninck, 1984). Eichler (1983) found indications to show that in terms of mental health, self-esteem, and marital happiness, wives with paying jobs fare better than fulltime housewives, possibly because paying jobs confer feelings of status, satisfaction, self-fulfillment, and prestige, a measure of economic independence, and the potential to gain more power in the marital relationship, factors often unavailable to fulltime homemakers. However, we must be careful not to obscure the fact that the contributions of women wage earners in the form of housework are still not acknowledged, and that our position in the labour market most often entails second class, unrewarding, and low status working conditions.

Women are changing and the traditional definition of "normal" womanhood is being challenged; more people than ever are questioning what it means to be masculine or feminine. However, society has made only minimal

concessions to the demands of women for full, structural equality with men and, for the most part personal and cultural changes in society have not been met with significant political and economic changes in the structure of social institutions (Greenspan, 1983). Men's oppression of women in the areas of housework, reproduction, and the labour market are connected by the sinews of patriarchal politics; all of these oppressions ensure women's powerlessness by keeping women dependent on men (Pogrebin, 1983).

The preceding discussion has shown how the roles of wife, mother, and paid worker can affect women's mental health. It can be seen that the problem is not one of female "mental illness", but is for the most part systematically produced symptoms of sexual inequality (Greenspan, 1983). The next section will examine how women are generally treated by the mental health system.

Chapter 3. CRITIQUE OF THE MENTAL HEALTH SYSTEM

INTRODUCTION

Women tend to cope with problems by visiting doctors and other professionals. Weissman and Klerman (1981) found that by every measure of utilization of the general health care system, women predominate. Compared to men, we have higher rates of use of outpatient facilities, of visiting physicians, of receiving prescriptions and of psychotropic drug use.

One phenomenon of the last twenty-five years is that of turning to chemical solutions for human problems (Innes et al, 1984). The incidence of women taking prescription drugs is frighteningly high. In reviewing numerous U.S. studies from the 1960s to the present, Ruth Cooperstock (1981) found a two to one ratio of female to male users of psychotropic drugs. Women receive more repeat prescriptions than men and stay on the drugs for more years than men (Innes et al, 1984).

As women, we find ourselves feeling overworked, emotionally drained, undervalued, tired, and confused as we try to survive and fit the female stereotype (Innes et al, 1984). Cooperstock (1981) found that women consistently report more distress, anxiety, and depression than men; we accept the label of psychiatric illness, enter treatment more willingly, and accept the role of patient more readily than men. She notes that at all ages, females go to physicians' offices more than males.

We seek out and use drugs more than males, but at the same time, physicians are more likely to offer tranquilizers to women than to men presenting the same complaints.

Cooperstock (1979) defines two major problems regarding women's drug use. One is the issue of dependency, which can further encourage women's feelings of inadequacy and self-blame. There is little indication that the anti-anxiety effects of many drugs exceeds two to four weeks, yet there are large numbers of prescriptions which are written and repeated over months and years. The second issue is the economic, social, and personal costs involved in women's drug taking. Many anxieties and stresses brought to physicians are the result of social issues such as poor marriages, family stresses, inadequate housing, and underemployment. By redefining these problems as inherent in the individual, and prescribing drugs to help women cope and adjust, there is a tendency to see pharmacological solutions as acceptable and easier than long term structural and social solutions.

Women are the primary users of all health care services, including mental health services, in a system controlled and administered largely by men (Brodsky and Hare-Mustin, 1980). At every level, the power structure of the mental health system is male dominated; men occupy the policy and decision making roles. The effect of sexist biases in the mental health professions has led to tolerance of practices and behaviours that are

inappropriate, degrading, and dehumanizing with regard to women (Donadello, 1980). Sexism has been documented in all the mental health professions (Brodsky and Hare-Mustin, 1980), but as a social worker I believe it is important to investigate the sexism in our own field.

SEXISM IN SOCIAL WORK

Social work is considered to be a woman's profession because the majority of social work clients are women (Rauch, 1978). It is also generally described as a woman's profession because the majority of social workers are women; in sociological terms, social work is a sex-typed occupation. It is natural that women would gravitate toward a helping profession since the nurturing and caring qualities required can be seen as a logical extension of the traditional socialized female role. Some writers argue that this is one of the major reasons for the relatively low prestige awarded social work by the general public (Jeffery and Wiebe, 1982). As a profession, social work was developed by women, and originally women were centrally involved as administrators and professors although this is no longer the case.

Social work is one of the last of the helping professions to recognize the institutionalized sexism within its own field. The notion that social work is truly a woman's profession is somewhat misleading given that social work executives, administrators, supervisors,

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and educators are now mainly men. In the area of administration Norman and Mancuso (1980) found that it is generally men who plan social work policies, determine academic curricula, direct practices, and decide where and for whom monies are to be spent. In Canada, in a survey of social service agencies and schools of social work in the Atlantic Region, Joan Cummings (1981) found that full time female social service employees were earning considerably less than males. She found an overrepresentation of women in the lower salary categories, and an underrepresentation in the higher ones, taking into account equivalent educational levels and social service experience. Jeffery and Wiebe (1982) found a similar situation in Saskatchewan. As salary levels increased, the proportion of females in the higher paying jobs decreased dramatically. Their 1980 figures indicated that the salary differential between men and women has not improved over the past ten years.

Cummings (1981) also found that the more time staff spent on administration, supervision, policy analysis, staff training, planning, and research, the higher their salaries, and the higher the representation of men. The lower salaries and predominance of women were in the areas of counselling, case management, and concrete service giving. Administration, supervision, staff training, policy analysis, and research all involve, directly of indirectly, control over other forms of labour

and those performing it. These areas qualify as the "real" work that is paid and valued more, and thus are the prerogatives of the more dominant and valued sex.

In schools of social work, a Canadian Association of School of Social Work Task Force Report in 1977 (cited in Cummings 1981) found that women employed in social work schools across Canada earned less, received fewer job promotions, and enjoyed less job security than their male counterparts. As students, females outnumber males three to one but are predominantly studying for direct work with clients at the bachelor's level, while men are found concentrating their efforts on the more valued practice areas of planning, research, supervision, administration, and staff training at the master's level. Thus, schools of social work exhibit sex role stereotyping as a factor in the selection of casework by women and administration by men. As well, schools of social work do not have the proportionate number of female faculty members in relation to the number of female students (Jeffery and Wiebe, 1982).

Discrimination also occurs in social work education which uses theories almost universally borrowed from other disciplines, such as psychiatry, psychology, sociology, and economics. Many of these theories have been developed by men, out of a male perspective derived from male experience, and are often highly discriminatory to women, assuming for us the traditional role which men

have assigned to us (Cummings, 1981). The predominance of male social work authors also contributes to sexism as a factor in practice (Rauch, 1978). Much of the concrete research knowledge that has been accumulated about the characteristics and needs of various social work populations is relevant only, or primarily, to men because the research in many areas of concern has been done with research samples of men only (Norman and Mancuso,1980; Gilligan, 1982). Courses about women are relatively new in social work curricula and are given little priority. They are frequently seen as peripheral to the core curriculum, and are only of tertiary interest to the majority of faculty members (Jeffery and Wiebe, 1982).

In the area of research social workers might assume that the amount of space given to research about women's issues has increased dramatically over the past 15 years. However, Quam and Austin (1984) found that that is not the case. In 1970, 233 articles were published in five major U.S. social work journals. Nine articles, or 4% of the total pertained to women's issues. By 1981, the percentage increased only slightly to 6.3%. In fact, the authors found some suggestion in the data that the amount of space devoted to women's content may be declining in the 1980s.

Only the increasing awareness and questioning provided by the women's movement have uncovered these issues of sexism. At every level of social work evidence

of discrimination exists in education and forms of employment for women. Sexism occurs not only in the profession of social work but in its everyday practice in a number of subtle and pervasive forms.

SEXISM IN PRACTICE

Studies stimulated by the women's movement have provided evidence demonstrating that clinicians, particularly men, engage in sex role stereotyping, although Brodsky and Hare-Mustin (1980) found that more recent studies have indicated a moderating of such stereotyping.

However, Broverman, Broverman, Clarkson, Rosenkrantz, and Vogel (1970) in a now famous study showed how mental health is perceived in a sexist way by a variety of mental health professionals. Male and female clinicians were asked to choose attributes describing a healthy, mature, socially competent a) adult (sex unspecified), b) man, or c) woman. The assumption was that what the majority of clinicians considered to be healthy for an adult of unspecified sex reflected an ideal standard of mental health. The results showed that the definition of general mental health coincided with the masculine stereotype. The definition of a healthy woman included the following characteristics: more submissive, less independent, less adventurous, less aggressive, less competitive, more excitable in minor crises, more easily

influenced, having their feelings more easily hurt, less objective, more conceited about their appearance, and disliking math and science. Thus, for a woman to be considered mentally healthy, she must conform to the behavioural norms for her sex, even though they are less socially desirable and less healthy by adult, male standards. This creates a double bind for women reflecting women's inferior position in society. To be mentally healthy by the male adult standard means not being seen as a woman, yet to be a woman means being less mentally healthy than an adult. The Broverman study was replicated by Nowacki and Poe (1973) and Fabrikant (1974) with similar results (cited in Sturdivant, 1980).

Mental health professionals still tend to accept the traditional definitions of masculinity and femininity, and to support sex typed definitions of roles and relationships within the family (Norman, 1980). All psychology and psychotherapy, including that practiced as part of social work, has come increasingly under fire by feminists as being dominated by males, and as adhering to a standard of mental health determined by males (Thomas, 1977). It is largely men who label the variety of problems of those who are seeking help, and largely women who are seeking the help (Greenspan, 1983). There are data providing evidence that therapists' sex role values are operative during therapy and counselling; data also

indicate that there is sex role stereotyping in mental health standards, and that sex role discrepant behaviours are judged as madadjusted (Sherman, 1980).

Psychoanalysis, developed by Sigmund Freud at the end of the 19th century, was the cornerstone upon which many of the twentieth century theories regarding masculinity and femininity were based. Psychoanalytic theory, long a major foundation of social work practice, has been charged by feminists with sexism, with lacking an empirical basis for major theoretical concepts related to women, with failure to take into account the impact of social institutions on behaviour, and with encouraging women to adapt to oppressive conditions (Rauch, 1978). It can be seen as a theory reflective of its historical and cultural context of patriarchy.

Penis envy was Freud's organizing principle of femininity. He equated femininity with passivity, and insisted that women were "failed men", and therefore inferior to men. Feminists criticize Freud's sexist bias in using male standards as normative for all behaviour (Rauch, 1978; Feminist Therapy Support Group, 1982; Donadello, 1980; Sturdivant, 1980; and Rice and Rice, 1973). Femininity was for Freud the absence of masculinity, but since masculine traits were the valued ones, the presence of femininity was always ultimately negative. Freud's impact was to legitimize sex role stereotypes by embodying them in a so-called scientific

theory which he developed only from information received from his patients. He succeeded in enshrining the subordination of women to men as psychological law (Greenspan, 1983). One example of this was his view on incest. Early in his career, Freud believed his women patients when they reported childhood instances of sexual molestation. Later he referred to these reports as fabrications to protect his self image and the men of his class. Recently, Freud's distortion of female patients' reports of childhood sexual abuse as being fantasy has come under attack (Rush, 1980).

Another major criticism of Freud's theory is that it lacks recognition of the social reality that in addition to having different anatomy than men, women also have a different social status than men and this status is viewed as inferior. He created the myth that an individual's psyche can be understood apart from the specific society in which he or she lives (Greenspan, 1983). Feminists reject the notion of penis envy stating that it is not men's penises that women envy, but their greater social, economic, and personal power. We are particularly critical of Freudian theory's insistence on intrapsychic causation of mental illness and its failure to recognize the impact of sociolcultural variables on personality development (Sturdivant, 1980).

The practice of traditional psychotherapy evolving from Freudian psychoanalysis is based on a hierarchical

relationship where the therapist is the authority. The patient's role is relatively passive, submissive, and dependent. Because Freudian theory has defined a woman as a "second class male", therapy often involves helping a woman accept this status. The myth of the therapist as expert leads to a therapeutic relationship which is based on a fundamental inequality of power between the therapist and the client. Feminists believe that adapting to a situation of powerlessness has negative effects on most people, especially when social powerlessness is related to why they are seeking help in the first place (Greenspan, 1983). Sturdivant (1980) also notes that throughout the history of modern psychotherapy, from Freud on, female inferiority and the secondary status of women have been almost universally assumed and accepted, gradually becoming psychotherapeutic dogma and heavily influencing the practice of therapy with women.

By the 1950s, humanist psychology, founded by Carl Rogers, arose as a major force in psychological circles. This approach centred on the therapeutic relationship as a major factor in therapy, and stressed that three qualities conducive to developing this relationship were necessary in the therapist: unconditional positive regard, empathy, and self-disclosure. Rogers stressed the importance of holding the client responsible for his or her feelings and behaviour rather than viewing them as predetermined by childhold as the Freudians did. The more positive aspects

of this school of thought were its focus on health rather than pathology; its emphasis on therapy as a relationship between more or less equal people, rather than the Freudian model of expert and patient; and its emphasis on becoming aware of and expressing feelings. However, the humanist approach did not extend to helping clients, particularly women, make sense of their feelings in the context of the rest of their lives. The focus on the "here and now" and individual responsibility for personal growth does not make connections between the individual and the structure of social life. For women, the myth of individual freedom is another betrayal. (Greenspan, 1983).

In the traditional models of therapy, differences between males and females are viewed as natural and unchangeable. The male represents the normal way to be in the world, the standard against which all else is measured, while the female is considered to be substandard, an imperfect male (Brickman, 1984). As noted before, to be a "healthy" woman by society's standards is to be a "sick" adult. Feeling healthy means feeling powerful but feeling powerful for women is closely associated with not feeling womanly, which is a fundamental threat to identity (Greenspan, 1983). Under the guise of expert definitions of normalcy developed primarily by men, women have been kept firmly tied to the traditional institutions of marriage and motherhood (Levine, 1983). Women who are unable or unwilling to

conform to the traditional roles of wife and mother, or who aspire to a societal definition of adulthood do so at the risk of being considered deviant and at personal cost. Even today, a woman striving to develop and integrate adult behaviours does so in the face of powerful internal and societal injunctions against violating traditional female roles and male prerogatives. Women are caught in a no-win situation where femaleness is devalued regardless of behaviour, and access to adult behaviour is fraught with conflict (Heriot, 1983).

Carol Gilligan (1982) notes that many of what have been accepted as universal truths about the nature of human behaviour are actually truths about men, and that differences between the experiences of women and men are experienced as problems and inadequacies in the lives of women. This includes an assumption that there is a single mode of social experience and interpretation. Based on an extensive study of how men and women make decisions, she concluded that the major difference between men and women is located in our experience of relationships. Masculinity is defined through separation, while femininity is defined through attachment. For men, individuation and autonomy are critically tied to gender identity, while women grow up with a basis for empathy built into our primary definition of self in a way that men do not. As women we not only define ourselves in a context of human relationships but also judge ourselves in

terms of our ability to care. In the traditional value system as exemplified by the Broverman et al (1970) study, these female characteristics are considered less valuable than the male stereotype that favours the separateness of the individual over connection to others. In a patriarchy, the autonomous life characteristic of males is valued more than the interdependence of love and care. Gilligan makes a case for the recognition of the importance of attachment in the human life cycle and insists that theories must end their suppression of the "female voice".

Helen Levine (1983) sums up the mental health system this way: "By and large women have found that helpers stress adjustment rather than change; individual not collective or political solutions; personal pathology; weakness rather than strength; the psyche unrelated to economic and social hazards in women's lives; and the authority of male experts, male management and male decision makers, in and beyond the home" (p. 77). Stereotypical views of female development, an antiwoman bias in personality theories, and traditional sex role standards pervade the theoretical framework for much social work knowledge. This kind of theoretical background must influence the ways in which problems are perceived, the stratiegies by which they are addressed, and the treatment goals decided upon for clients (Donadello, 1980).

It should come as no surprise that services planned by men, designed by men, and often delivered by men have not met the needs of women. Clearly, it is time for major attitudinal and structural changes in the way therapy is practiced with women clients. In the next section alternatives provided by a feminist framework are reviewed.

Chapter 4. FEMINIST COUNSELLING

INTRODUCTION

The emergence and growth of feminist counselling has its roots in consciousness-raising (CR) groups which arose in the late 1960s as an alternative solution to traditional therapy for women, and as one manifestation of the growing interest of women in feminism and the women's movement. CR groups are small, autonomous, face to face support groups often only loosely affiliated with the larger feminist movement. CR is the term used to describe a change in women's awareness and interpretation of their problems. Individual conflict, tension, and discomfort are explained within a sociocultural context. Central to the ideology behind CR is the belief that the individual, the social structure, and the culture are interrelated (Wesley, 1975). The personal becomes political through the process of women sharing their experiences. CR groups help women assess the reality of oppression; recognize how we participate in this oppression by believing in our own and other women's inferiority; and encourage us to continue to seek equal treatment in the face of negative sanctions. CR groups provide a resocializing experience for women in which group members' views of themselves and their social world are reconstructed (Levine, 1979).

Outcomes of CR groups most frequently reported in the research are: changed perceptions and attitudes toward self, others, and society; and a reorganization of

attitudes and beliefs in a profeminist direction (Kravetz, 1980). Wesley (1975) states that individual member's changes often consist of an improved self image, increased self acceptance, a greater sense of self worth, and an improved image of women in general. Women also report more independence, confidence, and higher ambition. From a sociopolitical point of view, Kravetz (1980) notes that women report an increased awareness of the effects of traditional sex roles and sexism; increased awareness of a commonality and sense of solidarity with other women; the development of a sociopolitical analysis of female experience and the nature of female oppression; and participation in work and/or community activities to change the options and opportunities for women.

Kravetz (1980) and Lieberman and Bond (1979) found that women have two central and separate motives for joining CR groups. The first goal, which tends to be met for participants, is to explore what it means to be a woman and to develop a more feminist perspective. The second goal is to gain psychological help to solve personal problems. CR groups serve a therapeutic function with their egalitarian, leaderless structure, their focus on the sharing of thoughts and feelings in the group, and the increase in awareness of oneself and of women's problems in general while gaining personal support from others (Brodsky and Hare-Mustin, 1980). However, CR groups define women's distress as primarily a social

problem with society held responsible for distortions and prejudices against women. They focus on changing society through an expansion of one's awareness of what it means to be a woman in a sexist society (Daley and Koppenaal, 1981). While this is crucial in terms of beginning to make changes in society, CR groups are not designed to help women find personal solutions to the problems in our lives that would take into account both the sociopolitical context and our own personal history, personality, life situation, and potentials. Many women still turn to individual counselling to find ways of dealing with the more debilitating effects of the powerlessness and alienation experienced in our roles and lives as women (Feminist Therapy Support Group, 1982).

