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Blowing in the Wind: '70s Questions for Millennial Therapists

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### Abstract

Psychotherapy came in for a drubbing by the Women's Liberation Movement of the 1960s. Indeed, some movement members declared that Feminist Therapy was an oxymoron. Despite the antipathy, feminists in the mental health professions borrowed practices, ethical ideals, principles, and goals from the Women's Liberation Movement to create innovative models of therapy. This progressive impetus came to an abrupt halt with the sweeping re-medicalization of psychiatry in the 1980s and the corporatization of medicine that followed thereafter. As the landscape of psychotherapy changed, so too did the founders' vision of Feminist Therapy. Drawing on interviews with feminist therapists, I examine some of these changes. I close by asking about the conditions of possibility for feminism in therapy today.

*Keywords:* Feminist Therapy; consciousness-raising; medicalization; managed care; Women's Liberation Movement

### Blowing in the Wind: '70s Questions for Millennial Therapists

Every history of the past is constructed from the vantage point of the present. I look at the beginnings of Feminist Therapy through the lens of the present; I cannot do otherwise. Stories are not copies of reality; they are “edited versions” of it (Magnusson & Marecek, 2015). When we tell stories about the past, we rely on memories, which are always colored by the present. Our understandings of the past change as new events and experiences lead us to adopt new perspectives. Stories always smuggle in moral judgments of the events and the actors. As you’ll see, I make no effort to scrub such judgments out of my stories.

I chose my stories with an eye to highlighting the contrasts between then and now. My first story is about my graduate training just as the sun was setting on the era of “womanless” psychology. The second story focuses on the Women’s Liberation Movement in the U.S. and the gestation and birth of Feminist Therapy in the womb of that movement. The third story spans a longer time period. From the eighties to the present, the mental health professions have been buffeted by drastic ideological and material changes. Few, if any, feminist therapists have escaped those changes. My third story, then, is about the conditions of possibility for Feminist Therapy in the decades since the 1970s.

#### **In the Academy**

Today, the sheer presence of women in psychotherapy and the centrality of their contributions as researchers, clinical theorists, and organizational leaders makes it next to impossible to imagine the near-womanless state of psychology in the late '60s. During my graduate training, I went through four years of study, several practica, and an accredited internship in clinical psychology without encountering any female instructors, mentors, or clinical supervisors. That was the norm, and though it seems incredible in hindsight, I did not find this absence of women notable or objectionable at the time.

I entered graduate school while the Vietnam War was raging. The U.S. military was conscripting young men by lottery; deferments for graduate education were far from assured. War or no war, the members of the psychology department needed workers to run rats, pigeons, and college students through their experiments. To assure a supply of labor, they admitted an unprecedented number of women into the class – almost one-third of the incoming class. (Previously, the rate of admissions for women seemed to have hovered between zero and one.) At the welcome event for new students, the Director of Graduate Studies – seemingly oblivious to the presence of female students – took pains to reassure those present that this unusual gender composition was only a temporary aberration. Once the war ended, things would revert to normal. As it turned out, his promise went unfulfilled. History (and Title IX) intervened.

Some of the male faculty members actively resisted the intrusion of female graduate students into what had been a boys' club. One senior social psychologist ruefully opined that once he took female students into his research group, there could no longer be Friday afternoon beer-drinking sessions, Thursday night poker games, or Saturday fishing trips. On top of that, men would no longer be able to curse. An eminent psychoanalyst and personality theorist wanted to bar female students from his classes. Women, he said, were not capable of doing therapy. He was told that he had to enroll women. He did, but he insisted that they take seats out of his line of vision. How ironic that the history of his field is replete with distinguished female writers and practitioners. Could it be that he had never heard of Karen Horney, Anna Freud, Frieda Fromm-Reichmann, Clara Thompson, or Melanie Klein?

In this insular and rarified corner of the academy, words like sexism, feminism, sex discrimination, lesbian, or even sex difference were not in the lexicon. Training in clinical psychology was entirely psychoanalytic – theories of psychopathology (*pace* Norman

Cameron!), projective tests for assessment, and psychodynamic psychotherapy. Psychoanalytic theory was the sole framework within which mental disorders and normal development were defined and understood. It was the sole framework within which we students learned to carry out assessments, and the sole framework within which therapy was conducted.