THE EMERGENCE OF FEMINIST COUNSELLING

The last decade has witnessed widespread questioning of the various forms of counselling available for women clients. This questioning comes in the wake of the CR movement as well as in response to the increased awareness of sexism in the practice and theory of therapy. As a result, a new form of help, called feminist counselling, is evolving. The ideology of consciousness raising groups has heavily influenced the conceptual development of feminist counselling (Sturdivant, 1980). Central to this new model is the recognition that the traditional intrapsychic model of human behaviour fails to

recognize the importance of social context as a determinant of behaviour, and that the sex roles and statuses prescribed by society for females and males disadvantage women (Hare-Mustin, 1978).

Feminist counselling arose primarily in response to the demands of women, who as major consumers of mental health services, were demanding a type of counselling that would really meet their needs. While the appearance of women's centres and CR groups met a variety of needs for women, the great majority of women seeking help with problems continued to look to professional counsellors for assistance (Sturdivant, 1980).

The second impetus for the development of feminist counselling was that some people saw themselves as both feminists and counsellors, and found the roles and values associated with each to be contradictory. As feminists, we believe that it is desirable to equalize power in relationships with women clients but as counsellors find ourselves with considerably more power than our clients. Feminists who are counsellors experience a need for a consistent ideology with which to lead our personal, political, and professional lives (Gannon, 1982). A meshing takes place whereby feminism and counselling no longer exist as discrete parts of an individual's life but can become integrated into feminist counselling (Thomas, 1977).

Webster's Dictionary defines a feminist as "a

person who advocates political, social, and economic equality between men and women". Feminism can be defined as the conscious, explicit awareness that women in our society are systematically denied equal rights, opportunities, and access to services and goods in society, and are consequently oppressed by this patriarchal system (Donadello, 1980). In some respects this is a negative definition of feminism - it is defined in terms of what women do not have. While feminism pre-supposes that women's oppression must end, an alternative perspective is to consider feminism as a valuing of women's strengths and attributes and putting women first. It requires identification with women, and acknowledgement that all of us, as women, are affected by women's oppression. By starting with women's experience and analyzing how women live in society, it is clear that women are oppressed, socially and economically and that women's oppression is institutionalized in our society. Feminism is a mode of analysis, a method of approaching life and politics, and a way of asking questions and searching for answers as a basis for working toward ending women's oppression.

DEFINITION OF FEMINIST COUNSELLING

Feminist counselling is a system of values and attitudes, as well as beliefs about how these values should be implemented in the counselling setting

(Sturdivant, 1980). It rests on a critical analysis of the sexism embedded in the theory and practice of the helping professions and on the search for different and more effective kinds of help for women (Levine, 1983). The feminist value system differs from all three prevalent schools of psychotherapy - psychodynamic, humanistic, and behavioural, in that it is consciously based on the female value system rather than the male and defines the world through female experience. Traditional therapies have assumed that the male value system applies to women as well as men and have overwhelmingly negated women's experience. For feminists the starting point, the centre of the universe, is women, with the assumption that there are no experts on women's experience except women (Brickman, 1984).

Women's experience of life is very different from men's and the female value system is different from the male value system. As Julie Brickman (1984) notes, feminists believe that women have been the custodians of special and important values, which are the traditional strengths of women: nurturance, caregiving, flexibility, responsiveness, relatedness, empathy, depth of feeling, altruism, warmth, creativity, and spirituality. Women are socialized to the female value system but live largely by the male system because it is culturally dominant. Thus women are always experiencing some kind of value conflict (Sturdivant, 1980). Feminist counsellors

recognize that women are expected to accomodate without strain to a set of discriminatory role behaviours and sex typed personality characteristics (Gilbert, 1980) and the effect this expectation can have on women's mental health.

Feminist counselling is an approach to the treatment of women focusing on the interrelationship of women's oppressed status in society, the socialization process, the experience of life as women know it, and the resulting mental health problems of women. The basic assumption underlying feminist counselling is that ideology, social structure, and behaviour are inextricably interwoven. Power and authority are viewed as central issues. The feminist model explores both sides of the power structure: the effects of too little power on women, and of too much power on men (Brickman, 1984). There needs to be an understanding of how the social environment and intrapsychic structure both together and separately contribute to women's mental health and mental illness. Such an understanding is certainly consistent with what is referred to as systems theory and the ecological approach to understanding human behaviour. This feminist model has both limits and potential. As long as basic structural inequalities of power exist in society, large numbers of women will show symptoms of this inequality. Working to correct inequalities is the only final cure for much female emotional distress. Counselling can help improve some intolerable social conditions by raising the

consciousness of individual women so that they will be less likely to tolerate them (Greenspan, 1983) and in this way counselling has the potential to be an instrument of social change. Counselling cannot end women's oppression but it can help women understand oppression and minimize the ways in which we internalize and comply with it.

The general goal of feminist counselling is to lead women to perceptions and understandings which will make possible a new life based on a healthy self-esteem, and feelings of competence, interdependence, and hope (Donadello, 1980). The task of feminist counselling is not to encourage women to develop a male style of behavour based on a model of competitive and aggressive individualism, but to help women develop their own female style of self without the subservience this has always entailed (Greenspan, 1983). It aims at clarifying the distinction between the internal and societal causes of women's problems in order to help us develop into autonomous individuals with personal strength and trust in self and in other women (Brodsky and Hare-Mustin, 1980). The ultimate goal of feminist counselling must be to help a woman see how her own power as an individual is inextricable bound to the collective power of women as a group (Greenspan, 1983). Levine (1979) states that feminist counselling carries within its definition a healing process, an educational process, and a political process, based on a feminist understanding of society's

institutions and structures, and their impact on women.

Feminist counselling must be pro-woman and have a fundamental respect for women's knowledge and strength within themselves. Sturdivant (1980) defines several criteria for feminist counsellors: they must be feminists who are aware of their own values and willing to make these explicit to their clients; they should be involved in some kind of social action for women; and they should be working toward optimal functioning in their own lives. She sees the functions of the counsellor as follows: facilitating personal problem solving, growth toward self-actualization, and the resocialization process; modeling women relating intimately with other women and modeling nurturance; and acting as an advocate for clients. Feminist counselling includes elements missing from the many of the traditional male orientations: specifically, compassion, empathy, intuition, and nurturance rather than discipline, control, and distance (Greenspan, 1983). Finally, feminist counselling means being knowledgeable about life cycle and reproductive issues in women's lives.

In a review of relevant literature, Lucia Gilbert (1980) found consensus on two important principles of feminist counselling: the notion that the personal is political, and a view of the therapist-client relationship as egalitarian. These two principles form the backbone of the feminist counselling approach and each will be

explored in detail.

THE PERSONAL IS POLITICAL

The principle that the personal is political involves helping women understand that individual problems have social as well as personal causes (Sturdivant, 1980). The counsellor helps women differentiate social prescriptions from personal needs and goals, and evaluate the influence of social roles and norms on personal experience; in other words, separating internal from external oppression (Gilbert, 1980). The process involves helping women differentiate external, relatively uncontrollable sociocultural conditions, from internal feelings and reactions to these conditions which can change (Sturdivant, 1980). The counselling work is aimed toward separating the personal from the political by sorting out how much personal responsibility a woman has in her life, and how much is really beyond her control, and political for all women.

An important aspect of the feminist approach to counselling involves reframing women's problems from a political perspective. This implies that the answers to personal dilemmas often lie in a redefinition of the struggle itself (Levine, 1983). Specifically, it may involve viewing a woman's pain and symptoms as healthy, adaptive responses to oppressive conditions rather than indicators of pathology (Klein, 1976, cited in Howell,

1981). Battered and raped women are no longer seen as provoking men's responses but as victims of male violence. Women's anger is often seen as a healthy response to oppressions (Levine, 1983), as in "I'm not mad, I'm angry" (Smith, 1975). Depression can be interpreted as "on the job stress" for mothers in the home (Rosenberg, 1981).

According to Levine (1979), feminist counselling assumes that "women's work" as defined by our society is frequently a fundamental factor in what is called "mental illness" and that social control is often a fundamental factor in what is called "treatment". Marriage and motherhood are seen as key institutions for women to examine in terms of how they traditionally contain women in a limited, dependent, service position under male control. A feminist analysis of society shared with women is a vital part of the helping process; this analysis is not imposed but connected in some way with the kinds of feelings, pain, work and struggles that women experience (Levine, 1983).

The personal is political notion includes validating the female experience. It involves assuring women that their feelings are valid and joining them in discovering precisely how these feelings make sense in the context of a particular woman's life (David, 1980). Emphasis is placed on the commonalities shared by all women and the universality of our dilemmas and joys is acknowledged. Feminist counselling cultivates the shared

experience of being female in a way that benefits the client (Greenspan, 1983). In particular, women are helped to see the strengths we possess that are not valued in a male dominated culture.

This principle also involves using feminist values to help women become aware of the existence of sex role stereotyping, sex role oppression, and the effects of social influences on our personal experience (Thomas, 1977). Women clients are encouraged to work with the counsellor to stop colluding in their own oppression. If, as women, we believe ourselves to be passive and intellectually inferior to men, we will behave passively and rely on men for assistance in thinking and problem solving. For counselling to help women, it must offer a more positive image of women than it has done in the past (Sturdivant, 1980). Feminist counselling enables the feminist value system to be validated not only by the therapist but to be transferred in turn to the client (Thomas, 1977).

Finally, the personal is political principle places an emphasis on positive change rather than adjustment to the status quo. Feminist counselling recognizes the historical and present day oppression of women as a group in a society in which men have the power. The counsellor helps women recognize the ways in which we have internalized our oppression and helps us act on the conditions which create the oppression. This principle

recognizes that women have experienced a long history of conditioning to accept an "inferior" status so women are encouraged and supported in challenging social and political structures rather than accepting and adapting to them, in questioning the traditional definitions of the family and sex roles, and in trying to find healthy lifestyles that fit for women (Feminist Therapy Support Group, 1982). As women we have a vested interest in changing our situations and we have the potential power to do so. Feminist counselling can help women come to a fuller awareness of our personal power, both as individuals and as members of a community of women (Greenspan, 1983).

The focus of the counselling intervention is on women's right to self-actualization. Feminist counselling attaches value to action, decision making and risk taking because it recognizes that women have been trained to talk, feel, and react rather than act and decide (Levine, 1983). Women are encouraged to work upon the problems facing them, both individually and collectively, and not be satisfied with ventilating, taking drugs, and finding only temporary relief from tension (Levine, 1979).

EGALITARIAN COUNSELLOR-CLIENT RELATIONSHIP

The second principle of feminist counselling Gilbert (1980) identified in her review involves attempting to make the therapist-client relationship as

egalitarian as possible through a variety of methods. Feminists reject the notion of the hierarchical helping arrangement (Russell, 1979), and believe that a woman-oriented approach to therapy must dissolve the rigid line between the expert and client (Greenspan, 1983). As part of that, the client is encouraged to "shop around" and interview several therapists before deciding on one that best suits her needs, and with whom to continue therapy (Gannon, 1982; Levine, 1979). As well, the client needs information about the counsellor's view of women in society so the values and attitudes of the counsellor as well as the client must be open to examination (Brodsky and Hare-Mustin, 1980), Counsellors must explore their own attitudes and beliefs, and confront tendencies within themselves to maintain the status quo regarding the status of women.

Another part of equalizing the counsellor-client relationship is reducing the professional power of the counsellor and enhancing the power of the client. The counsellor has inherent power in the relationship because of her ability to provide a service that the client needs at a point in time (Gannon, 1982). Feminist counselling does, however, provide a model in which the therapist and client are seen as equals in a struggle. The personal power differential can be reduced by the therapist using self-disclosure of her own life events when appropriate, sharing personal experiences, and dispelling the myth that

the counsellor is a problem-free human being. Clients can be encouraged and given permission to disagree with the therapist, and educated to be their own future therapists (Gannon, 1982). Eliminating jargon, professional mystification about the counselling process, and mechanistic techniques, as well as sharing information and knowledge with clients can contribute to equalizing the relationship (Levine, 1979).

A third aspect of equalizing the therapist-client relationship involves encouraging women to nurture themselves. Women need to be on the receiving end of more caring and less giving, and the counsellor works with her to recognize her own needs as a person (Levine, 1983). Women clients are encouraged to attend to themselves by actively asserting their limits and needs in relation to others. They are helped to value themselves as women, and to value other women as sources of support and nurturance. Levine (1979) states that women must break down their dependence on men, children, and the traditional family, and learn to view inclusion of and affiliation with other women as important ways of nurturing themselves.

A fourth factor relating to the therapist-client relationship is modeling by the therapist. Effective female models may provide a form of social sanction for certain roles, behaviours, personal attributes, and attitudes not generally experienced in our lives, and may help clients not only in validating their experience but

also in broadening their self-perceived options and goals (Gilbert, 1980). The counsellor needs to model both vulnerability and strength to present a more holistic view of women. As part of this, it is crucial for the therapist to be struggling with integrating feminist values and attitudes into her own life and behaviour (Sturdivant, 1980).

The final factor relating to this principle is that the expression of women's anger is encouraged. Greenspan (1983) believes that the hidden component in female symptoms is a powerhouse of suppressed rage. Women's anger is viewed as a legitimate response to both internal and external oppression, and is treated as an important therapeutic issue. Anger is seen as a potential source of constructive energy for change, and owning their own anger is seen as an important step toward personal power for women (Sturdivant, 1980). There is an assumption that one key for women to regain and retain dignity, energy, and self-esteem is the anger that propels them to fight back against oppressive situations and join together in acting to change their lives (Levine, 1979). Also, there is evidence that affect expressed in the form of anger and hostility is positively related to therapeutic outcome; therapists' perceptions also support the facilitative effect of clients' experience of strong feelings (Gilbert, 1980).

OTHER CONSIDERATIONS

As well as the two major principles of feminist counselling just discussed, there are other factors that can be considered part of the feminist approach to counselling. The first is the use of groups. Helen Levine (1979) considers it most helpful for women to work together in groups with an emphasis on mutual aid and the commonality of experience. Sara David (1980) also feels that groups are an especially effective way to work with women because they provide a sheltered setting for learning and practising new skills and behaviours. Also vicarious learning occurs from watching other women work through their variation on shared problems. All-woman groups are helpful in allowing women to share their struggles and experiences, to offer one another peer support, to discover that their problems may be caused more by circumstances than by their own faults and deficits, and to begin solving problems cooperatively.

The second consideration is the use of a holistic approach to working with women. The Feminist Therapy Support Group (1982) stresses a recognition that emotional stress can have physical and spiritual effects on women and that clients should be offered resources that take into account all parts of their lives. Worell (1981) encourages the feminist counsellor to have knowledge about the developmental, psychological, biological, and mythological aspects of women's lives, and to be

up-to-date and informed about community resources and alternative options and services for women.

A third consideration is a commitment to social learning theory as a theoretical model for dealing with women's problems. A growth/developmental model of therapy rather than the illness/remediation model used by traditional therapies promotes personal and social change as the primary goal of therapy rather than adjustment (Sturdivant, 1980). This theory dovetails well with the feminist approach and the resocialization process that is often a part of feminist counselling to help women change dysfunctional patterns of a lifetime.

The final consideration to be mentioned here is the feminist counsellor's promotion of androgyny. An androgynous individual is one who possesses characteristics typically regarded as socially acceptable for his or her own sex as well as those traits believed appropriate for members of the opposite sex (Bem, 1974, cited in Pyke, 1980). Thus, an androgynous woman could be both tender and independent, competitive and nurturing using each trait as called for by a situation. Sturdivant (1980) stresses the integration of emotion and intellect, feelings and intuition with thinking and problem solving, giving both equal status and equal importance for the androgynous person. The goal is to augment the cognitive and behavioural response repertoire of clients by encouraging the development and expression of repressed or

unlearned traits typically more characteristic of the other sex (Pyke, 1980).

Assertiveness training is an approach in this category used by feminist counsellors to help women deal with day to day situations (Levine, 1979). This is seen only as a tool; it is recognized that social change is needed to significantly improve women's lives. Feminist counsellors must be careful not be place undue emphasis on women taking on "male" characteristics with an implication that "female" traits are not valuable. If only the "male" characteristics are valued and added to women's repertoire, this is in a subtle way perpetuating the patriarchal system that negates women's way of relating to others. As Brickman (1984) notes, the danger is that "women may be taught to say what they want (assertiveness training) without teaching men the complementary skill of listening and responding (submissiveness training)" (p.58).

In summary, the differences between traditional therapies and feminist counselling are delineated in the definitions of the symptoms, the locus of the problem, the goals of therapy, the role of the therapist, and most importantly, the value placed on women's experience. Feminist counselling, as an approach to working with women is still evolving and building on new theories. However, this new school of counselling is characterized by the conscious integration of feminist ideology into a

conceptualization of the nature and process of therapy, and is increasingly drawing professionaly trained women to a commitment to feminist counselling as a way of meeting the needs that women bring to counselling (Sturdivant, 1980).

Chapter 5. SUMMARY AND CONCLUSIONS

Many studies researching sex differences in mental health problems have produced a similar result: the female population has a higher percentage of "mentally ill" individuals than does the male population. The single most common characteristically feminine symptom is depression. In the area of depression, women consistently present higher rates than men, usually at a ratio of two to one (Weissman and Klerman, 1981). Feminists believe the reason for this is that sex differences in mental disturbance reflect differences in the social experiences of women and men (Pearlin, 1975). A feminist approach to understanding this phenomenon emphasizes factors in women's environment which adversely affect mental health. These factors are various forms of oppression: female sex role socialization, lower social status, sex discrimination, and violence against women. From the perspective of women, female symptoms may well be viewed as largely unconscious attempts both to adapt to and rebel against being a woman in a man's world (Greenspan, 1983).

Feminist analyses have helped social workers understand the numerous ways in which the dominant patriarchal ideology of our culture has precluded equality for women. Feminist theory explains the intricate relationships between women's personal experiences and oppressive social circumstances. Feminists must be credited with first naming and documenting the

victimization of women and locating the roots of the problem within the social structure instead of in the female psyche; for developing networks of support among women; and for building alternative social services for women that provide protection and assistance (Berlin and Kravetz, 1981; Levine, 1983). Rape, incest, battering, and harassment were all invisible problems, concealed, condoned, and protected by fear and silence prior to the current women's movement (Berlin and Kravetz, 1981; Levine, 1983). Physical, psychological, and sexual abuse of women and female children are finally surfacing as major social problems, and the social work profession is beginning to respond. Social workers are challenging sexism in the profession, and the antiwoman aspects of prevailing therapeutic approaches to working with women.

Discriminatory employment practices, sex-biased community attitudes and organizations, and restrictive family roles severely limit the efforts made toward autonomy and growth by individual women. A woman's socialization ingrains in her the prevailing patriarchal attitudes and norms regarding "appropriate" roles. Women are perceived as potential wives and mothers to the exclusion of other roles and this stereotype is particularly effective in oppressing women. Women have been taught to define the central and primary tasks of our lives as marriage and motherhood. The inevitable conflicts engendered by our growing up female and second

class frequently create severe personal difficulties at one time or another in women's lives (Levine, 1983). It is then that we are most frequently perceived by the helping professionals as inadequate, irresponsible, sick or abnormal. A feminist framework applied to social work practice can help us redefine struggles within the family by taking into account the political, economic, and personal context of women's lives (Levine, 1981).

Social workers hear repeatedly from wives and mothers the recurring feelings of guilt, self-blame, and low self-esteem. Such themes are structured into the very heart of women's lives and embedded within the institutions of marriage and motherhood. The success of patriarchy relies on internalized guilt and self-blame in women to immobilize and to contain us within the private sphere of life (Levine, 1983). Women are actively discouraged from expressing anger and hostility, from being self-assertive, and from taking control of our own lives. The denial of anger and negative feelings because "normal" women are expected to be predominantly giving and nurturing, helps to create the depression so common among women that results from internalized anger. A feminist perspective suggests that "when women are paralyzed by depression, they are often on strike against killing roles and expectations. When women end up in psychiatrists offices or become dependent on drugs and alcohol, they may well be political refugees from narrow and suffocating

lives. And when women are poor or on public assistance, seem resigned, apathetic or explode with anger, their responses are seen as normal - not abnormal - responses to untenable life situations" (Levine, 1983, p. 79). Depression in women can be associated with a mourning for the lives women are not permitted to pursue and with a sense of helplessness in determining the course of our present lives (Brodsky, 1981a).

Feminist counselling assumes that women's work, paid and unpaid, is frequently a fundamental factor in the creation of what is labelled mental illness. Very serious occupational health hazards are rampant in the home and paid workplace for women (Levine, 1983). The majority of social work clients continue to be women living out cultural mandates that prescribe economic powerlessness and sexual exploitation. Women must not be blamed for their abuse or be held solely responsible for change. Social workers can help women assume the personal responsibility that follows from the availability and awareness of choices. We need to be able to create options and give women the skills and support to stand against their socialization and actively oppose their victimization. "The patriarchy will crumble when, one by one, women refuse to participate " (Berlin and Kravetz, 1981, p. 448).

SECTION II: INTERVENTION

INTRODUCTION

As the preceding literature review has revealed, women as a group are socially, culturally, and economically oppressed in our society, particularly by the institutions of marriage and motherhood. Feminist counselling has evolved over the past fifteen years as a more comprehensive and politically aware approach to helping women that can be used by professionally trained social workers in agency settings.

The literature on feminist counselling describes it as an approach to working with women which incorporates the major principle that the personal is political, and utilizes an egalitarian counsellor-client relationship. The information does not outline in-depth counselling procedures or clearly define the feminist counselling process. During the process of the practicum, I struggled with finding ways of intervening with the women I saw that would demonstrate the feminist approach, knowing that the basic components of engagement, assessment, contracting, intervention, and evaluation were necessary phases of the counselling work.

My first assumption was that while I have experience, knowledge, and skill as a counsellor, the women themselves are the "experts" on their own lives. As a woman-oriented approach to therapy, feminist counselling

must begin with a validation of women's experience of life. Second, counselling is always a relationship between people and requires mutual respect, caring, and trust between the counsellor and the client. A feminist counsellor emphasizes the cooperative aspects of the counselling process between the two parties. Third, I believe that a counsellor's most essential tool is herself as a person. As a feminist and social worker I needed to experiment with different ways of using myself in order to more effectively help women make changes in their lives.

As a wife, and most recently a mother, I had feelings and experiences common to other wives and mothers, and politically, as a woman I share a heritage of oppression with all women. The practicum was an attempt to translate into practice a changing perception of myself and other women in this society. As a woman who identifies with women, I hoped to encourage women to validate and like themselves as persons, and appreciate their own significance. Most importantly, I wanted to use the commonalities between us as a way of understanding, sharing, and working together to enable counselling to become a truly "woman to woman" experience with the women I saw.

Chapter 1. THE SETTING

The setting of the practicum was Family Services of Winnipeg, Inc., a private nonprofit social service agency that was established in 1936 "to foster the development of family and individual life in the community, and to provide strength to families under stress". Since 1968, this agency has been an accredited member of the Family Service Association of America. Family Services consists of three separate departments: Special Needs Family Day Care; Homemaker Services; and Counselling and Community Services. This agency is located in the heart of downtown Winnipeg close to Portage and Main, and is accessible to the handicapped.

The specific location of the practicum was the Counselling and Community Services Department which is funded primarily by the United Way of Winnipeg. Its services are provided by professionally trained counsellors, and are available on a voluntary basis to anyone living or working in the City of Winnipeg. The services include individual, couple, or family counselling; groups; and a variety of community services including workships, and speaking engagements.

Clients are for the most part self-referred, with a small percentage referred from the community by doctors, lawyers, and other social service agencies. To illustrate the variety of counselling services provided, a breakdown of requests for counselling service in 1983 showed that

32% of clients asked for individual counselling, 34% wanted couple counselling, and 25% requested family counselling. 9% of the requests were undefined. Clients desire help in dealing with a number of family-related issues including separation and divorce, wife battering, poor communication in marriage, parenting concerns, stepfamily life, sexual dysfunction, depression, anxiety, incest survival, extramarital affairs, and loneliness. The average number of counselling sessions per client is five, with a wide range from one interview to several years of service.

Groups are developed in response to issues arising on counsellors' caseloads, and are seen as an alternate or additional form of counselling service. Groupwork provides an opportunity for clients with similar concerns to share problems and work together with others with the help of trained leaders. Recent groups at Family Services have dealt with concerns of stepfamilies, abused women, abusing men, adjustment to separation, and communication in marriage.

I chose the Counselling and Community Services Department of Family Services as my practicum setting for a number of reasons. First, the 1983 department statistics showed that 70% of clients who requested counselling service were women, and 67% of clients attending a first interview on an individual basis were women. Clearly, more women than men are seeking

counselling at this agency, and a service which focused on women's needs and lifecycle issues, and which incorporated a feminist philosophy seemed very appropriate in such a situation.

Second, the department has a commitment to the philosophy and profession of social work. As a Family Service agency, we take a systems approach to helping people, recognizing the interrelationship between the individual and her or his family. People are viewed as part of the environments in which they live. This is reasonably consistent with a feminist approach which expands systems theory to include an examination of the political and cultural context of women's lives as well as an historical analysis.

A further advantage of using this department for the practicum was that I have been an employee of the agency for almost six years. My familiarity with the policies and procedures allowed me to move quickly into the work of the practicum. I was comfortable in my workplace and was able to specifically request cases that would be appropriate to my focused area of study.

THE COUNSELLING PROCESS

a) Intake

When consumers call Family Services for asking for counselling, they initially speak to an Intake Worker, who fills out a Request for Service Form over the telephone,

gathering basic demographic information such as name, address, telephone number, other family members, and marital status, and a brief description of what the client perceives to be the problem. The client is then given the information that a counsellor will be assigned to them as soon as possible, and the counsellor will contact them to arrange an appointment. Due to variations in the numbers of requests and workers' ongoing caseloads, potential clients usually have to wait a period of time before hearing from their assigned counsellor. Waiting periods have fluctuated over time from a minimum of a few days to a maximum of several months, particularly if the client wants an evening appointment.

b) Assessment

Shortly after choosing cases for this practicum, I called each woman to arrange an appointment time that suited both of us. Since all the women were mothers, this often necessitated planning around the children's schedules of school and naps. As well, some of the women were employed and had varying abilities to take time off work. Some of the women had difficulty obtaining child care and were not prepared to bring their children, especially if they had to travel by bus. Of the nine women, seven were seen during daytime office hours, and two were seen in the evening. Several brought their children with them on different occasions since Family

Services has a semisupervised play area in which they could stay during their mothers' counselling sessions. One woman was a fulltime student and worked her appointment times around her class schedule, and one employed woman came on her lunch hour. Generally, I kept the first phone call brief unless the woman initiated a longer conversation. I encouraged them to write down the phone number, address, my name, and the appointment time and asked them to call me if they could not attend. I agreed to do the same. I wanted to encourage the notion of the value of both their time and mine, as a beginning way of equalizing the counsellor-client relationship.

I would generally tell the women that part of my purpose in the first session was to learn something about their situation so that I could decide whether I thought I could be helpful to them. I would encourage them to consider carefully whether they wanted to continue in counselling with me by indicating that they had a choice. If they decided against working with me I would gladly refer them to another counsellor at Family Services or at another appropriate agency. While this is a component of the feminist counselling approach, it was often not a true choice for women because they may have waited up to six weeks for this appointment, and were usually not prepared to wait again for another counsellor. However, they were given the choice.

After the decision to work together was made, I

worked through the assessment phase of counselling with the help of the paper and pencil measures. I explained the purpose of the assessment forms and asked the women to fill them out early in the counselling process. They were all agreeable to this. I informed them that I was working on a graduate degree in Social Work, specializing in working with women and that the forms would give me information about their current life situations that would be helpful in our work together. I also explained that I might on occasion want to videotape some of our sessions with their consent in order to consult with my supervisor about my work with them.

c) Intervention

The intervention process was flexible, although it usually contained educational, supportive, and change-oriented elements with an emphasis on expressing feelings and exploring strengths. I recognized women's isolation and the importance of their having someone to talk to, and the pace of the counselling was to a large extent determined by the women. The sessions were usually approximately ninety minutes so that the women would not feel rushed. I discussed the various possibilities of intervening, such as continuing individually, or couple and/or family work if appropriate. Two of the women were in fact seen once with their spouses. Two other women were referred to an agency-sponsored group for abused

women as well as continuing with individual counselling. Some situations required practical help or crisis intervention, and some were topic-oriented while others followed themes. In each case, we contracted to work together until some of their initial concerns had been dealt with.

d) Termination and Evaluation

Some of the women terminated prematurely because of pressures in their lives that made it difficult to continue, such as a new fulltime job, loss of a babysitter, or overtime at a paid job. Others terminated after they had in some ways resolved the issues that brought them to counselling. All the women were asked to fill out the post-test forms and evaluation questionnaire and none objected, although only seven of the total of nine returned the forms. In all cases, though, the women took some steps to make changes in their lives, thus increasing their personal power.

Chapter 2. THE WOMEN

The practicum provided an opportunity to put into pracctice the feminist approach to counselling with a total of nine women seen over a period of eight months, from May to December, 1985. These women had all called Family Services of Winnipeg voluntarily asking for counselling, and they were all seen on an individual basis. I chose as clients women who presented mental health issues that appeared to be related to their roles of wife and mother, because as outlined in the preceding literature review, marriage and motherhood are two of the major societal institutions which oppress women. Generally, the women indicated that they felt depressed, and asked for help dealing with such issues as living with an abusive husband, deciding whether or not to separate, managing their children, and handling the end of a marriage.

It became clear early on in the practicum that the number of counselling sessions per client would vary widely depending on the woman's particular situation, and that some women might continue with counselling beyond the parameters of the practicum. At the end of the practicum, the number of counselling sessions per woman ranged from three to 26. Most sessions were 90 minutes in length. Table 1 shows a detailed breakdown.

TABLE 1

NUMBER OF COUNSELLING SESSIONS PER WOMAN CLIENT (N=9)

5 or less	2
6 - 10	3 *
11 - 20	2 *
over 20	2

* 1 client is ongoing

DEMOGRAPHIC CHARACTERISTICS

Table 2 provides a summary of descriptve characteristics of the nine women seen, including age, employment status, marital status, financial status, number of children, age of children, and age of mother at birth of first child.

TABLE 2

DEMOGRAPHIC CHARACTERISTICS OF WOMEN IN COUNSELLING (N=9)

AGE	
26 - 30	4
31 - 35	4
36 and over	1

EMPLOYMENT STATUS	
employed	4
unemployed	1
student	1
fulltime homemaker	3

MARITAL STATUS	
(At first interview)	
married	2
common law	2
separated	5
(During counselling)	
married	1
common law	0
separated	8

FINANCIAL STATUS	
social assistance (includes U.I., student subsidy, and social allowance)	4
$10,000 or less per year	1
more than $10,000 per year	4*

NUMBER OF CHILDREN	
one	2
two	2
three	5**

AGE OF CHILDREN	
0 - 5	8
6 - 10	8
11 - 15	5

AGE OF MOTHER AT BIRTH OF OF FIRST CHILD	
20 or under	3
21 - 24	5
35	1

* for one woman this figure reports her husband's income.

** includes one woman pregnant with her fourth child.

As can be seen from the table, the women's ages ranged from 26 to 37, with an average age of 30. All the women had at least one child with one woman being pregnant with her fourth child. The children were aged one to thirteen years old. A number of the women had first become mothers at an early age while one woman had her first child at age 35. Five of the women had religious affiliations including Roman Catholic, Pentacostal, and The Church of the Latter Day Saints.

Regarding marital status, only one woman remained with her partner throughout the course of counselling. Five were separated at the onset of counselling, and three more separated during the counselling process. Five of these partnerships were legal marriages and four were common law relationships. Five of the women had been physically abused by their partners; of these, four had separated prior to counselling, and the fifth left her marriage during counselling. Only one of the separated mothers did not have custody of her children.

With respect to employment status, only one was a fulltime homemaker with no income of her own. The others were employed full or part time, on social assistance, receiving unemployment insurance or a student subsidy.

ASSESSMENT MEASURES

Several paper and pencil measures were used for

assessment and evaluation purposes on a pre- and post-test basis. Five areas were felt to be particularly relevant to the experience of women seeking counselling. They were loneliness, depression, self-esteem, problems related to mothering, and support networks. The results will be discussed briefly in this chapter as assessment measures, and the results outlined in more detail in Chapter 4: Evaluation. All of the scales were completed by the nine women either at the end of the first interview or prior to the second interview.

The first was a four item, short form of the UCLA Loneliness Scale developed by Russell, Peplau, and Cutrona (1980). It was used to assess the extent of the women's isolation. The scale was selected from several available measures of loneliness because of its shortness. The items are an optimal subset of the longer UCLA scale which has a high alpha coefficient (.90+), and encouraging known-group, discriminant and construct validity (Russell, Peplau, and Cutrona, 1981). In a Los Angeles study involving 250 people between the ages of 18 and 40, the mean score was 8.2 (Russell, 1974). The scale ranges from 4 to 16 with high scores indicating a greater degree of loneliness. The scale is shown in Appendix A.

The Beck Depression Inventory developed by Aaron Beck (1967) was also administered. This measure consists of 21 symptom categories describing behavioural manifestations of depression (e.g. sadness or social

withdrawal). It contains a graded series of four self-evaluative statements for each item, which are ranked in order of severity of expression of the symptom. Each woman was asked to choose the statement which most nearly matched her present state. For example, 0 -I do not feel sad, 1 -I feel sad, 2 -I am sad all the time and I can't snap out of it, 3 -I am so sad or unhappy I can't stand it. Internal consistency of this measure has been demonstrated by significant relationships between each item and the Back Depression Inventory total scores, and by an odd-even item correlation of 0.86, Spearman-Brown corrected to 0.93 (Beck et al, 1961). No test-retest reliability data are reported in the original reports but Miller and Seligman (1973) report a test-retest reliability of 0.74 for 31 normal undergraduates with a three-month interval. Pehm (1976) describes this scale as the best of presently available, self-report measures of general depression severity. The scores range from 0 to 63, and Beck suggests the following interpretation: under 10 (normal), 10 - 16 (moderate depression), and 17 and over (severe depression). The Inventory is reproduced in Appendix B.

The third measure was a 10 item Self-Esteem Scale developed by Rosenberg (Robinson and Shaver, 1973) as a self-report measure of the self-acceptance aspect of self-esteem. Test-retest reliability over a two-week period is reported as $\overline{r}$ = .85, and mean concurrent

validity with other self esteem measures approximates .60. The scores range from 10 to 40 with high scores reflecting a positive self-concept. This scale can be found in Appendix C.

The fourth measure was a checklist of difficulties other new parents have experienced. The checklist was developed by Hobbs (1965), and Hobbs and Cole (1976) report the ten most and the ten least discriminating items. The checklist was modified by McCannell Saulnier in 1983 to include items experienced by new mothers in particular, and it was further modified for purposes of this practicum to include items significant to women who have been mothers for some time. This was given to the women and each was asked to indicate the degree to which she had been "concerned" by each item - not at all, somewhat, or very much (scored 0, 1, and 2 respectively). Thus, the scale measures reactions to events often experienced by women rather than the existence of these events. While Hobbs did not assess the reliability or validity of the scale, McCannell Saulnier (1983) in a longitudinal study of difficulties experienced in the transition to motherhood, found a significant correlation of .4 between the checklist and a subjective question which asked the women to rate the degree of difficulty they have experienced. Cronbach alpha was found to be .76 in the above study. This scale has 28 items and scores range from 0 to 56 with high scores representing greater

difficulty with mothering. Scoring categories developed by Hobbs are as follows: 0 - 11.5 (slight), 12 - 22.5 (moderate), 23 - 33.5 (extensive), and 34 and over (severe). This checklist now entitled Problems Related to Mothering, can be found in Appendix D.

A further dimension of assessment involved exploration of each woman's support system. To assist in this several written questions were asked. This measure has no score but simply gives an indication of each woman's support network, thought to be an important contextual factor in mental health. It is titled Support Systems Questionnaire and can be found in Appendix E.

In Table 3, the women's scores on the various measures at the beginning of the counselling process are reported. Nine women completed the forms but one woman's scores were misplaced leaving a total of 8.

TABLE 3

PRE-TEST SCORES OF WOMEN IN COUNSELLING (N=8)

UCLA LONELINESS SCALE*		BECK DEPRESSION INVENTORY	
0 - 4	0	under 10 (normal)	1
5 - 8	3	10 - 16 (moderate)	2
9 - 12	4	17 and over (severe)	5
$\overline{X}$ = 10		$\overline{X}$ = 24.5	

SELF ESTEEM SCALE		PROBLEMS RELATED TO MOTHERING	
0 - 10	0	0 - 11.5 (slight)	0
11 - 20	4	12 - 22.5 (moderate)	2
21 - 30	3	23 - 33.5 (extensive)	4
31 - 40	1	34 and over (severe)	2
$\overline{X}$ = 23.1		$\overline{X}$ = 29.9	

* one score was incomplete so was omitted.

Chapter 3. THEMES AND CASE EXAMPLES

COMMON THEMES

While each woman's story was unique, and each had her own experience to relate, certain common themes emerged. These themes reflect the common experience of women. This practicum confirmed Carol Gilligan's (1982) thesis that women are predominantly concerned with connectedness: relationships with others, concern for others' feelings, nurturing and caring, and efforts to keep relationships running smoothly. For the most part, the women's issues were related to their relationships with men and with their children, as well as some concerns with their relationships with their parents.