### **In the Real World: A Tidal Wave of Feminism!**

Outside my graduate school bubble, women were on the move, and gender relations were in upheaval as women questioned everything. In the U.S., people by the thousands pored over *The feminine mystique* (Friedan, 1963). In the U.K., *The female eunuch* (Greer, 1970) was raising a firestorm of controversy. Freud's ideas about women came in for an unrelenting drubbing at the hands of feminist thinkers (e.g., Gilman, 1971; Koedt, 1970). We feminists in psychology read *Women and madness* (Chesler, 1972). We handed around mimeographed copies of *Psychology constructs the female* (Weisstein, 1968) and *Training woman to know her place: The power of a nonconscious ideology* (Bem & Bem, n.d.). (Photocopy machines, let alone pdfs or email attachments, did not yet exist.)

In those days, feminists pursued a double agenda. One sector pressed for women's rights, that is, changing the legal status of women. This sector included bureaucratic organizations as NOW, Women's Equity Action League (WEAL), and the National Women's Political Caucus. The other sector pushed for women's liberation, that is, the transformation of cultural beliefs about women and personal relationships. By the mid-1970s, the ideological distinctions between equal rights and women's liberation had blurred. A profusion of organizations of women from particular backgrounds (e.g., the National Association of Black Professional Women and the Older Women's League) and occupations (e.g., the Association for Women in Psychology, Sociologists for Women in Society) had emerged, pursuing varied agendas.

What was the take-home message for me as a young feminist and, by then, an assistant professor? First, women *qua* women constituted a political interest group, and as a political interest group, women could command a presence in the public arena. Second, solidarity among women was necessary to force societal change. I witnessed this solidarity in the form of mass demonstrations (such as the New York Radical Feminists Speak-Out on Rape in 1971) and protest marches (such as pro-choice rallies in Washington leading up to the passage of *Roe v. Wade*). I witnessed the power of this solidarity on a local scale when women on my own campus united to press a class action suit concerning unfair hiring and promotion practices.

### **Feminists' Dis-ease with Psychotherapy**

The litany of psychoanalysts' sexist and mother-blaming pronouncements about women did not sit well with many feminists of this era. Many drew upon the ideas of the left-leaning Radical Therapy and anti-psychiatry movements. In their most extreme form, these ideas denied that mental disorders were other than politically useful labels. Such labels protected entrenched social arrangements and power structures. As Ellen Herman noted in her cultural history of psychology, the feminist critique of psychotherapy,

dovetailed neatly with the core propositions of anti-psychiatry: that the medical establishment had inappropriately usurped authority over vital social issues, including gender and sexuality; that psychotherapeutic practice harmed women by teaching that their problems were personal and intrapsychic rather than social and relational; that the neutral language of testing, diagnosis, and treatment concealed clinicians' complicity with male domination and their determination to make women adjust to sexism; that "mental health" was nothing but shorthand for gender conformity; that faith in experts (especially male

experts) was counterproductive because experience—not expertise—imparted deserved authority. Only women could liberate themselves. (Herman, 1995, pp. 286-287)

This hard line appeared frequently in the writings of radical feminists of the sixties. Carol Hanisch, for example, declared:

The very word “therapy” is obviously a misnomer if carried to its logical conclusion.

Therapy assumes that someone is sick and that there is a cure, e.g., a personal solution. ...

Women are messed over, not messed up! We need to change the objective conditions, not adjust to them. Therapy is adjusting to your bad personal alternative. (Hanisch, 1969, p. 3)

Dorothy Tennov (herself a psychologist) deemed psychotherapy to be “monstrous,” an “opiate,” and an “agent of patriarchy.” Her book, *Psychotherapy: The hazardous cure* (Tennov, 1975), was only a trifle more generous. Mary Daly (1979), the radical feminist theologian, went the farthest, arguing that psychotherapy of any sort was “mind rape.” In therapy, Daly (1979) believed, women were infected with disease, not cured of it. How then would therapists who were feminists move past the idea that Feminist Therapy is an oxymoron? By taking a detour through consciousness-raising.

### **Consciousness-raising and Women’s Liberation**

Consciousness-raising (CR) groups were the hallmark of the Women’s Liberation Movement. Whether hip young singles or suburban mothers, women across the U.S. came together in small group meetings to explore and analyze their experiences. CR theorists were adamant that the groups were not support groups or therapy groups, but vehicles for cultural and personal transformation. This is how Carol Hanisch (the woman who coined the phrase “The personal is political”) described the transformative power of consciousness-raising.