As women we have learned to see and think about ourselves in a way that is shaped primarily on the basis of how others have treated us, and what we have been told about ourselves, beginning in childhood with our parents, moving on into adulthood with our spouses, and our self-perception is further affected by having children ourselves. Throughout our lives, societal norms and expectations have played a major role in how we see and value ourselves. Many women in our culture have been taught to focus their attention on getting a man, and many women in our male-dominated society have had to be dependent on men for survival. This concern with relationships with men was evident with the women I saw in counselling.

Mothering can also increase a woman's sense of connectedness. However, in our society, the primary responsibility for nurturing and raising children falls on mothers whether they have a partner or not. We are bombarded with ideal images of the "perfect" mother, and are constantly admonished to live up to an endless set of unrealistic expectations. Consequently the women I saw were often trying to meet impossible demands for themselves about how they raised their children.

The female way of seeing the self in connection to others has traditionally been viewed in our culture as evidence of a deficiency, an inability to be autonomous and independent. In intimate relationships, many women have trouble keeping a clearly defined boundary between themselves and their loved ones and this results in the woman being so closely attuned to her loved one's feelings that she does not fully experience her own. Many women experience little sense of their own individuality and separateness, and therefore do not assume sufficient responsibility for their own individual needs. However, women generally take complete responsibility for relationships, and the women I worked with saw themselves as often behaving inadequately, and they wanted help to become "better" people. The most common emotions expressed were depression, self-blame, guilt, fear, frustration, helplessness, and confusion. With the exception of one woman, anger was not mentioned initially,

confirming that it is not an "allowed" feeling for women.

These were women who, like most of us, valued others and relationships with others, but who did not highly value themselves. For all the women, putting others first was their practice. The idea that they had needs of their own, and a responsibility to take care of themselves was usually met with some resistance. For all of them, beginning to find the balance between responding to others' needs while taking care of their own was the substance of their work in counselling.

In this chapter, the process of treatment is illustrated with four case examples. Themes and issues discussed in the literature review are explored as they pertain to these women, whose names have been changed to protect confidentiality. Throughout the narrative, practice principles which illustrate a feminist perspective are described. The information gleaned from the assessment measures is woven into the accounts to add richness to the women's stories. Evaluation of the interventions will be discussed in detail in Chapter 4.

CASE EXAMPLES

CASE 1: MICHELLE'S STORY "I must be stupid"

A. ASSESSMENT

Michelle was a 37 year old single parent who separated from her abusive partner, Phil, approximately one year before approaching Family Services for counselling. She and Phil had lived together for three years and their child, Daniel, was in Michelle's custody. Michelle was currently employed part time as a dental hygienist, work she had studied for immediately after high school at her mother's suggestion, and that she had continued to do on and off for over fifteen years.

Michelle called Family Services initially seeking help dealing with Phil's harassment of her. He had been phoning her, threatening her, and dropping over uninvited since the separation, and while Michelle encouraged his visits to Daniel, she did not want to see him herself and was still afraid of him. She had taken no legal action against Phil because she had felt there was no need; she owned the house and the majority of its contents, and Phil had not disputed her sole custody of Daniel.

By the time Michelle met me for the first appointment, she had taken several steps to deal with Phil. She had arranged to move in with a cousin temporarily after selling her house until she solidified her future career plans, and she was planning to withhold the address and telephone number from Phil. She had made

arrangements with her mother to take messages from Phil, and to use her mother's house as a place for Phil to pick up and drop off Daniel for visits. It was an indirect way of dealing with Phil's unwanted attention but Michelle felt it was a positive move.

What Michelle wanted help with in counselling was to make sense of the battering relationship she had had with Phil in order to avoid such relationships in the future. The assessment measures indicated that Michelle has a low score on the loneliness scale, a score within the "normal" range on the depression inventory, and relatively high self-esteem. Her score on the problems related to mothering scale was "extensive" indicating the stresses of raising an active eighteen month old child alone. The support systems questionnaire revealed a well-established, helpful support network. Table 4 shows Michelle's pre- and post-test results. These strengths suggested that intervention would be short term and focused on education and validation.

B. INTERVENTION

Michelle presented herself as a poised, self confident woman. However, she reported a number of fears and self doubts regarding the violent relationship she had had with Phil. She felt good about herself because she had separated from Phil, and was making plans for the future for herself and her young son. However, she had

questions about why she was abused, why she stayed so long with this man, and was it her fault? She described herself as "stupid" and felt that she must be in part to blame for the violence she had endured. Michelle had internalized many of the prevalent myths in our society about wife battering.

Together we discussed woman abuse. I gave her information about the characteristics of men who batter, the cycle of violence, and the societal messages women receive about abuse, and let her know that all people get angry at times but we have choices about how to express that anger. When I stated that the violence was in no way her fault but Phil's responsibility, she seemed relieved. She seemed to have a cognitive understanding of this but had received mixed messages from members of her family regarding her relationship with Phil, and had become confused about what to believe. She welcomed the reassurances I gave her that she was not in fact "stupid". She seemed to need professional external validation to alleviate her self-doubts.

Michelle was concerned about what had caused her to fall in love with this abusive man, and felt she needed to understand her motives so that she could avoid such relationships in the future. We explored some of her life history prior to meeting Phil in order to gain some insight. Michelle had been married previously for eight years to a man who was emotionally distant from her. She

loved this man very much but they had different interests and spent little time together. She had wanted to have children but when she had become pregnant early in the marriage, he had insisted that she have an abortion, and she grieved this loss alone. In many ways, Michelle's situation illustrated what Carol Gilligan (1982) describes as women seeking connection in relationships while men see danger in intimacy. That is, her husband focused his attention on his career while Michelle focused energy on the marriage. She had internalized many of the beliefs that women grow up with about wanting to be a traditional wife and mother. Michelle tried many ways to become closer to her husband by attempting to please him and be the kind of woman he wanted. For example, she took a university degree in Education because he was a teacher and thought it would be a good idea for them to have the same working hours and holidays. He clearly made the rules of the marriage. After eight years of marriage, the husband stated flatly that he never wanted to have children. Feeling devastated, Michelle filed for separation hoping that he would reconsider his stance with the threat of losing her. The tactic failed. The husband stayed away and shortly after remarried, and has since fathered two children.

Michelle tried to pull her life back together. She enrolled in the School of Fine Arts to study pottery. This was the first career plan she had made that was her

own choice. However, personally she felt rejected, vulnerable, and unlovable. When she met Phil, she felt desirable again since he was fun and wanted to be with her. The facts that he was financially irresponsible and quickly abusive were overlooked because she did not want to be alone again. Phil encouraged her to make her own decisions and was not opposed to her desire to have a child. His abuse of her ranged from slapping and shoving, to punching and throwing her around. She minimized the abuse to herself, and feeling the pressure of her "biological clock", she became pregnant at 35 when she graduated with her Fine Arts degree. After many years of wanting to be a mother, she had Daniel, the joy of her life. Shortly after his birth, she took stock of the relationship with Phil and began to recognize the danger she and her child were in. She decided that she needed to separate from him and asked him to leave which he reluctantly did.

Michelle realized that one of the reasons she chose Phil was her vulnerability at that point in her life. We also talked about how women's sex role stereotyping resulted in Michelle's believing that she needed to be loved by a man, and have a child within the context of a relationship in order to be considered "acceptable" in society. While the societal pressures still exist, and her Catholic background has played a large part, Michelle now recognizes her strengths as a

person in her own right and is less interested in a fulltime relationship with a man.

Having put the issue of abuse somewhat to rest, Michelle needed to consolidate her plans for the future. She had a varied educational background which allowed her a number of choices. She was trained as a dental hygienist initially and though she disliked the work, had been employed in this field periodically over the years. She also had a university degree in teaching but had never taught full time because she had not been able to find a position after she graduated. She had most recently acquired a degree in Fine Arts, specializing in pottery and this was her true love. She had stopped working at it when Daniel was born because it required long periods of uninterrupted time unavailable to her with a baby, and she wanted to spend as much time as possible with her child. She had written it out of her future plans because it might not provide a secure income.

Teaching offered the best financial security and hours of work so she recently had decided to go to Montreal with Daniel for three months in the new year to intensively study French. With the current increase in French immersion programs, she hoped that this added training would better qualify her for a teaching position upon her return. It seemed clear to me that pottery was very important to Michelle even though her family, particularly her mother referred to it as a "hobby", and I

reinforced her desire to consider some way she could continue to pursue it. This was another area where she seemed to need some external validation to help her attend to her own needs. This seemed to be the turning point in the counselling. The next session she showed me some slides of her work and announced that she intended to try to find a part time teaching job and rent a studio for doing pottery when she returned from Montreal, as a way of incorporating job security with work she liked to do.

After three sessions we terminated the counselling, agreeing that the presenting concerns had been dealt with. Michelle knew she was free to recontact me should the need arise. A followup call a month later revealed that she was leaving for Montreal shortly and felt quite excited and confident about her future.

C. EVALUATION

Michelle seemed to have spent the majority of her life doing things to please others until she became involved in pottery and had Daniel. These two decisions were the start of Michelle beginning to attend to her own needs. However, since this taking control was quite new for her, she sometimes felt unsure about herself, and seemed to need validation from someone outside her immediate cirle of family and friends in order to pursue her goals.

Michelle's post-test measures indicated

improvement in all areas (see Table 4). She was slightly less lonely, and her depression score dropped to 0, indicating reductions in her feelings of failure, guilt, self-blame, and her feeling that she may be punished. Her self-esteem score rose showing an improvement in her sense of respect for herself. Her problems with mothering score dropped dramatically to "slight", not because the problems had decreased, but because she now felt more confident in her ability to handle them. A change in her support systems questionnaire indicated that she was now involved in more social activities with the people in her life.

On her evaluation form, Michelle listed sexuality, dependence, fear, marriage, violence, assertiveness, personal power, and her relationship with her mother as themes that were relevant for her. She defined self-esteem, relationships, and guilt as the three themes she worked on, noting that the first two were "better", while guilt was "much better". She had combined "relationships" into one category probably because she felt that she had touched on issues regarding her relationship with her mother, her ex-partner, and men in general, as well as relationships with women in her life.

Overall, it seemed that at this point in her life, Michelle felt that she had some power over her life. She was making decisions about her future that felt right for her, and was no longer trying to accomodate other people in her life at her own expense. However, since this was a

relatively new stance for Michelle, she benefitted from a brief intervention to help normalize and affirm her feelings and plans. She had felt that it was important to talk to a woman, and the fact that we happened to be close in age both having small children simply reinforced the counselling as a "woman to woman" experience.

TABLE 4

MICHELLE'S ASSESSMENT MEASURES

	Pre-Test	Post-Test
Loneliness Scale	7	6
Beck Depression Inventory	6	0
Self-Esteem Scale	32	40
Problems Related to Mothering	24	10

CASE 2: SUSAN'S STORY I'm angry with everyone

A. ASSESSMENT

Susan was a 29 year old Metis woman employed full time at a native agency as a bookkeeper, who had custody of her five year old son, Steven. She had been separated from her husband, Allan, for a year and a half and had recently divorced him on the grounds of physical abuse. She had called the Manitoba Committee on Wife Abuse crisis line after her ex-husband tried to break into her apartment. Although she had called the police to remove him, she still needed someone to talk to about the incident. The MCWA gave her my name as someone who does counselling with abused women and she called to set up a appointment. She said that she was becoming aware of some of the long term effects of having been battered for a number of years and wanted help dealing with them. Susan had been in a group for battered women after she first separated from her husband last year and had found it very helpful at the time in terms of learning that other women shared similar experiences and feelings. As well, she learned a great deal about the phenonmenon of wife battering.

A brief exploration of Susan's life history revealed a somewhat insecure childhood. Her biological mother had given her up shortly after birth because she was unable to care for her being 17, unmarried, and an alcoholic. The adoptive parents were Susan's mother's

older sister and her husband, who were unable to have children of their own. However, the adoptive mother was also an alcoholic and battered by her husband, and the father was often absent from home. Susan was an only child and took on a role of taking care of the family, particularly her mother. She had a somewhat "wild" adolescence becoming sexually active early and experimenting with alcohol. She married Allan at 22 because she wanted to be loved and feel secure, even though he was abusive during the courtship. She had left him several times before the final separation the previous year.

Susan described herself as having low self esteem but the assessment forms revealed a fairly lonely, "moderately" depressed woman, with quite high self esteem, and "moderate" problems related to mothering. Table 5 shows the results of her pre- and post-test scores. My sense was that because she had few close friends that she could confide in, she needed someone to talk to to sort out some of her feelings of inadequacy. The intervention would likely be fairly short term with a focus on validation, clarifying feelings, and normalizing.

B. INTERVENTION

The counselling turned out to be quite sporadic. Of 17 appointments made over a period of four months, Susan was able to attend only eight. The problem was her

lack of time. Susan was employed in a clerical position and had a busy job. We scheduled appointments at lunch time thinking that would be the most convenient for her. She was unable to come after work or in the evening because of her responsibilities to her son. She did get permission from her supervisor to take extra time off work for counselling but this seemed to mean only when her work responsibilities were not pressing.

The time lag between appointments made it difficult to explore in depth Susan's issues. The sessions tended to be topic oriented and in this manner we covered a number of subjects, specifically: motherwork, sexuality, body image, her relationship with her mother, and anger but were unable to tie them together in a way that made sense to Susan.

We started by talking about the wife abuse. Susan seemed to have a good understanding of the basic components: she knew that she was not to blame for the violence, and that Allan had other choices of dealing with his anger. She knew some of the reasons why she stayed with him: she had loved him, and having grown up in a household where her father beat her mother, some abuse seemed almost "normal". She realized that she had not passively accepted the beatings because she had tried to separate on several previous occasions but had returned to Allan because she was afraid of what he would do to her if she stayed away. She left him finally because her fear

that he might kill her if she stayed spurred her into action. She had made herself as safe as she could through legal measures, such as the divorce, a restraining order, and forbidding Allan access to Steven, and practical measures, such as extra locks on the doors and an unlisted phone number. Still, Allan had occasionally come to her apartment block and caused a scene serious enough to warrant calling the police. He had also made threatening phone calls in the middle of the night. She felt that she could never be truly safe from him but life on her own was such an improvement that she managed to think about him less often.

The major element that permeated the counselling sessions was Susan's anger. She seldom allowed herself to feel hurt or sad, and said that she "needed to learn to cry again". It seemed that she wanted so much to feel strong, powerful, and safe that she had obscured other emotions with an overwhelming anger at the world.

One of the areas where this caused her problems was in her relationship with her son, Steven. Part of her wanted to be "supermom", the perfect, calm, efficient, understanding parent. Another part of her found herself irritated and exploding verbally at her child and feeling overwhelmed with guilt. We talked about some of the "myths of motherhood", the expectations that we as women place on ourselves because of society's message about maternal instinct, that "women are meant to be mothers".

Susan acknowledged that she found it very difficult being a mother, particularly a single parent mother with full time employment outside the home. The pregnancy had been unplanned and shortly after Steven's birth, she had had a tubal ligation to ensure that she would not become pregnant again. She also felt that somehow she needed to make up for Allan's absence, believing that a child really needs two parents. Although she knew that Allan had not been a good father and in fact was dangerous to Steven, she felt guilty at "depriving" Steven of his dad. At the same time she felt overwhelmed with the responsibilities involved in caring for Steven, and found it difficult to organize her home life to make things easier for herself. She also worried that Steven would turn out to be violent like his father. It was as though parts of her own childhood were repeating themselves. I helped her express some of these feelings, and together we planned a few strategies that could help her life run more smoothly, such as trying to get enough sleep, and planning less elaborate dinners.

Susan's other concern regarding Steven about her quick anger was her fear that she might some day lose control and physically abuse him. At this point she had never hurt him but felt she yelled at him far too much. We talked about this and discovered that her anger had more to do with frustration in herself for not being the "perfect" mother, and also her unrealistic expectation

that Steven would be a consistently well-behaved child. We discussed the realities of raising a child and tried to separate the stereotype from the actuality. I provided Susan with some concrete ways of handling her anger with Steven: by beginning to recognize when she was feeling stressed, and by taking control of the situation when she felt rage coming on, she was able to leave the room or count to ten before speaking. I also expanded the discussion to include the perspective that as women we do not have innate skills to make us good mothers. In fact, we have virtually no preparation for the job and need to learn how to parent "on the job". This helped Susan realize that she was not "stupid", only human, and quite capable of learning new ways of behaving that would help her develop the kind of relationship with her child that she desired.

Susan had a number of personal issues that were touched on during the counselling. One was her sexuality. She had been sexually assaulted as a young girl and had never told anyone. She had thought that perhaps it was her fault. Her first actual sexual intercourse at 16 was a "gray rape" situation. She had agreed to kiss the boy but had said no to intercourse. He forced her and she felt somehow that she was obligated to cooperate. She continued to have sexual experiences with other boys because she hoped it would be better and also because she felt that she had no choice if the boy insisted. We did

not deal with this in depth but touched on the way she had learned that she did not feel that she had a choice regarding sex. Partly she knew that she had been looking for the love and affection that had been missing from her life. It seemed that some of this sense of "obligation" stemmed from the early sexual assault, while most of it came from the broad sex role stereotyping most women experience. The message we receive is that it is esseential for a woman to have a man, but that a man in many ways then owns us. Under the system of "male rule", a woman's body is her source of power but it is also her powerlessness because her body is used by men.

Susan had a poor self image. She felt unattractive and was quite concerned about her appearance. Part of this negative view came from her husband. During their time together, he had denigrated her appearance as part of his emotionally abusive behaviour toward her. This was further exacerbated by her developing Bell's Palsy shortly after Steven's birth. This is a sudden paralysis of one side of the face for which there is no treatment other than physiotherapy. She did recover most of the muscles in her face but when she was tired or stressed one side of her face sagged. She was trying to come to terms with her appearance by changing her hair style and wearing contact lenses, but found it difficult accepting her single status and wanted to know that she is still attractive to men.

Currently Susan was feeling sexually frustrated and wanted to have a sexual partner but knew that sexual terms tend to be defined for and by men. She was prepared to wait until she felt more able to handle a sexual relationship without feeling coerced. She had dated several men since her separation but felt she was often in a position of responding to men when she would rather refuse. We talked about how she could be more assertive with men, noting that by being "nice" and concerned about not hurting their feelings, she was sometimes taken advantage of by them. Because of her history of abuse by men, Susan was at high risk to experience further abuse. We role-played several situations, and she began to work through her fear of saying no in order to take her own needs and desires into consideration.