First and foremost is consciousness-raising, which has been THE radical organizing tool for women's liberation.... We saw how it made things clearer—how it resulted in the higher levels of determination and courage and willingness to take risks that people have when they are sure they are right and when they know that others feel the same. (Hanisch, 1999, p. 3)

Feminist consciousness-raising groups were modeled after the practices of a number of revolutionary movements. As in such revolutionary struggles, creating the broad base of support necessary to succeed depends on creating a broad-based critical consciousness (Echols, 1989). For example, the campaigns of Chairman Mao's revolutionary brigades, for example, organized “speak bitterness” (*su ku*) sessions in order to incite serfs to revolt against feudal landlords. Similarly, *conscientizacao* (conscientization) was a central practice in the peasant liberation movements in the Caribbean and Latin America, intended to arouse dissatisfaction among the oppressed (Freire, 1970/1984). In the Civil Rights Movement in the American South, activists encouraged African Americans to come together to testify to the oppressive conditions of their lives.

In circumstances in which subordination has been naturalized, change first requires critical consciousness – the recognition of unfair treatment. In consciousness-raising groups, the everyday experiences of the members were the focus of discussion. As those experiences were brought forward, group members could draw connections that revealed the common aspects of women's condition in society. Further analysis enabled members to see how those experiences were embedded in sociopolitical structures and cultural beliefs. This is what Hanisch meant by “making the personal political.” With raised awareness, group members would be ready to

mobilize for change (Kravetz, Marecek, & Finn, 1983). To quote Carol Hanisch again, reflecting back on her CR experiences:

It was through consciousness-raising—using the wealth of women’s collective experiences—that we were able to make these major theoretical leaps that helped us organize ourselves and made us able to organize others effectively. Consciousness-raising helps women to understand our oppression in concrete ways and makes every woman’s life experience a part of the analysis. (Hanisch, 1999, p. 3)

### **Grassroots feminist organizations**

The 1960’s were a time of progressive social movements that challenged the status quo and agitated for social change. Progressive movements included the Civil Rights Movement, the Black Power Movement, student movements such as SDS and SNCC, and the anti-war movement. Some movement members defied the law, and some engaged in civil disobedience. Encounters between the protestors and the state sometimes were violent. One example was the shootings by the National Guard of unarmed college students at Kent State during an anti-war protest in 1970. Another was the “police riot” during the anti-war protests surrounding the 1968 Democratic National Convention in Chicago. Alienation from and distrust of the state ran deep among members of these movements and among youth more generally.

Many feminist activists shared this distrust of the state and of the established institutions, most of which were male-dominated. This distrust led feminists to develop grassroots organizations and social service agencies of their own (Ferree & Martin, 1995; Kravetz, 2004). Run by women for women, these organizations not only delivered services to women; they also engaged in public information campaigns and advocacy for women’s issues. Some, like Jane – a grassroots abortion service on Chicago’s Southside -- flouted the law. In Philadelphia, where I

was living, feminist agencies included a service for women who were separating and divorcing (which soon re-invented itself as a service for women in violent relationships); a safe house for battered women; a rape crisis center; a women's health center, which provided abortions as well as low cost medical care; a hotline providing information and referrals regarding contraception, sexuality, and prenatal care; a feminist legal center that engaged in litigation, advocacy, and education; and a collective that offered therapy groups for women. It has become the custom to slam the Women's Liberation Movement as exclusively for White, middle class women. But in Philadelphia at least, all these organizations had a strong commitment to ethnic diversity and mainly served low-income women. Kravetz (2004) reported a similar commitment to diversity and inclusion in the feminist agencies that she studied in Wisconsin.

These women-run agencies adopted a number of feminist principles. Among the staff, decision-making was collaborative and democratic. The organizational structure was nonhierarchical; some organizations operated as collectives. The service models they developed focused on the crises or situations for which their clientele sought help. Agencies that offered counseling emphasized group work as a means through which women could share their wisdom and life experiences with one another and join together to support each woman's efforts to change. In this way, the group experiences validated women's perspectives and their competence at managing their lives. In addition, group work often included elements of consciousness-raising – that is, clarifying how women's experiences were connected to the societal subordination of women.

### **Building Feminist Therapy on the Shoulders of Movement Activism**

Despite the denunciations of psychotherapy from some quarters of the movement, feminists who were therapists held onto the hope that psychotherapy could foster the women's liberation.

Although CR theorists saw CR as the politically informed *replacement* (or even *antidote*) for therapy, the pioneers of feminist therapy drew upon CR as the template for a new form of therapy (Brodsky, 1993). Consider what Diane Kravetz and I wrote in 1977,

Feminist therapy reflects the conviction that personal change and sociopolitical change are inextricably linked. Thus, in feminist therapy, identifying sexism and its effects on the client and other women is an important active ingredient of the treatment process.... The relationship between the goals of treatment and social change is emphasized... (Marecek & Kravetz, 1977, p. 326)

Feminist therapists also entertained ideas about therapy outcomes (and, by extension, mental health) that were based in movement politics and CR theory (Klein, 1976). For example, some therapists held that clients should come to endorse feminist beliefs; others thought clients should come to engage in feminist activism; some spoke of female solidarity. For some, becoming angry about societal injustices was a positive outcome of therapy.