Another issue Susan spent some energy on in counselling was her relationship with her adoptive mother. Because of the adoption, her father's battering of her mother, and her mother's alcoholism, Susan had taken on a role of responsibility for the family. She had tried to protect her mother from her father, and tried to help her mother stop drinking. Consequently she seemed to have missed out on a significant part of the carefree, happy times of childhood. She had taken care of her mother, rather than being the one taken care of, and the result was that she was unsure of her mother's love. She also had not allowed herself to be angry at her mother, or

resentful about her childhood. I encouraged her to express those feelings, while pointing out that she could still love her mother even if she was angry about certain behaviours. She chose to tell her mother how she felt about some parts of her childhood because she felt it was important that she share them. She felt good about the conversation and felt it was the beginning of developing a closer relationship with her mother. However, since her mother was drinking again, it might not have been a realistic expectation for Susan to be able to change the dynamics of the relationship.

After 8 sessions we terminated counselling because Susan was finding it increasingly difficult to get away from work to attend the sessions. It was understood that should Susan's workload lighten and she have more free time, she was welcome to return to counselling to continue the work we had begun together.

C. EVALUATION

Because of the lack of continuity in the counselling sessions, Susan was not able to deal with any of the issues fully, and we did not have the time to work on making connections between the various concerns in her life. In particular, her overwhelming anger was not discussed in depth. In retrospect, I feel that Susan may need to spend more time mourning the childhood she never had, as well as her former abusive marriage which she

refers to as "a waste of years". Her unexamined and unresolved source of anger is likely toward all men. While she has good reason to be angry, she needs to find some method of putting this anger into perspective, possibly by exploring her personal past more extensively within a political context that allows her to move forward with the rest of her life.

However, Susan did need someone to talk to openly and honestly with and stated that she had never talked to anyone before about many of these events and feelings. On the post-test measures, she indicated improvement in all areas (see Table 5). There was less loneliness, almost no symptoms of depression, higher self esteem, and fewer problems related to mothering.

On her evaluation form, Susan listed depression, sexuality, guilt, violence, body image, mothering, independence, helplessness, her relationship with her mother, her relationship with her father, and relationships with men as themes that were relevant for her. She reported self-esteem, anger, and assertivenss as the three main themes she had worked on in counselling. She felt she had made positive changes in self-esteem and assertiveness but that her anger was "the same". I interpret that to mean that she still feels confused and overwhelmed by her angry feelings and feels unable to handle them.

I felt that Susan and I had made a start but the

counselling in many ways simply reflected the nature of Susan's current reality. A followup telephone call a month later revealed that Susan wanted to resume counselling with me to focus on dealing with her anger. Her work load had lightened and she felt more confident that she would be able to come for counselling sessions more regularly.

TABLE 5

SUSAN'S ASSESSMENT MEASURES

	Pre-Test	Post-Test
Loneliness Scale	10	7
Beck Depression Inventory	11	2
Self-Esteem Scale	30	36
Problems Related to Mothering	21	12

CASE 3: HEIDI'S STORY "I am afraid I will hurt my kids"

A. ASSESSMENT

Heidi was a 32 year old married mother of three children ages 8, 4, and 2. She was a tall, slim, well-groomed woman who had been born in Germany, and who was currently a fulltime homemaker. She had called Family Services requesting service urgently because she was on the verge of abusing her children. She indicated that she had been physically abused as a child herself and was concerned that she would repeat this cycle with her children. She had heard about Family Services through her church, the Church of the Latter Day Saints (Mormon), and wanted to bring her husband with her to the counselling sessions. Knowing little about their family functioning, I agreed to see them together to assess the situation.

My purpose in the first interview was to assess the extent of the child abuse and decide how best to intervene. Heidi had experienced a crisis several weeks earlier when she had thrown one of her children on the floor in an uncontrollable rage. She realized at that point that her behaviour toward her children was deteriorating, and that she was in danger of becoming physically abusive toward them. She called the Child Protection Centre at the Children's Hospital for help and was able to get an immediate appointment. She spoke with a worker there for several hours about her concerns. That

worker then notified the child welfare authorities and a social worker came to Heidi's home to assess the family. The child welfare worker felt that the situation was under control since Heidi was attempting to get help for herself, and a plan was established to monitor the home. Arrangements were made for a volunteer parent aide to visit Heidi weekly to provide support and assistance. Heidi had meanwhile called Family Services for counselling to learn how to more appropriately handle her children.

Heidi described herself as being an inadequate mother. She was frustrated that she was not able to live up to her expectations of how a mother should behave, and said that she had little patience with her children and yelled at them more than she thought was necessary. It appeared that the children were in little danger of physical harm at this point, and this assessment of risk was later confirmed with the child welfare worker who agreed with me that ongoing counselling was an appropriate measure at this time.

The question of how I could best help was discussed next. I told the couple that I would need some information about their life as a family and did a brief history of the marriage. The couple married when Heidi was 20 and her husband was 21, after having known each other for five years. They had their first child four years later. The baby had colic, and Heidi had a difficult time managing. At that time, the husband had an

affair and considered leaving the marriage. However, the couple went for marriage counselling and apparently resolved the issues between them. Both state that the marriage since then has been solid. Later they joined the Church of the Latter Day Saints (Mormon) and both became active in church work. In time, they had two more children, even though Heidi had been content with one. However, their church promoted the practice of large families, and at that time they felt that to be true to their faith they had to continue having children. They have since realized that they have as many children as they can handle, and Heidi had a tubal ligation even though sterilization is frowned upon by the church. She had felt that her mental health would be in danger should she become pregnant again.

The couple described their relationship as good and referred to each other as their "best friend". Heidi, a fulltime homemaker, reported that her husband was fairly helpful with the housework and child care. The family income was not high and they were currently living in crowded quarters in a duplex. They had few extended family connections because his family lived in the United States, and relations with hers were strained.

My initial assessment was that Heidi was experiencing "burn out" and "on the job stress" related to her responsibilitiess of motherwork. I did not feel that marriage counselling was appropriate in this situation,

but was concerned that Heidi would feel more self-blame if I suggested individual counselling to her. However, Heidi said that she wanted to learn how to be a better mother, and would "try anything" to accomplish that. She was very emotional and sobbed throughout this interview. I suggested some of the issues we could talk about in counselling sessions, such as exploring her feelings about mothering, making connections with her childhood abuse, and finding ways that she could get her own needs met. She was concerned that I would tell her to lower her expectations and she did not want to consider that possibility. I felt that she was seeing me as the "expert" and I clarified that I would not be telling her how to live her life but would work with her to help her make her own decisions. She seemed skeptical but agreed to try it. Heidi's husband was supportive of her decision to seek counselling although he minimized her fears and said that she was a "good mother".

The assessment measures indicated that she was quite isolated, "severely" depressed, had low self-esteem, and "extensive" problems related to mothering. Table 6 shows her pre- and post-test results. The measures supported my belief that she was feeling trapped and seriously unhappy in her roles of housewife and mother.

B. INTERVENTION

Some disturbing issues about Heidi's situation

became clear early on in the counselling process. One was her lack of affect. Other than in the first interview, she exhibited few feelings and came across as consistently calm, understanding, and "nice". When I asked about other feelings she might have about people or events such as anger or fear, she admitted that she did not allow herself to feel these emotions. She confessed to experiencing anger and rage which she directed toward the children but she was not sure that the children themselves elicited those emotions, feeling instead that perhaps they came from some other source.

A second concern Heidi identified was that nobody, not even her husband, really "knows" her. She had contact with a number of people in her life through the church but she did not feel close to any of them since she revealed little of her self to them. I used the image of her "inside" self which nobody sees, and her "outside" self which she presents to the world. We agreed that some of her time in counselling might be spent getting to know that inside self better.

The third issue was Heidi's consistent lack of confidence in herself. She said that she could not recall ever feeling "ok" about herself as a person even as a child. In many ways she seemed childlike in her need for approval from others and experienced difficulty making decisions for herself.

Given my initial assessment, I talked with Heidi

about the difficulties of motherwork from a feminist perspective, mentioning the poor working conditions in the home, the lack of status ascribed to fulltime homemakers, and the neverending work. This was met with strong resistance. Heidi described a belief, heavily supported by the church, that mothers are supposed to be perfect, and that she knew many women who seemed like "saints" regarding their children. She felt that she simply needed to try harder. I found it difficult to "join" with her because of her well-developed exterior facade. She had let no one become close to her and possible did not know how. Yet when I asked her if she felt comfortable talking with me, she said "yes" and added that she had let me see more of her "inside" self than anybody but her husband. I encouraged her to ask me questions about myself and my beliefs in the hope that we could connect "woman to woman" rather than supporting her view of me as an expert who would provide all the answers she, the client, needed, or "play God" as she commented. This helped a little, although she tended to see me as a woman who had her life all figured out, balancing a child, husband, and career.

We discussed her relationship with her children at length. She spent her days on housework as a way of avoiding spending time with the children, particularly the two youngest ones who were home all day. She felt that she needed time away from them but could not allow herself to take advantage of available resources that would give

her a break from the children. She said she was usually impatient with them, but then described a number of occasions when she talked with them at length in a patient manner. She seemed more able to tolerate the children one at a time, which is not surprising, but all together they overwhelmed her with demands. Heidi's reaction seemed consistent with Jessie Bernard's (1974) description of motherwork as an "impossible job". However, it sounded as if she was handling her role much better than she perceived.

Somehow the counselling process seemed stuck. The problem seemed clear to me but somehow Heidi was invested in maintaining her belief that she could be a perfect mother; she denied that there were inherent difficulties in the work. This was complicated by the fact that she wanted to view me as a person with magic answers. I initially fell into this trap and provided her with a number of suggestions to help, all of which were rejected. I felt that there were pieces of the puzzle of Heidi's life that were missing and that needed to be uncovered before she could move on.

During our conversations, Heidi had frequently mentioned her mother in passing, and I realized that it was important to explore her childhood, particularly in light of her previous mention of physical abuse at the hands of her mother. She agreed to talk about her life as a child but stated that she had no memories before the age

of ten. "I only remember after I was 10, after my sister was born". Apparently she carried a great deal of responsibility for this child. Her father worked days and her mother worked fulltime nights. Heidi was responsible for the child care in the evenings while her mother slept. The parents believed in strict discipline, and Heidi was seldom allowed to go out and play with the other children. She was assigned a number of household duties including housecleaning, cooking, and babysitting. She recalls no overt affection from either parent, but a significant amount of physical abuse by her mother in the form of slapping and throwing things at her.

I shared my sense of her incredible loneliness and sadness regarding her childhood. In one session when I commented "There must be so much pain inside you", she burst into tears and sobbed uncontrollably for the entire hour. After the first session, she had not shown any overt emotion even though we had discussed many painful subjects. Her calm exterior was like a fortress behind which she hid her feelings. During this outpouring of emotion, Heidi was unable to talk or explain what was going on for her so I simply sat with her until she stopped. I felt that even though she was unable to express herself in words, she had let me see her cry. I interpreted that as some level of her trust in me and chose not to press for information.

Heidi recognized that she still carried a great

deal of unexpressed anger toward her mother for the abuse and lack of love she experienced as a child. At this point in her life, she had little contact with her mother. She had been afraid that she would treat her children the same way, but realized when we talked that she could make different choices about mothering and learn new ways of handling situations now that she was an adult. I gave her the book A Child is Crying on the Stairs by Nanette Cormier to help her see that she was not alone. This book vividly draws a portrait of child abuse and is a moving, thoughtful, and sensitive story of one woman's life. Gradually, Heidi began the process of mourning the childhood she had missed.

Since Heidi had seldom mentioned her father, I asked about him to see where he fit in the family. She described him in glowing terms as a very special person who was creative and bright. He read a great deal and played classical guitar. Yet, at other times she stated that he seemed to have had little involvement with the family, and early on in her life had been reported to drink heavily, have involvements with other women, and be out of work sporadically. He seldom talked with the children and Heidi remembers no indication from him of affection or interest in the children. When I pointed out these inconsistencies to Heidi, she denied my perception and reiterated that he was a wonderful man. She was currently trying to develop a closer relationship with her

father now that she was grown up, by visiting him when her mother was not at home.

The turning point in the counselling came in the tenth session. I had asked more questions about Heidi's early years and she seemed puzzled about my concern about her lack of memories. I asked more about what kinds of events she remembered after she was ten besides her mother's physical abuse. She related several anecdotes about Christmas and birthdays, and recalled feelings about these events, the people who were involved, and a number of details. I pointed out that most people have those kind of memories of their entire childhood. She asked what kinds of things make people forget, and I shared with her that sometimes people forget very traumatic events such as childhood sexual abuse, or repress painful memories as a means of coping with their lives. First she looked shocked, and then she became quite animated hoping that this might be perhaps the "magic answer" she had been looking for to explain so much of her life. I was unprepared for this reaction and commented that she should be careful not to jump to any conclusions at this point that she had in fact been sexually abused.

In the next session Heidi was quite upset. She had been thinking of nothing but sexual abuse since we last talked. She had been unable to sleep and found herself wondering, thinking, and trying to remember. She asked again what had drawn me to inquire about sexual

abuse and I listed the factors: the lack of memories, the idealized view of her father, her incredible anger at her mother, her childlike view of herself, and her inability to feel. We then discussed how the counselling should proceed in order to be helpful to her. At this point she wanted to try to remember and I agreed to help.

Heidi had already begun to remember several incidents of sleeping in the same bed as her father, and recalled one occasion when he touched her buttocks. At the time she remembered thinking he must have mistaken her for her mother. She recalled that she also seemed to "know" about sex even though she did not recall how she learned. Her husband had commented that she certainly seemed experienced sexually yet she had few sexual partners prior to becoming involved with him. She assumed from these recollections that the abuser was her father, and she found herself feeling incredibly furious with him. She had always found it difficult to look at family photographs, and had refused to keep any albums in her home because behind the happy smiles she saw only pain. At first she did not want anyone but me to know about this but after much discussion she decided to share this information with her husband.

I gave Heidi two books about childhood sexual abuse to read: Kiss Daddy Goodnight by Louise Armstrong, and I Never Told Anyone edited by Ellen Bass and Louise Thornton, and we discussed them together. Both

books are first person writings by women survivors of child sexual abuse. Heidi wrote down some thoughts she had as she read and they proved to be quite revealing. For example: her father told her not to ever get fat or no man would love her; there are certain parts of her sexual activities with her husband that make her feel sick; and she remembered a neighbor man who exposed himself to her when she was out playing in the yard. Using a feminist analysis of child sexual abuse, we talked about how the child is always innocent, and how secrecy can be so damaging. Even now she was afraid to talk to her parents about this feeling that her father would deny it and her mother would not believe her. She had several nightmares where she seemed to be observing a child being sexually molested by a man. In the first one she felt rooted to the spot, unable to help the child yet wanting to make the assault stop. In the second one she had felt sexually excited and was disgusted with herself when she awoke. I explained that although a child's body can respond sexually, that does not mean that she wanted the abuse.

After several sessions, I noticed how much more confident and open Heidi seemed. Somehow this exploring of sexual abuse had given her an explanation for so many of her insecure feelings. It had freed her from her childhood and allowed her to make the transition to adulthood. She had started seeing the world through "adult" eyes. In an encounter with her parents, she had

suddenly seen her father as a pathetic, older man, and her mother as a superficial, shallow person. This insight depressed her for several days but then she realized that it was more accurate than her previous view of her father as a knight in shining armour, and her mother as possessing an all-encompassing power over her. She began to view her husband differently and changed from referring to him as "dad" to using his name. It was as if she suddenly realized that she was a grown-up.

With her children, Heidi took charge and began acting more like the mother she wanted to be. Together we discussed some ways she could handle her irritation with them and she put some of these ideas into practice. Now, the whole idea that motherwork is difficult made sense to her and she had adjusted to being annoyed with the children sometimes. She recognized that mothering is hard work and that she was often exhausted. Heidi no longer saw herself as a victim who felt helpless and resentful about how badly she had been treated. She now saw herself as a survivor who could make her own decisions about her life. She stopped punishing herself for not being perfect and no longer punished her children for being underfoot.

Heidi had made a decision, influenced by her religious beliefs, to find a way to develop a better relationship with her parents. The family had for years had little to do with each other apart from Christmas and the children's birthdays. We devoted a number of sessions

to exploring ways she could accomplish this such as visiting her parents together or separately, asking them questions about her childhood, or telling them how she felt about what she remembered.

Assuming that the counselling would be a long term process given Heidi's dual aims of finding out more about her childhood and beginning to deal with her parents, I gave her the post-test measures and evaluation form to complete after 26 counselling sessions. However, after several sessions of talking about ways she could proceed it became clear that Heidi was not ready to work through either of these issues at this point in her life. She felt that she needed a break from counselling in order to consolidate her gains and decide whether she wanted to go further. While deciding that she had accomplished her initial goal of becoming a better mother, she did not want to pursue the abuse matter further at this time. Heidi had begun a process of self-exploration and understanding that would likely include further counselling at a future date. It was her choice to terminate now with the understanding that she was free to call me back when and if she wanted to resume this work.

C. EVALUATION

Through the counselling process, Heidi made significant gains in a number of areas. First, she was able to get in touch with her feelings. As a child, she

had learned not to express feelings and, more importantly, not to allow herself to feel them. With my encouragement and validation she had begun to recognize and accept a broader range of emotions within herself.

Second, she had begun to see herself as an adult. Our exploration of sexual abuse seemed particularly meaningful to Heidi. While at this point she had few memories of her early childhood, it seemed clear that something personally traumatic must have happened to her to give her a "victim" perspective on life. While many pieces of the puzzle remain missing, Heidi was able to do some mourning about her childhood and to move on emotionally to adulthood.

Third, Heidi felt less irritable toward her children. It was interesting that she became more positive toward her children through further knowledge about her own negative childhood. Her new perspective on herself as a separate person with unmet needs enabled her to see her own children more realistically. Heidi had enrolled in an evening school English class as a way to beginning to attend to her own needs for outside stimulation. A followup telephone call from the child welfare authorities revealed that they were no longer concerned about Heidi's potential abuse of her children and had closed the file.

Finally, the most significant change from the perspective of feminist counselling was Heidi's

realization that I was not an expert on her life. Our sessions together helped her experience a process of working together and a sharing of ideas with the ultimate responsibility for action remaining in her hands. She wryly commented that this counselling was more difficult than she had predicted because she had had to do the majority of the work, but on the other hand felt good about the progress she had made.

Heidi's post-test scores on the paper and pencil measures reflected these gains (see Table 6). While she was still quite isolated and lonely, she was now "moderately" depressed. She was no longer discouraged about the future, and did not expect to be punished. She had progressed from "hating herself" to being "disappointed in herself". She was less irritated with herself and more able to make decisions. On the negative side, she still did not sleep well and tired easily. She felt less attractive and had lost interest in sex completely. This was not surprising since her issues regarding sexuality had not been resolved. Her self-esteem score rose significantly indicating that generally she felt more positive about herself. Her score on the problems related to mothering decreased to "moderate", mostly in the areas indicating how she felt about herself as a parent; her workload and child care responsibilities had not decreased.

On her evaluation form, Heidi listed guilt,

self-esteem, and her relationship with her father as themes that were relevant for her. She reported depression, anger, and her relationship with her mother as the three main themes she worked on in counselling. Her depression she rates as "better", and the other two areas she reports as "worse". This was predictable since Heidi was now more aware of these issues but had not yet taken steps to deal with them. In her comments on helpful aspects of the service she stated "Having the counsellor continue to ask questions and encourage me to talk about my feelings even though I resist is of the greatest benefit to me. I believe deep down I would like to express all my feelings and this approach though it may be slow will be most effective".

TABLE 6

HEIDI'S ASSESSMENT MEASURES

	Pre-Test	Post-Test
Loneliness Scale	data incomplete	11
Beck Depression Inventory	26	15
Self-Esteem Scale	18	23.5
Problems Related to Mothering	27	22

CASE 4: NANCY'S STORY "I'm nothing without a man"

A. ASSESSMENT

Nancy was a petite 30 year old mother of three sons aged eight, six, and two, who had been separated from her husband, George for almost a year. This was the third separation in as many years for the couple but for Nancy this one was final. Nancy was studying Business Accounting fulltime at Success Business College and hoped to be finished her course within the next few months. She wanted to be eligible for a well-paying job so that she could support her family and be financially independent. She was currently subsisting on a student subsidy which she received as long as she was a student, sporadic maintenance payments from George, and occasional gifts of money from her mother.

I had seen Nancy before on several occasions over the past three years. The first time was during an reconciliation with George when I worked with the couple to try to make improvements in their relationship. The second time was last year during her second separation from George when I worked with her on beginning to make plans for her life as a single parent. Separating from George had been extremely difficult for Nancy for a number of reasons. First, she believed strongly in marriage and had tried throughout the marriage to be a "good" wife. Also, she came from a wealthy, traditional family in which her mother had been a fulltime homemaker during her entire

marriage, and her father had earned a great deal of money, allowing the family to have a live-in maid during the years the children were small. Nancy had wanted the same for herself hoping to be home fulltime when her children were young, and be supported by a husband. However, the man she married was not as ambitious as her father and as a consequence he had been periodically out of work. Thus, Nancy had at various points been employed in the labour force so that the family could eat. The last child had been an accidental pregnancy, the result of a brief reconciliation with George, and Nancy felt that she was not prepared to do paid work while the baby was still small. This was compounded by the fact that she had no specific career training and any job she found would likely pay little.

She had applied for social assistance shortly after she separated from George the second time soon after the baby was born, but found it to be a humiliating experience in addition to the fact that she was allowed barely enough money for the family to live on. This resulted in a second reconciliation with George who happened to be employed at the time. After six months, she separated again deciding that she could no longer tolerate his alcoholism, his verbal abuse, and several episodes of physical abuse. She had begun to make plans for herself and her children. Realizing that she needed further education, she had investigated several courses of action

and enrolled in her current training program. This of course necessitated making various arrangements regarding the children for the hours she would be away from home: the two older boys were registered in a lunch and after school program, and the youngest one was placed in a licensed day care centre fulltime.

At the point at which she recontacted me to resume counselling, Nancy was depressed, overwhelmed with motherwork, schoolwork, and housework, and most importantly, still unable to separate emotionally from George. Her pre-test measures indicated a high degree of loneliness, "moderate" depression, relatively high esteem, and "moderate" problems related to mothering. Table 7 summarizes her pre- and post-test scores. My initial assessment was that Nancy needed moral support, someone to talk to, and some reassurance during this difficult time. She sounded as if she was overloaded with responsibilities and quickly coming to the end of her own resources in terms of time and energy.

B. INTERVENTION

The first issue we discussed was Nancy's continuing attachment to George. She said that if she did not see or talk to him, she was able to put him out of her mind. The difficulties arose when she was face to face with him, for example on the occasions when he came to visit the children. Her feelings for him revived to the

point that on several occasions they had had sex and he had spent the night. Once she had thought she might be pregnant, and this helped her realize that continuing a sexual relationship with him was not healthy for her. She also began to face the fact that he had coerced her to have sex with him. His behaviour alternated between abusively trying to force her to do what he wanted, and acting helpless, knowing from past experience that she would feel sorry for him and give in to his wishes. Either way he was manipulating her and she resented it. Through our discussions, Nancy began to better understand the dynamics of this relationship. Initially she felt that she could not do anything about his continuing hold over her and a helplessness overwhelmed her. She felt that she loved him and responded with guilt to his accusations that she did not care about him. Gradually she began to see that she needed to try to act more assertively with him even though she felt guilty saying no to his demands.

This issue was complicated by two factors. The first had to do with money. Because Nancy was not yet able to support herself and her children adequately on her own, she badly needed George's child maintenance cheques. She believed that it was necessary for her to be "nice" to him in order to get the money from him. He had been refusing to pay claiming that he could not afford to. Nancy's lawyer had pursued the matter through the

Maintenance Enforcement Act but it had been a long involved process to get George's wages garnisheed. Even then his maintenance arrears of six months had been "forgiven". The garnishment did not help Nancy much because George regularly took time off work to go on drinking binges, and since he earned only commission, rather than a regular salary, his take home pay varied from month to month. She felt powerless to remedy this situation. She also fluctuated between feeling resentful and bitter at his apparent freedom from responsibilities, and relief that she was no longer living with him.

The second factor keeping Nancy emotionally attached to George was his relationship with the children. Nancy had felt that it was crucial for the children to see their father regularly. However, this was another area where George's behaviour was erratic. When he first separated from Nancy, he had gone to stay with his sister. Then he shared an apartment with two other men before moving to a place of his own. Recently he had been evicted from his apartment and currently had no fixed address. This allowed him to refuse to take the children for any length of time and certainly not overnight or for a weekend. He also claimed that he could not afford to take them out so proposed that he visit them at Nancy's house. This was a dilemma for Nancy. She wanted the children to see their father but she preferred to have nothing to do with George. She was annoyed that she was

not able to have a break from the children, but at the same time refused to leave her home when he came. Thus she had to see him. It became clear early on that George had little interest in the children, and that he used the visits to either attack Nancy for having ruined his life, or to try to wheedle himself back into her good graces. If Nancy refused to talk with him, he would stop calling the children or visiting for weeks on end.

Nancy believed that children need their father, no matter how he behaved toward them, and she would sometimes phone George begging him to come and see his children. We discussed this issue at length and Nancy gradually came to the conclusion that George's uncaring attitude was likely not beneficial to the children and in fact might be harmful to them in the long run. She decided to stop asking him to visit and leave the responsibility up to him. She hoped that the children would understand and felt they might since he had broken many promises to them regarding visits. In fact, her oldest son had said, "Please don't make us phone daddy any more. He never comes to see us when he says he will."

Nancy was finally able to see how she was helping George maintain his hold over her, and while it was very difficult for her, she decided to stop trying to be responsible for his behaviour. She still cared about him at some level and felt sorry for him because he seemed to be making a mess of his life. However, she also realized

that she had spent eight years of her life trying to assist him in improving his life, and it had not helped. She began to accept the fact that she could not make life better for him and that if he was going to change, he would need to make that decision for himself. It was painful for Nancy to let go of her dream of a happy family but she also knew that she had to begin taking care of her own needs.

The second major issue Nancy wanted help with in counselling was dealing with her motherwork. Now that she was a full time student, she felt guilty that she no longer had the time or energy to spend with her children. She found herself losing her temper with them and raising her voice. This behaviour was new for her and she was distressed by it. I pointed out to her that her life at this point was extremely full and that expecting herself to always remain calm and patient might not be realistic. Coincidentally she had read a book about "supermoms" and saw herself in the description. Through her reading and our discussions, she gained a broader perspective and no longer felt as guilty. She acknowledged that she was in a difficult position with the burden of the responsibility of the children on her shoulders, while at the same time trying to plan a career for herself. She finally began to allow herself to be less than "perfect".

One of the themes of Nancy's life was her dependence on men for her identity. She desperately

wanted to have a "special" man in her life. She had few women friends and described women as "boring" while men were more "interesting". She was convinced that if she could find the right man he would fulfill all her needs for companionship, sex, and a social life, and she would then be happy. She believed that "a husband should be your best friend", as well as an equal partner in parenting and household responsibilities, and that George had simply been a poor choice. Like most women, Nancy believed that men would be nicer if she chose the "right" one, rather than facing the reality of all men's power over women. When I tried to discuss this in terms of sex-role stereotyping and learned expectations, she became almost hostile, implying that there must be something wrong with me if I did not feel the same way.

Part of this attitude was a result of her great admiration for her father who taught her that money is power and only men get rich. Nancy had no sympathy for her mother who had been dominated by this man for twenty years before being rejected for a younger woman. She did not like her mother, and like most women was terrified of being like her but was unable to acknowledge this fear. Nancy had married George hoping that he would provide her with the kind of life she was accustomed to. In fact, George was very much like her father in that he was an alcoholic, domineering, and abusive to women. It took some time for Nancy to see the similarities and even then

she denied the negative aspects of their commonalities. I felt frustrated at her admiration of male power gained at the expense of women. However, Nancy had begun reading several books about women's issues as part of her coursework and finally began to see the commonalities men share in terms of power, and the oppression experienced by all women. She was not yet able to see the value in relationships with women but at least she began to identify herself with women as a whole.

This devaluing of women was also evident in her relationship with me. She liked to think of me as a "friend" although the friendship was one-sided; she talked, and I listened. She seemed reluctant to involve herself in the counselling process. I attempted to deal with this issue but was unable to resolve it. I also was not sure if it was my being a woman that she did not take seriously, or the fact that I was a social worker whom she seemed to consider as less knowledgable than a psychologist or psychiatrist. At the same time, she continued to come to counselling sessions. The turning point came after a visit to her family doctor that resulted in a referral to a psychiatrist. Nancy met with the male psychiatrist and became very frightened in the session. He had used professional jargon and hinted that therapy was a mysterious and secret process. Nancy realized at that point that she would rather talk to a woman and decided to take her counselling more seriously.

She began to open up more and risked sharing painful feelings with me.

A number of other issues were touched on but not dealt with in depth. Nancy revealed that she was concerned that she might have a drinking problem but she was not prepared to deal with it at this time. She had a number of unresolved issues with her father that had surfaced through her separation and more recently as a result of his recent life-threatening illness. She also felt confused about her relationship with her mother whom she had always thought of as a helpless, passive woman but who had proved to be very helpful and supportive to Nancy during her separation.

After 11 sessions, we terminated the counselling, partly because Nancy had finished her schooling and was actively looking for work, and also because she felt much more resolved about her separation and was less concerned about her behaviour toward her children. A followup telephone call several months later revealed that Nancy had indeed found a position and was involved in trying to establish a more regular routine with her family. While she was exhausted with adjusting to the new job, she was ecstatic about the direction her life was taking. She thanked me profusely for being supportive to her during a difficult time in her time, and agreed to call me back if the need arose.

C. EVALUATION

Nancy made a great deal of progress in her life through the counselling process. In particular, she seems to have come to terms with her separation from George. She was behaving assertively toward George when it was necessary for her to speak with him, and she was no longer as concerned about his future. She felt calmer about her behaviour toward her children believing that when her life became less stressful, she would handle them better. She was no longer desperate to find a new man. She felt in control of her own life and enjoyed this personal power. Overall, Nancy seemed to see herself as a competent individual. She felt more independent, and was quite confident that she could provide a good life for her children.

Her post-test scores reflected this positive attitude (see Table 7). Her loneliness score dropped one point, her depression score dropped substantially to within the "normal" range, and her self-esteem score rose. The problems related to mothering score became "moderate" and were fewer particularly in the areas relating to concerns about her husband's involvement in the family. His lack of attention ceased to be of major importance to her. Although she was experiencing "an additional amount of work", she was feeling "less pressured by the responsibilities of parenting".

On her evaluation form, Nancy indicated that

guilt, dependence, fear, assertiveness, personal power, relationships with men, and relationships with women were themes that were relevant to her. She reported that marriage, independence, and depression were the three major themes she worked on in counselling. Unfortunately, I had neglected to list "separation" as a theme on the form but I assume that when she refers to marriage she includes feelings about her separation. She described changes in marriage as "much better", independence as "better", and depression as "better". Interestingly, she indicated that it was important for her to speak to another woman, and that her awareness of issues concerning women had increased a great deal. Her final comment was that "the best thing I ever did was seek counselling".

TABLE 7

NANCY'S ASSESSMENT MEASURES

	Pre-Test	Post-Test
Loneliness Scale	13	12
Beck Depression Inventory	14	3
Self-Esteem	25	31
Problems Related to Mothering	21	13

Chapter 4. EVALUATION

The evaluation procedures selected for this practicum involved three major strategies. The first was the individual verbal consumer evaluation of the service usually shared in each woman's last few counselling sessions, as well as informally throughout the counselling process. Illustrations of this are shown in the preceding four case examples.

The second strategy to measure the effectiveness of the feminist counselling approach was the pre- and post-test assessment measures described in Chapter 2. To recap, these were: UCLA Loneliness Scale, Beck Depression Inventory, Self-Esteem Scale, and Problems Related to Mothering Scale. There was also a Support Systems Questionnaire which was administered pre- and post- for clinical purposes as well but which will not be used to measure effectiveness of the counselling service. These pencil and paper forms were administered pre-test either at the end of the first interview or prior to the second interview for each of the nine women. As assessment measures in the pre-test phase, the forms were designed to help identify primary areas of concern to each woman in order that I could plan how best to intervene.

The five scales were administered post-test to six of the women approximately one month after they had terminated counselling, and for the remaining three women

who were continuing counselling beyond the paramenters of this practicum, the forms were given in December of 1985 so that I could use their interim results as part of the total evaluation of this practicum. As evaluation tools in the post-test phase, the forms could be used to help measure the changes that had occurred through counselling in these specific areas both for each woman individually and for the group as a whole.

The third approach to evaluation of the practicum involved the use of a consumer feedback form developed in conjunction with my advisor that was designed to measure the usefulness of the feminist approach. It asked questions more specifically related to issues of concern to women. The questionnaire was accompanied by an explanatory letter and given or mailed to the nine women at the same time as the post-test measures. The letter and questionnaire are reproduced in Appendix F.

The results of the latter two evaluation tools will be discussed in detail in the remainder of this Chapter.

THE POST-TEST MEASURES

The post-test measures were given or mailed to all nine of the women, but only seven completed sets of scales were returned. Since one of these seven was the woman whose pre-test forms I had misplaced, there are pre- and post-test comparisons for a total of six women. The

results of the four scales pre- and post- are summarized in Table 8.

TABLE 8

PRE-TEST AND POST-TEST SCORES FOR 6 WOMEN IN COUNSELLING

UCLA LONELINESS SCALE *	PRE	POST	BECK DEPRESSION INVENTORY	PRE	POST
0 - 4	0	0	Under 10 (normal)	1	3
5 - 8	2	2	10 - 16 (moderate)	2	1
9 - 12	2	3	17 & over (severe)	3	2
13 - 16	1	0		$\bar{X}$=19.8	$\bar{X}$=14.8
	$\bar{X}$=9.3	$\bar{X}$=9.1			

SELF-ESTEEM SCALE	PRE	POST	PROBLEMS RELATED TO MOTHERING	PRE	POST
0 - 10	0	0	0 - 11.5 (slight)	0	1
11 - 20	2	1	12 - 22.5 (moderate)	2	3
21 - 30	3	2	23 - 33.5 (extensive)	3	1
31 - 40	1	3	34 & over (severe)	1	1
	$\bar{X}$=24.5	$\bar{X}$=27.4		$\bar{X}$=28.1	$\bar{X}$=22.1

* one score was incomplete on the pre-test so is omitted.

Regarding the UCLA Loneliness Scale, four women had scores reflecting less loneliness, and one was more

lonely. Of the four scales used, the least improvement occurred in the area of loneliness. My hypothesis is that talking to one woman, a counsellor, does not significantly decrease a woman's loneliness. As part of the counselling intervention, I encouraged all the women to develop more relationships with other women; however, it was not always possible given the circumstances of various women's lives, and not all the women came to fully appreciate the value of relationships with women. Groups could be a more effective way of helping women reduce their feelings of isolation, and as will be seen in the next section regarding the evaluation feedback form, all of the women expressed some interest in group sessions. The woman who reported more loneliness was in fact in a group but apparently this experience did not help her feel less isolated. It may be that her loneliness increased as she became more aware of her feelings of isolation.

On the other three scales, five of the six women showed improvement and one showed deterioration. This woman was continuing in ongoing counselling. She was a non-custodial parent in the process of attempting to regain custody of her children from her ex-husband, and was feeling quite distressed during the time that she completed the forms. She also had two of her children visiting during this period thus accounting for her increased perception of problems with mothering.

Looking at the women as a group, their average

scores on all four scales improved, with the most dramatic changes occuring in the Beck Depression Inventory and the Problems Related to Mothering Scale. It is not possible to attribute the positive changes solely to the feminist counselling approach, but it does appear that the process of counselling itself helped most of these women experience fewer symptoms of depression, feel more positive about their self-worth, and perceive fewer problems in their mothering role.

The paper and pencil measures gave me useful clinical information in the assessment phase of counselling in terms of pinpointing specific areas of concern for each woman. The scales gave validity to the women's feelings and perceptions of their lives. In particular, the use of a scale detailing the problems related to mothering reinforced the reality of mothering as serious work with difficulties inherent in the role of mother. In my future practice, I would be inclined to use some assessment measures with the women I see, especially the Beck Depression Inventory and the Problems Related to Mothering Scale because of their specific nature.

THE CONSUMER FEEDBACK FORM

As mentioned before, the third evaluation strategy was a consumer feedback form accompanied by an explanatory letter (see Appendix F) given or mailed to the nine women seen in counselling. Seven of the nine women returned the

forms, answering all of the questions. The seven completed forms can be found in Appendix G. The form asked a number of questions designed to give information about the value of the feminist counselling approach to these women. The most important findings arising from the form are summarized below with the numbers corresponding to the question number on the form. The results are compiled from the information given by the group of women.

1. When asked how important it was to have a woman counsellor, all seven women indicated that it was important for them to talk with another woman. This was an unexpected, although hoped for, response. None of the women had requested a female counsellor, although it is possible that they were not aware that they could make such a request. This response indicates to me that the women felt more comfortable talking about their feelings and lives to another woman.

2. A number of themes that are often important to women in counselling were listed and the women were asked to circle the ones that were relevant for them. Table 9 summarizes the frequency of themes that were relevant to seven of the women seen.

TABLE 9

FREQUENCY OF THEMES RELEVANT TO 7 WOMEN

Theme	Frequency
guilt	7
depression	5
anger	5
assertiveness	5
self-esteem	5
violence	4
fear	4
relationship with mother	4
sexuality	3
independence	3
relationship with father	3
relationships with men	3
dependence	3
personal power	3
body image	2
mothering	2
helplessness	2
marriage	2
relationships with women	2

As can been seen by the Table, all seven of the women circled "guilt" as an issue that was important for them in counselling. Five women circled both "depression"

and "self-esteem". It seems clear that women are quite aware of the negative feelings they have about their lives. What is unclear is the extent to which they are able to link those feelings to the social conditions of life that women experience. Two separate women circled "marriage" and "mothering", and three circled "relationships with men". I assume from this that some women make the connection between their guilt, depression, and low self-esteem and the societal institutions of marriage and motherhood.