The first feminist therapists also drew upon the principles and practices of the alternative service agencies I described above. One such principle was a commitment to what they termed “self-help” (that is, helping women to discover their strengths and take responsibility for making changes in their lives). Feminist therapists also experimented with ways to diminish the authority of the therapist, for example, by using contracts or co-writing case notes (Hare-Mustin, Marecek, Kaplan, & Liss-Levenson, 1979). Other feminist therapists promoted models of therapy in which the therapist limited her role to that of a facilitator, placing responsibility for many of the functions usually undertaken by a therapist on the group members (Johnson, 1976; Kravetz & Marecek, 1977). The purpose behind these models was to curb the therapist’s power and to foster women’s respect for and trust in one another.

### **Outsiders on the Inside? Feminist Therapists and the Mental Health Establishment**

Psychotherapy as it existed in the seventies no longer exists. It has not “evolved” nor is its new form a reflection of scientific progress. Rather the transformation came about as a result of the broad-scale re-ordering of the political economy of mental health. The conditions of possibility for Feminist Therapy today bear little resemblance to those of the seventies.

In the seventies, ideas about the social causes of suffering – racism, poverty, sexism, and unemployment – fell on receptive ears. Feminist Therapy was but one effort among several kindred efforts to rethink mental disorders. Examples are innovations in family therapy at the Philadelphia Child Guidance Clinic, the communications theories of the Palo Alto Group, and the experimental therapeutic community of R.D. Laing. The seventies supported both political critique and bold experiments in treatment. The Community Mental Health Center Movement (a part of John F. Kennedy’s Great Society initiative) supported grassroots mental health centers in low-income urban settings; these centers were tasked with developing programs of prevention and early intervention, as well as treatment.

Ronald Reagan’s election in 1980 marked an abrupt and extreme swing toward social and fiscal conservatism. Almost immediately, the rug was pulled out from under progressive initiatives. The federal government wiped out funding for the community mental health program. The National Institute of Mental Health (NIMH) cut off funds for research on poverty, unemployment, social class, and urban problems. A new doxa was proclaimed; mental disorders were brain diseases, which were largely inherited.

Nineteen Eighty also was the year in which the DSM-III was released. The DSM-III entailed a sweeping revision of psychodiagnosis. The categories of mental disorders were re-engineered to mimic the categories of biomedical diseases. As is well documented, this re-

conception was not grounded in science; it was purely pragmatic (Horwitz, 2002; Wilson, 1993). With corporatization and managed care barreling down on medicine, psychiatry had to re-invent itself as a *bona fide* medical subspecialty if it were to have a viable financial future. Clinical psychologists leapt right onto the ersatz-medical bandwagon, with textbooks and training materials re-written to conform to the new reality. Even a college sophomore in an Abnormal Psychology course would get the new message. The APA invented new monikers for clinical psychologists like “behavioral health care providers.”

Describing psychological suffering as if it consisted of disease-like entities exemplifies what is called medicalization. When psychological suffering is re-described as a medical condition, it then is subjected to medical scrutiny, diagnosis, and treatment. This effectively frames psychological suffering as residing “inside” the person and depoliticizes it. That is, if the putative causes of suffering are chemical imbalances, childhood experiences, dysfunctional cognitions, and the like, factors that lie “outside” the person -- such as social inequality, poverty, gendered subordination, and difficult living conditions – are rendered invisible (Hare-Mustin & Marecek, 2009).

Mimicking biomedical diagnoses, the DSM-III defined mental disorders in terms of lists of symptoms. Such symptom criteria reduce human experience and personal difficulties to a series of sub-personal parts. Diagnosing under the DSM-III (and DSM-IV and DSM-5) does not comprehend a person; it instead portrays a collection of sub-personal parts. In the 1980’s, this way of thinking about clients and their troubles became the “new normal.” One student of mine, for example, reported with disdain that the patient intake forms she was required to fill out at her practicum site allotted “only” eight spaces for diagnoses. I have watched a senior clinician conduct an intake interview by barking out a checklist of symptoms and demanding yes/no

responses from the client. (And this while the clinician faced the computer screen, not the person.) A student in an advanced psychotherapy class questioned why I had assigned a book with the title *Change* (Watzlawick, Weakland, & Fisch, 1974). What, she asked, does “change” have to do with psychotherapy? Therapy, for her, was about curing symptoms.