"Anger" was circled as a relevant issue by five women. Since only one of the women had begun the counselling process verbalizing anger, this indicates an emerging awareness. A significant proportion of the women became more aware of anger in their lives and began to acknowledge it as relevant.

"Assertiveness" and "self-esteem" were also circled by five women. It seems that these are two themes that women are familiar with and feel they need to improve in. My concern is that these areas seen in isolation from the political context of women's lives can end up being simply one more task they feel they need to take on to add to their list of "shoulds" and to relieve their "guilt".

"Violence" was circled by four of the five women who had been physically abused by their partners (one did not return the forms), and three of those women also circled "fear". Of the four women, three had been

separated from their abusive spouses for various lengths of time ranging from six months to eighteen months. The fact that violence and fear are still issues for these women confirms the literature findings that wife abuse has long term effects on victims.

Four of the women circled "relationship with mother" as an issue for them. The women usually had intense and ambivalent feelings about their mothers. Few had come to terms with their relationships with their mothers, and often had unfinished business in this area. The women were usually either trying to create a better relationship with their mothers, one that was more honest and open as between two adult women, while others were trying to separate emotionally and put some distance between themselves and their mothers. Unfortunately, few appeared to see their mothers as victimized by the same institutions of marriage and motherhood as they themselves were.

Three of the women also circled "relationship with father" as an important issue. In one case, the woman had, through the counselling, begun to suspect her father had sexually abused her as a child, while the other two felt rejected by their fathers and were concerned about this.

The more "standard" women's issues of day care, discrimination, women's cycles, sexual assault, employment, health problems, and money were circled only

once by a variety of women, although a number of them had been discussed in the counselling sessions. These are more task-oriented problem areas than the feeling issues normally dealt with in counselling. My sense was that these women felt that little could be done about the more practical issues in their lives through counselling, and I tend to agree. Other than attempting to understand these issues from a feminist perspective, and providing information about resources where available, major social change is required to help women alleviate problems in these areas.

A result that I found surprising was that none of the women circled "childbirth", "pregnancy", or "birth control" as relevant issues for them in counselling, yet a number of these had appeared in counselling sessions. The one woman who was pregnant during the counselling did not return the forms. For example, several of the women had talked about their pregnancy and childbirth experiences and how these had affected their lives, and several women had discussed birth control and decisions to have tubal ligations as a permanent form of birth control. Like marriage and mothering, it seems that women find it difficult to realize the impact that their reproductive capabilities have on the course of their lives.

3. When asked to list the three main themes that they worked on in counselling, depression, guilt, anger,

violence, fear, and self-esteem were the ones most often mentioned. This is consistent with the themes detailed in the preceding literature review. Four women reported depression as a major area of work in counselling. Of these, two reported that their depression was "better", and two reported it as being "the same".

Three women listed guilt as a major area they had worked on in counselling. One reported feeling "much better", one "better", and the third "the same".

Anger was listed by three women. Two reported it as "the same", and the third as "worse". This seems to indicate a distressing belief that anger is "bad" if it exists and that only by making it go away would it be considered "much better". However, in the case of the woman who defined her anger as "worse", she had learned through counselling that she had possibly been sexually abused as a child, and was much more angry generally at discovering that this had happened to her. At the point at which she completed the evaluation form she had begun to acknowledge this anger, and I suspect that her overwhelming rage frightened her and caused her to feel that she had a great deal more work to do before she could use this anger constructively in her life. One of the women who reported her anger as "the same" had begun counselling feeling a generalized anger at the world, and was unable for a number of reasons to understand these feelings. The last woman who also reported her anger as

"the same" had separated from her partner during counselling, and while this separation seemed like a positive move for her, it also entailed moving in with her parents with two children ages one and three. She was employed fulltime and was receiving no financial support from the children's father. She was angry about this situation but felt helpless at the moment to change it.

Two women listed violence as a major area they had worked on in counselling. One of these felt "much better" since she had during counselling left her abusive husband after sixteen years of marriage. The other reported her amount of change in the area of violence as "the same". This woman had separated from an abusive partner approximately eight months previous but was receiving threatening phone calls from him and was afraid for her life. Fear was also listed by these two women. One reported it as "much better" and the other "the same".

Self-esteem was mentioned by two women, and both felt it was "better". Several other issues were listed only once each: relationship with mother - "worse", body image - "the same", marriage - "much better", independence - "better", and assertiveness - "better".

In summary, of the 21 issues worked on, none were reported as "much worse", two were "worse", eight were "the same", seven were "better", and four were "much better". Overall, there appears to have been a great deal of improvement in a number of areas.

4. When asked to what extent they became more aware of issues concerning women, two women reported that their awareness "did not increase", one said that she "became somewhat more aware", two responded at a point on the scale between becoming "somewhat more aware" and awareness increasing "a great deal", and two reported that their "awareness increased a great deal". Since five out of seven did develop some increased awareness about women's issues, this suggests that counselling can be a political process as we understand our membership in an oppressed group, and the commonality and interdependence of our themes. For the two women whose awareness did not increase, they were seen only five and eight times respectively. Perhaps that is too short a time to effectively help women become aware of issues that affect all women.

5. When asked if they would have been interested in group meetings as part of their counselling, four women said "yes", and three said "maybe". None of them said "no". Some of the comments were: "I would have enjoyed it so that I knew I was not the only one in my situation"; "I think it would have been beneficial"; "I would have been interested to hear what they would have to say and discuss". One woman who did in fact participate in a group for abused women during her individual counselling

and noted that: "The group therapy helped. It helped me know we are not the crazy ones and we're not alone." These responses suggest that Family Services should incorporate more group services for women in their program development planning.

6. When asked whether they would recommend the kind of help they received to other women with similar problems, six of the women said "yes", and one said "maybe". Several of the comments were: "The best thing I ever did was seek counselling"; and "It helps to talk about problems".

7. In the area of the form allowed for comments, six of the seven women filled in their thoughts. Most of the comments expressed appreciation for the opportunity "to talk about problems and realize that other women have and will go through the same as you", and "being able to speak with someone I can identify with". One woman felt that "the availability of my counsellor when I was in need of talking" was important. Others focused more on the counselling process. "Individual therapy has helped me to open up, instead of holding it all inside"; "having the counsellor continue to ask questions and encourage me to talk about my feelings even though I resist is of the greatest benefit for me"; and "I started to be aware of my feelings because I would make an effort to talk about the

problems I was having rather than pushing them aside".

Overall, I felt that I had in some ways been able to equalize the counsellor-client relationship. It seems clear that all the women appreciated speaking with another woman and most of them began to recognize the commonalities shared by all women. Most also verbally reported that they were able to be honest and open with me because as a woman they felt that I would understand what they were going through. The area where gains seem unclear is in the "personal is political". Although the women began to accept themselves as part of a "community of women" and identify areas of personal power, it is difficult to assess the extent to which they understood and accepted the reality of the societal oppression of women.

SUMMARY AND CONCLUSIONS

The themes described in the four case illustrations: "I must be stupid", "I'm angry with everyone", "I am afraid I will hurt my kids", and "I'm nothing without a man" represent issues that often surface in counselling work with women. The importance of relationships is evident in these themes, as is the negative impact of defining self only through relationships with others. The women I saw were all at a similar point in their life cycle: a time of high demands with young children, and ambivalence about their need for a male partner with whom to share their lives.

The most overriding characteristic in the women I saw was guilt. They felt guilty about not being good enough wives, mothers, workers, and people. Many were coping with both instrumental and affective roles, struggling to achieve some kind of balance. This theme of balance repeated itself in relation to self and others, work, and family. As well, finding a comfortable spot on the continuum of dependence, independence, and interdependence was also important.

For women, the impact of intimate relationships with men is great. Raised to be nurturers and believing in the importance of connectedness, most women place a high value on marital relationships, and our sense of self-worth is tied up with whether we are successes or failures in these relationships. For many women, sexual

relationships are pivotal to self-esteem as relationships with friends are not. As well, violence at the hands of a chosen intimate is particularly shattering. Women often end relationships when over the long haul those relationships hurt them more than help them. No matter when or how a marriage breaks up, separation can be devastating because of the feelings of failure and loss it typically calls up. Many of the women I saw were either separated or contemplating separation and initially reflected those feelings of failure, inadequacy, and guilt. However, as they began to take their own needs more seriously, many of them were able to come to terms with the endings of these relationships and value themselves as individuals, and women, more highly.

As well, mothering is sorely devalued in our society. The use of the problems related to mothering scale implied that it was "real work" and helped the women recognize the ambivalence inherent in motherwork, and of the "anger and tenderness" (Rich, 1977) involved in the mother role. This made it possible to address the guilt most of the mothers experienced because mothers are supposed to be self-sacrificing and many women cannot live out that dictum. Mothering is often less than fulfilling for women because even though the potential pleasures are great, in our society, so are the costs of lost freedom, leisure time, isolation and feelings of entrapment. Yet many women still try to fullfill the societal image of a

mother.

Women's work - both paid work in the labour market or our unpaid work in the home - occupies a substantial portion of our time. It shapes us, defines, us, and gives meaning and purpose to our lives. However, the load that women carry in terms of responsibility is overwhelming and can lead to feelings of depression and guilt. Assisting women to understand the way women's work is devalued by society often helped the women I saw redefine work for themselves.

The feminist counselling approach helps women see themselves through their own eyes rather than through male eyes, and help us to understand and value ourselves in our own terms. Feeling good about oneself has to do with empowerment. I believe that women are depressed in part because they cannot get angry. As they begin to develop a sense of their capacity to feel and express anger, women can start to gain a sense of their own personal power as individuals and as members of a community of women. The women I saw began to stop suffering when they realized that their symptoms of depression and low self-esteem were parts of themselves that arose for very good reasons. As they began to realize that they were not "crazy" and began to understand themselves in relation to the society in which they live, they were able to turn weaknesses into strengths and begin to experience a sense of personal power.

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PERSONAL COMMENTS

This practicum was intended to be an opportunity to develop skills in feminist counselling and it presented many challenges in that regard. I enjoyed doing this practicum and learned a great deal about women's lives and about helping women. One of the major results for me is a belief that feminist counselling is indeed an effective approach to working with women. It is not simply a series of counselling techniques and procedures but is a way of viewing women, and focusing on areas of women's lives that are important to explore, such as marriage, motherwork, and violence against women. This confirms the information I found in the literature review.

I gained confidence in the counselling skills I already possessed, and realized that I am capable of engaging in the counselling process with most women, and that I follow through the various phases of assessment, contracting, intervention, termination, and evaluation. I did make some discoveries about the nature of counselling itself. I had previously been using a humanistic value base, focusing on the "here and now", and engaging in short-term, task-oriented problem-solving. I now proceed at a much slower pace, defined primarily by the women and am less concerned with specific contracting goals. I appreciate more fully women's isolation and their need to simply talk to someone who can understand. I see counselling less as a linear process but more as weaving

of themes in and out of women's lives. Through the course of the practicum, I have come to realize that women often need to spend more time exploring their pasts, particularly their childhood experiences, because the patterns of the past are threads which may help women find their way into the present.

I became more comfortable helping women talk about the pain and sorrow in their lives as well as the joys, and helping them accept these emotions as part of who they are. I had previously shied away from such explorations feeling helpless myself about events that could not be changed or improved. I also became more able to help women identify and express their anger, and understand the value of acknowledging anger as a valid emotion. While many women were afraid of admitting to their anger because it was so unfamiliar to them, I tried to help them expand the range of emotions considered appropriate for females, which tends to restrict us only to sadness, fear, neediness, and despair.

During the course of the practicum, I came to a deeper understanding of the meaning of the feminist counselling approach. I value women and believe in our ability to learn and grow, and felt that I was able to communicate that in many ways to the women I saw. I enjoyed the process of therapy as a cooperative effort and encouraged the women to ask question of me as I did of them. I encouraged them to share their thoughts and

feelings about the work we were doing together and often we defined the process of therapy together. Carol Gilligan's book In A Different Voice had a tremendously positive impact on me and I began to emphasize the special value of women's traditional strengths of caregiving, nurturing, relatedness, and warmth with the women I saw. I now believe that rather than simply fighting against the male system of patriarchy defensively, women will gain more power in society by increasing the value we place on ourselves and relationships with other women. As part of this, I tried to help women achieve some kind of balance between the energy they invested in relationships as well as a consideration of their own needs as individuals.

There were also frustrations involved in this practicum. I often became frustrated at some of the women's devaluing of women, both themselves and relationships with women until I realized how ingrained our internal oppression is, and how many years it took me to begin to appreciate the importance of relationships with women. Taking ourselves seriously is difficult to accomplish in a world dominated by male values and male experience.

A second frustration is related to how cemented women often are in the traditional way of thinking about life. I found that in trying to link the personal and political, I sometimes commented on the political aspects of women's oppression too quickly for some women and they

felt that I did not understand or appreciate their personal situations. One woman said, "It doesn't help me at this point to know that other women feel the same way. I need to know what to do about my own life." The issue of timing is one I will continue to work on. I need to remember to pay attention to the fact that women are often comfortable with the familiar and afraid of change.

Another frustration I experienced was the sporadic nature of the counselling with many of the women I saw. Many of them found it difficult to attend counselling sessions regularly. Some had problems with babysitters, finances, time, husbands who disapproved, summer holidays, and health. I tried to be flexible with my time; the agency has facilities for children to play in; and money is available for such things as transportation and babysitting. However, for some women, the realities of their lives made it difficult for them to use my services as regularly as I might have wished. I also believe that part of this was related to the fact that women have difficultly taking time for themselves, and their own needs.

In conclusion, this practicum represents a personal journey for me, through trial and error, in understanding that the power of femininity as a source of nurturance, love, and connectedness to others can be used to further our interests as women. I believe that "the potential for therapy to be a means to changing a woman's

consciousness in a way that furthers the transformation of society to meet women's - and human - needs has yet to be fully explored" (Miriam Greenspan, 1983, p. xxv). I hope that this practicum will be considered a contribution to this task.

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APPENDICES

APPENDIX A

Loneliness Scale

Following are four statements concerning your feelings. Please circle how often you feel the way described in each statement—never, rarely, sometimes, or often.

	Never	Rarely	Sometimes	Often
I feel in tune with the people around me.	1	2	3	4
People are around me, but not with me.	1	2	3	4
I can find companionship when I want it.	1	2	3	4
No one really knows me well.	1	2	3	4

Name ______________________ Date ______________

APPENDIX B

BECK INVENTORY

Name ______________________________ Date ______________

On this questionnaire are groups of statements. Please read each group of statements carefully. Then pick out the one statement in each group which best describes the way you have been feeling the PAST WEEK, INCLUDING TODAY! Circle the number beside the statement you picked. Be sure to read all the statements in each group before making your choice.

1
0 I do not feel sad.
1 I feel sad.
2 I am sad all the time and I can't snap out of it.
3 I am so sad or unhappy that I can't stand it.

2
0 I am not particularly discouraged about the future.
1 I feel discouraged about the future.
2 I feel I have nothing to look forward to.
3 I feel that the future is hopeless and that things cannot improve.

3
0 I do not feel like a failure.
1 I feel I have failed more than the average person.
2 As I look back on my life, all I can see is a lot of failures.
3 I feel I am a complete failure as a person.

4
0 I get as much satisfaction out of things as I used to.
1 I don't enjoy things the way I used to.
2 I don't get real satisfaction out of anything anymore.
3 I am dissatisfied or bored with everything.

5
0 I don't feel particularly guilty.
1 I feel guilty a good part of the time.
2 I feel quite guilty most of the time.
3 I feel guilty all of the time.

6
0 I don't feel I am being punished.
1 I feel I may be punished.
2 I expect to be punished.
3 I feel I am being punished.

7
0 I don't feel disappointed in myself.
1 I am disappointed in myself.
2 I am disgusted with myself.
3 I hate myself.

8
0 I don't feel I am any worse than anybody else.
1 I am critical of myself for my weaknesses or mistakes.
2 I blame myself all the time for my faults.
3 I blame myself for everything bad that happens.

9
0 I don't have any thoughts of killing myself.
1 I have thoughts of killing myself, but I would not carry them out.
2 I would like to kill myself.
3 I would kill myself if I had the chance.

10
0 I don't cry any more than usual.
1 I cry more now than I used to.
2 I cry all the time now.
3 I used to be able to cry, but now I can't cry even though I want to.

11
0 I am no more irritated now than I ever am.
1 I get annoyed or irritated more easily than I used to.
2 I feel irritated all the time now.
3 I don't get irritated at all by the things that used to irritate me.

12
0 I have not lost interest in other people.
1 I am less interested in other people than I used to be.
2 I have lost most of my interest in other people.
3 I have lost all of my interest in other people.

13
0 I make decisions about as well as I ever could.
1 I put off making decisions more than I used to.
2 I have greater difficulty in making decisions than before.
3 I can't make decisions at all anymore.

14
0 I don't feel I look any worse than I used to.
1 I am worried that I am looking old or unattractive.
2 I feel that there are permanent changes in my appearance that make me look unattractive.
3 I believe that I look ugly.

15
0 I can work about as well as before.
1 It takes an extra effort to get started at doing something.
2 I have put push myself very hard to do anything.
3 I can't do any work at all.

16
0 I can sleep as well as usual.
1 I don't sleep as well as I used to.
2 I wake up 1-2 hours earlier than usual and find it hard to get back to sleep.
3 I wake up several hours earlier than I used to and cannot get back to sleep.

17
0 I don't get more tired than usual.
1 I get tired more easily than I used to.
2 I get tired from doing almost anything.
3 I am too tired to do anything.

18
0 My appetite is no worse than usual.
1 My appetite is not as good as it used to be.
2 My appetite is much worse now.
3 I have no appetite at all anymore.

19 0 I haven't lost much weight, if any, lately.
1 I have lost more than 5 pounds.
2 I have lost more than 10 pounds.
3 I have lost more than 15 pounds.

I am purposely trying to lose weight by eating less. Yes _____ No _____

20 0 I am no more worried about my health than usual.
1 I am worried about physical problems such as aches and pains; or upset stomach; or constipation.
2 I am very worried about physical problems and it's hard to think of much else.
3 I am so worried about my physical problems that I cannot think about anything else.

21 0 I have not noticed any recent change in my interest in sex.
1 I am less interested in sex than I used to be.
2 I am much less interested in sex now.
3 I have lost interest in sex completely.