### **In the Institution: Psychotherapeutic Culture**

How do feminist therapists practice in a regime of a medicalized psychotherapeutic culture? Has this regime changed the way that feminist therapists work and think? As far as I know, there has been next to no systematic research on this question. Although we did not have this specific question in mind, a large study of self-identified feminist therapists that Diane Kravetz and I carried out in the mid-1990s offers some beginning answers.<sup>1</sup> When we asked therapists to describe what made therapy “feminist,” they spoke of the therapist’s personal qualities, often invoking feminine stereotypes. Feminist therapists, they said, were “nurturing,” “softer,” “less judgmental,” “compassionate,” and “respectful of women’s ways of doing things” (Marecek & Kravetz, 1998a). Few seemed to connect Feminist Therapy with emancipator goals for women.

Many of the feminist therapists in the study centered their ideas about Feminist Therapy on “PTSD” and “trauma” (Marecek, 1999). Several took pains to identify PTSD as the quintessential feminist diagnosis. Some regarded “taking the trauma history” as the proper feminist approach to assessment. Yet, others preferred to make liberal use of PTSD diagnoses because “PTSD means you are normal.” Yet, the diagnostic category PTSD is a medicalized diagnosis. Although the term gestures toward an external cause of suffering, PTSD, like every other diagnostic category, is defined in terms of a set of “inner” symptoms; little reference is made to the external stressor (Summerfield, 2001). Moreover, at present, traumatology is awash

with claims about neurobiological causes of PTSD, “body memory” of trauma, and pseudo-neuroscientific treatment regimes.

As psychotherapists well know, the material basis of therapeutic practice has further altered the conditions of possibility for feminist therapy. Managed care systems, with their overarching mandate to cut costs, control the delivery of mental health care. As Philip Cushman and Peter Gilford said,

Whoever controls the delivery of mental health care – by determining such things as the definition of mental disorder, triage criteria, and the nature and length of proper treatment – inevitably and deeply affects society-wide understandings of health and illness, the possibilities and limits of human nature, and thus what is believed to be proper and good. (Cushman & Gilford, 2000, p. 985)

Managed care organizations often require therapists to specify treatment goals in terms of symptom reduction. Such goals involve modest improvements in narrowly defined target behaviors and often they are formulated to be quickly attainable (Cohen, Marecek, & Gillham, 2006). By definition, the “inside” of the person, not the social surround, the larger social structure, or the political economy, is the target. Carol Hanisch’s (1969) complaint that “Therapy is adjusting to your bad personal alternative” comes to mind. What of the therapy outcomes that Feminist Therapy pioneers proposed in the 1970’s? Would an insurance company authorize a goal of helping a woman develop a feminist consciousness? Or a goal of instigating a client’s righteous anger over unjust treatment?

Feminist therapists have always been concerned with “the reparative psychological redistribution of power inside and outside the therapy relation” (Bruns & Kaschak, 2010, p. 189). But, this places today’s feminist therapists in a difficult position. Under managed care, the power

to define the terms of the therapy lies in the hands of the managed care organization. Patients are figured as the compliant recipients of the therapist's expert knowledge and techniques. When the therapy relationship is an asymmetrical triangle, wherein is the possibility of redistributing power?

### **W(h)ither Feminist Therapy?**

In the 1970's, members of the Women's Liberation Movement accused mainstream psychotherapists of imbuing treatment with sexist ideology. Mainstream therapists, on the other hand, accused feminist therapists of imposing their ideology on clients. In a certain sense, both were right; psychotherapy is inescapably a value-laden enterprise. Today, discourses of "health" (as in "health service provider"), "science," and "evidence" are invoked to occlude the value-laden nature of therapy (Marecek & Kravetz, 1998b). However, psychotherapy appears to be value-free only insofar as it is aligned with the values of the dominant culture (cf., Skoger & Magnusson, in press).

I opened this essay by saying that histories are re-presentations of past, constructed from the vantage point of the present. The history I tell here is no different. But, my history is also oriented toward the future. Although the political culture of the seventies cannot be revived, I tell this history with the hope of stirring debate and reflection. The medicalization of psychological suffering is now thoroughly embedded in both popular culture and therapeutic culture. For some, it is just the way things are, not one description of things out of many possible ones. Can we nonetheless recoup the emancipatory goals of Feminist Therapy?

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#### Footnote

<sup>1</sup>Although all these therapists identified themselves as feminist therapists in the screening interview, most of them did not declare openly themselves as feminist therapists to their colleagues or their clients. Some said they had openly used the label feminist therapist in the past.