APPENDIX C

Self-Esteem Scale

Please indicate whether you agree or disagree with the following statements:

	Strongly Agree	Agree	Disagree	Strongly Disagree
I feel that I'm a person of worth, at least on an equal basis with others.	1	2	3	4
I feel that I have a number of good qualities.	1	2	3	4
All in all, I am inclined to feel that I am a failure.	1	2	3	4
I am able to do things as well as most other people.	1	2	3	4
I feel I do not have much to be proud of.	1	2	3	4
I take a positive attitude toward myself.	1	2	3	4
On the whole, I am satisfied with myself.	1	2	3	4
I wish I could have more respect for myself.	1	2	3	4
I certainly feel useless at times.	1	2	3	4
At times I think I am no good at all.	1	2	3	4

Name ______________________________ Date ____________________

APPENDIX D

PROBLEMS RELATED TO MOTHERING

Below is a list of stresses many parents experience. Which of these have been of concern to you in the past 12 months?

		not at all	some-what	very much
1.	increased money problems	0	1	2
2.	feeling "edgy" or emotionally upset	0	1	2
3.	additional amount of work	0	1	2
4.	physical tiredness and fatigue	0	1	2
5.	having to change plans I/we had before the child/children's birth	0	1	2
6.	interruption of routine habits of sleeping, going places, etc.	0	1	2
7.	housekeeping not as neat as it should be	0	1	2
8.	decreased contact with friends	0	1	2
9.	feeling pressured by the responsibilities of parenting	0	1	2
10.	interference from in-laws	0	1	2
11.	decreased sexual responsiveness of myself	0	1	2
12.	worry about personal appearance in general	0	1	2
13.	worry about "loss of figure"	0	1	2
14.	doubting my worth as a parent	0	1	2
15.	feeling more "distant" from my husband	0	1	2
16.	meals being off schedule	0	1	2
17.	reduced feelings of privacy	0	1	2
18.	disturbed about feelings I have towards the child or children	0	1	2
19.	my husband showing too much attention to the child or children	0	1	2
20.	my husband showing too little attention to the child or children	0	1	2
21.	my husband showing too little attention to me and too much to the child or children	0	1	2
22.	being unable to sleep after going to bed	0	1	2
23.	feeling I am stagnating as a person	0	1	2
24.	concerned about slipping behind in my career	0	1	2
25.	feeling out of touch with old friends even when we do get together	0	1	2
26.	feeling tied down or burdened	0	1	2
27.	concerned about increased arguments with my husband	0	1	2
28.	feeling I do not have enough personal leisure time	0	1	2

NAME

DATE

APPENDIX E

SUPPORT SYSTEMS QUESTIONNAIRE

The following questions ask you to desribe your life as you now see it. Circle the best answer to each question.

1. Are there adults you know whom you could call upon for help if you really needed it?

YES	NO	NOT SURE
1	2	3

2. If you had to leave town quickly, is there someone whom you would trust to look after your child(ren)?

YES	NO	NOT SURE
1	2	3

3. Have you engaged in a social activity with other adults outside your home in the last:

24 HOURS	WEEK	MONTH
1	2	3

4. Have you engaged in a social activity inside your home in the last:

24 HOURS	WEEK	MONTH
1	2	3

5. Have you talked with an adult who cares about you, and you care about, in the last:

24 HOURS	WEEK	MONTH
1	2	3

6. Are most of your contacts with other adults initiated:

   a) by you
   b) by others
   c) sometimes by you and sometimes by others

7. Are most of your contacts with other adults:

   a) positive, supportive or pleasant
   b) neutral, neither positive nor negative
   c) negative, conflictual or aversive

8. How satisfied are you with the help you receive from your husband with regard to the child(ren)?

1	2	3	4	5	6	7
completely satisfied						not at all satisfied

9. How satisfied are you with the help you receive from your husband in other areas of your life?

1	2	3	4	5	6	7
completely satisfied						not at all satisfied

10. How satisfied are you with the help you receive from your friends and family?

1	2	3	4	5	6	7
completely satisfied						not at all satisfied

NAME ______________________ DATE ______________

APPENDIX F

Family Services of Winnipeg Inc.
400-287 BROADWAY, WINNIPEG, MANITOBA R3C 0R9, PHONE 947-1401

President: Brian Hodgson
Executive Director: J. H. (Jack) Waldron

Dear

As you know, I am currently working toward a graduate degree in Social Work, and have been specializing in counselling women. In our counselling sessions, we sometimes talked about issues that relate specifically to women. Your opinions and ideas are very valuable in helping counsellors understand what is important to women who come for help. As well, the information you provide will help me improve the service I provide to women in counselling. I would greatly appreciate you answering the questions on the attached forms. Please mail the forms back to Family Services of Winnipeg, Inc. in the enclosed, stamped envelope. If you have any questions, please feel free to call me at 947-1401.

Thank you very much.

Sincerely,

Sheila Rainonen, B.A., B.S.W.

Counsellor

A UNITED WAY SERVICE

Please read the following questions and circle the response that best answers the question for you.

1. How important was it to you to have a woman counsellor?

1	2	3	4	5
not at all important		somewhat important		it was important for me to talk to another woman

2. Below is a list of themes that are often important to women in counselling. Please circle the ones that were relevant for you.

depression	women's cycles	independence
anger	birth control	helplessness
sexuality	health problems	employment
guilt	body image	sexual assault
dependency	drug abuse	discrimination
fear	pregnancy	relationship with your mother
day care	assertiveness	relationship with your father
marriage	mothering	relationships with women
violence	self-esteem	relationships with men
money	personal power	other ______________
childbirth	alcohol abuse	______________

3. Please list 3 main themes you worked on in counselling. Then rate the amount of change you have noticed in each area.

1. ______________________________

1	2	3	4	5
much worse	worse	the same	better	much better

2. ______________________________

1	2	3	4	5
much worse	worse	the same	better	much better

3. ______________________________

1	2	3	4	5
much worse	worse	the same	better	much better

4. During your counselling, to what extent did you become more aware of issues concerning women?

1	2	3	4	5
my awareness did not increase		I became somewhat more aware		my awareness increased a great deal

5. Would you have been interested in group meetings with other women as part of your counselling?

Yes _____ No _____ Maybe _____

Comment ______________________________

6. Would you recommend the kind of help you received to other women with similar problems?

Yes _____ No _____ Maybe _____

Comment ______________________________

7. Please comment here on aspects of the service that were particularly helpful or not helpful for you.

____

____

____

____

____

____

THANK YOU!

NAME ______________________________ DATE ______________
(optional)

APPENDIX G

Please read the following questions and circle the response that best answers the question for you.

1. How important was it to you to have a woman counsellor?

1	2	3	4	(5)
not at all important		somewhat important		it was important for me to talk to another woman

2. Below is a list of themes that are often important to women in counselling. Please circle the ones that were relevant for you.

(depression)	women's cycles	independence
(anger)	birth control	helplessness
sexuality	health problems	employment
(guilt)	body image	sexual assault
dependency	drug abuse	discrimination
fear	pregnancy	(relationship with your mother)
day care	assertiveness	(relationship with your father)
marriage	mothering	relationships with women
violence	(self-esteem)	relationships with men
money	personal power	other ________
childbirth	alcohol abuse	________

3. Please list 3 main themes you worked on in counselling. Then rate the amount of change you have noticed in each area.

1. depression

1	2	3	(4)	5
much worse	worse	the same	better	much better

2. Anger

1	(2)	3	4	5
much worse	worse	the same	better	much better

3. relationship with mother

1	(2)	3	4	5
much worse	worse	the same	better	much better

4. During your counselling, to what extent did you become more aware of issues concerning women?

1	2	3	(4)	5
my awareness did not increase		I became somewhat more aware		my awareness increased a great deal

5. Would you have been interested in group meetings with other women as part of your counselling?

Yes ____ No ____ Maybe ✓

Comment I would need to discuss group meeting with a counsellor first.

6. Would you recommend the kind of help you received to other women with similar problems?

Yes ✓ No ____ Maybe ____

Comment ____________________

7. Please comment here on aspects of the service that were particularly helpful or not helpful for you.

Having the counsellor continue to ask questions and encourage me to talk about my feelings even though I resist is of the greatest benefit to me. I believe deep down I would like to express all my feelings and this approach though it may be slow will be most effective.

THANK YOU!

NAME ____________________ DATE Dec 19/85
(optional)

Please read the following questions and circle the response that best answers the question for you.

1. How important was it to you to have a woman counsellor?

1	2	3	4	(5)
not at all important		somewhat important		it was important for me to talk to another woman

2. Below is a list of themes that are often important to women in counselling. Please circle the ones that were relevant for you.

(depression)	women's cycles	(independence)
(anger)	birth control	(helplessness)
(sexuality)	health problems	employment
(guilt)	(body image)	sexual assault
dependency	drug abuse	discrimination
fear	pregnancy	(relationship with your mother)
day care	(assertiveness)	(relationship with your father)
marriage	(mothering)	relationships with women
(violence)	(self-esteem)	(relationships with men)
money	personal power	other ____________
childbirth	alcohol abuse	____________

3. Please list 3 main themes you worked on in counselling. Then rate the amount of change you have noticed in each area.

1. self-esteem

1	2	3	(4)	5
much worse	worse	the same	better	much better

2. anger

1	2	(3)	4	5
much worse	worse	the same	better	much better

3. assertiveness

1	2	3	4	5
much worse	worse	the same	better (circled)	much better

4. During your counselling, to what extent did you become more aware of issues concerning women?

1	2	3	4	5
my awareness did not increase (circled)		I became somewhat more aware		my awareness increased a great deal

5. Would you have been interested in group meetings with other women as part of your counselling?

Yes ✓ No ____ Maybe ____

Comment I think it would be beneficial.

6. Would you recommend the kind of help you received to other women with similar problems?

Yes ✓ No ____ Maybe ____

Comment It helps to talk about problems.

7. Please comment here on aspects of the service that were particularly helpful or not helpful for you.

I started to be aware of my feelings because I would make an effort to talk about the problems I was having rather than pushing them aside. I am aware now that I get angry + that I am allowed to do so, but I still have problems controlling my anger which in turn causes guilt.

THANK YOU!

NAME ____________ DATE Jan. 14/86
(optional)

Please read the following questions and circle the response that best answers the question for you.

1. How important was it to you to have a woman counsellor?

1	2	3	4	(5)
not at all important		somewhat important		it was important for me to talk to another woman

2. Below is a list of themes that are often important to women in counselling. Please circle the ones that were relevant for you.

depression	women's cycles	independence
anger	birth control	helplessness
(sexuality)	health problems	employment
(guilt)	body image	sexual assault
(dependency)	drug abuse	discrimination
(fear)	pregnancy	(relationship with your mother)
day care	(assertiveness)	relationship with your father
(marriage)	mothering	relationships with women
(violence)	(self-esteem)	relationships with men
money	(personal power)	other - verbal abuse physical and emotional abuse
childbirth	alcohol abuse	

3. Please list 3 main themes you worked on in counselling. Then rate the amount of change you have noticed in each area.

1. self-esteem

1	2	3	(4)	5
much worse	worse	the same	better	much better

2. relationships

1	2	3	(4)	5
much worse	worse	the same	better	much better

3. guilt

1	2	3	4	(5)
much worse	worse	the same	better	much better

4. During your counselling, to what extent did you become more aware of issues concerning women?

1	2	3	(4)	5
my awareness did not increase		I became somewhat more aware		my awareness increased a great deal

5. Would you have been interested in group meetings with other women as part of your counselling?

Yes ____ No ____ Maybe ✓

Comment ____________________

6. Would you recommend the kind of help you received to other women with similar problems?

Yes ✓ No ____ Maybe ____

Comment ____________________

7. Please comment here on aspects of the service that were particularly helpful or not helpful for you.

Speaking with someone I could identify with was very very helpful. I felt more normal when I realized someone else of similar age could understand and comment on my concerns.

THANK YOU!

NAME ____________________ DATE Dec. 13/85
(optional)

Please read the following questions and circle the response that best answers the question for you.

1. How important was it to you to have a woman counsellor?

1	2	3	4	(5)
not at all important		somewhat important		it was important for me to talk to another woman

2. Below is a list of themes that are often important to women in counselling. Please circle the ones that were relevant for you.

(depression)	women's cycles	(independence)
anger	birth control	helplessness
sexuality	health problems	employment
(guilt)	body image	sexual assault
(dependency)	drug abuse	discrimination
(fear)	pregnancy	relationship with your mother
day care	(assertiveness)	relationship with your father
(marriage)	mothering	(relationships with women)
violence	self-esteem	(relationships with men)
money	(personal power)	other ____________
childbirth	alcohol abuse	____________

3. Please list 3 main themes you worked on in counselling. Then rate the amount of change you have noticed in each area.

1. Marriage

1	2	3	4	(5)
much worse	worse	the same	better	much better

2. independence

1	2	3	(4)	5
much worse	worse	the same	better	much better

3. depression

1	2	3	(4)	5
much worse	worse	the same	better	much better

4. During your counselling, to what extent did you become more aware of issues concerning women?

1	2	3	4	(5)
my awareness did not increase		I became somewhat more aware		my awareness increased a great deal

5. Would you have been interested in group meetings with other women as part of your counselling?

Yes ____ No ____ Maybe ✓

Comment I would have enjoyed it at the beginning of counselling so I knew I was not the only one in my situation

6. Would you recommend the kind of help you received to other women with similar problems?

Yes ✓ No ____ Maybe ____

Comment The best thing I ever did was seek counselling

7. Please comment here on aspects of the service that were particularly helpful or not helpful for you.

______

______

______

______

______

______

THANK YOU!

NAME ______________________ DATE Dec 26/85.
(optional)

Please read the following questions and circle the response that best answers the question for you.

1. How important was it to you to have a woman counsellor?

1	2	3	4	(5)
not at all important		somewhat important		it was important for me to talk to another woman

2. Below is a list of themes that are often important to women in counselling. Please circle the ones that were relevant for you.

(depression)	(women's cycles)	independence
(anger)	birth control	helplessness
sexuality	health problems	employment
(guilt)	(body image)	sexual assault
dependency	drug abuse	discrimination
fear	pregnancy	relationship with your mother
(day care)	(assertiveness)	relationship with your father
marriage	(mothering)	relationships with women
violence	(self-esteem)	relationships with men
money	personal power	other ____________
childbirth	alcohol abuse	____________

3. Please list 3 main themes you worked on in counselling. Then rate the amount of change you have noticed in each area.

1. depression

1	2	(3)	4	5
much worse	worse	the same	better	much better

2. anger

1	2	(3)	4	5
much worse	worse	the same	better	much better

3. body image

1	2	(3)	4	5
much worse	worse	the same	better	much better

4. During your counselling, to what extent did you become more aware of issues concerning women?

(1)	2	3	4	5
my awareness did not increase		I became somewhat more aware		my awareness increased a great deal

5. Would you have been interested in group meetings with other women as part of your counselling?

Yes ✓ No ___ Maybe ___

Comment Yes I would have been interested to hear what they would have to say and discuss

6. Would you recommend the kind of help you received to other women with similar problems?

Yes ___ No ___ Maybe ✓

Comment every person is an individual and requires different kinds of help for problems that are similar.

7. Please comment here on aspects of the service that were particularly helpful or not helpful for you.

The availability of my counselor when I was in need of talking I found very helpful. I find when you're in need of talking to someone almost immediately it helps rather than having to wait days or even weeks when at that later time you might not need the need to talk.

THANK YOU!

NAME ______________________
(optional)

DATE Jan 6/86

Please read the following questions and circle the response that best answers the question for you.

1. How important was it to you to have a woman counsellor?

1	2	3	4	5 (circled)
not at all important		somewhat important		it was important for me to talk to another woman

2. Below is a list of themes that are often important to women in counselling. Please circle the ones that were relevant for you.

depression	women's cycles	independence
anger (circled)	birth control	helplessness
sexuality	health problems	employment
guilt (circled)	body image	sexual assault
dependency	drug abuse	discrimination
fear (circled)	pregnancy	relationship with your mother
day care	assertiveness	relationship with your father
marriage	mothering	relationships with women
violence (circled)	self-esteem	relationships with men
money	personal power	other ____________
childbirth	alcohol abuse (circled)	____________

3. Please list 3 main themes you worked on in counselling. Then rate the amount of change you have noticed in each area.

1. guilt

1	2	3	4 (circled)	5
much worse	worse	the same	better	much better

2. fear

1	2	3	4	5 (circled)
much worse	worse	the same	better	much better

3. Violence

1	2	3	4	(5)
much worse	worse	the same	better	much better

4. During your counselling, to what extent did you become more aware of issues concerning women?

1	2	3	4	(5)
my awareness did not increase		I became somewhat more aware		my awareness increased a great deal

5. Would you have been interested in group meetings with other women as part of your counselling?

Yes ✓ No ____ Maybe ____

Comment Provided they were evening courses.

6. Would you recommend the kind of help you received to other women with similar problems?

Yes ✓ No ____ Maybe ____

Comment ____

7. Please comment here on aspects of the service that were particularly helpful or not helpful for you.

To talk about problems and realize that other women have + will go through the same as yourself and to find out you are not the only one in this situation

THANK YOU!

NAME ____ ____ DATE 7/12/85
(optional)

Please read the following questions and circle the response that best answers the question for you.

1. How important was it to you to have a woman counsellor?

1	2	3	4	(5)
not at all important		somewhat important		it was important for me to talk to another woman

2. Below is a list of themes that are often important to women in counselling. Please circle the ones that were relevant for you.

(depression)	women's cycles	(independence)
(anger)	birth control	(helplessness)
(sexuality)	(health problems)	(employment)
(guilt)	body image	(sexual assault)
(dependency)	drug abuse	(discrimination)
(fear)	pregnancy	(relationship with your mother)
day care	(assertiveness)	(relationship with your father)
marriage	mothering	(relationships with women)
(violence)	(self-esteem)	(relationships with men)
(money)	(personal power)	other ______________
childbirth	alcohol abuse	______________

3. Please list 3 main themes you worked on in counselling. Then rate the amount of change you have noticed in each area.

1. abuse - mental & physical

1	2	(3)	4	5
much worse	worse	the same	better	much better

2. fear

1	2	(3)	4	5
much worse	worse	the same	better	much better

3. depression & guilt

1	2	3 (circled)	4	5
much worse	worse	the same	better	much better

4. During your counselling, to what extent did you become more aware of issues concerning women?

1	2	3 (circled)	4	5
my awareness did not increase		I became somewhat more aware		my awareness increased a great deal

5. Would you have been interested in group meetings with other women as part of your counselling?

Yes ✓ No ____ Maybe ____

Comment ____________________

6. Would you recommend the kind of help you received to other women with similar problems?

Yes ✓ No ____ Maybe ____

Comment ____________________

7. Please comment here on aspects of the service that were particularly helpful or not helpful for you.

The group theraphy helped. It helped to know we are not the crazy ones and we're not alone. Individual theraphy has helped me to open up, instead of holding it all inside

THANK YOU!

NAME ____________ DATE Dec 27/85
(optional)