Feminist Approaches to Therapy With Depressed Women: *A Discussion*

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ABSTRACT

Women are twice as likely as men to become depressed, and this gender difference is discussed in terms of women's sociocultural roles. The article presents a description of a hypothetical client who is depressed. Feminist therapy can be used in many clinical service settings, and depressed women may enter the mental health service sector via a number of different routes. Consequently, the article illustrates how a woman would be treated by feminist therapists in five possible mental health settings: (1) informal social support setting; (2) inpatient medical or rehabilitation setting; (3) child outpatient setting; (4) college counseling center; or (5) adult outpatient setting. The authors describe similarities and differences in feminist therapy in these settings.

Why Aren't All Women Depressed?

Women are about twice as likely as men to experience depression. This gender ration holds true across the U.S., most European nations, and several African nations, whether one is examining community surveys or people receiving mental health services for depression. In the U.S., Hispanic, African-American, and Caucasian women all exceed men in rates of depression, and this gender difference remains even when income, education, and occupation remain the same.

In 1987, American Psychological Association President Bonnie Strickland appointed a Task Force on Women and Depression to examine the research and specifically to identify the factors that placed women at risk for depression

(McGrath, Keita, Strickland, & Russo, 1990). The resulting report of the Task Force underscores the complexity of depression among women and indicates that depression must be understood in women's biological, psychological, and sociocultural context. Depression also changes across the life cycle and interacts with other mental health problems. Furthermore, as the Task Force Report has pointed out, there are factors that are precursors to depression (e.g., low self-esteem), that contribute to depression (e.g., gender role socialization), that mediate the response to depression (e.g., excessive rumination), that result from depression (e.g., negative self-perception), and that protect from depression (e.g., expressiveness of feelings).

Women's sociocultural roles provide a number of risk factors for depression (see Rothblum, 1983, for a review of this literature). While friends, family, and intimate relationships may serve as sources of social support for women, they may also be the cause of stress as women often need to provide support, become emotionally involved in the lives of others, or become caretakers. Kessler, McLeod, and Wethington (1984) have referred to this as the "cost of caring" for women. Some studies have found marriage to be a risk factor for women but a protective factor for men (e.g., Radloff, 1975), possibly due to women's increased caretaking responsibilities and men's access to this support during marriage.

Full-time employment generally protects women and men against depression (see McGrath et al., 1990, for a review of this literature). However, women are less likely to be employed full-time than are men and also hold jobs with lower pay and less prestige. Poverty is related to depression, and poverty is a particular risk factor for women. Married women who are homemakers as well as those who are married and employed may be depressed due to role overload and stress. There is also some evidence that professional women are at higher risk for depression and suicide than are women in the general population (see McGrath et al., 1990, for a review).

A major area affecting women that has been neglected as a contributor to depression is violence against women and the resulting emotional trauma. Women have a high likelihodd of being victimized as the result of childhood sexual or physical abuse (one-fifth to one-third of women in community surveys); rape by strangers, acquaintances, or husbands (one-tenth of women); battering (one-quarter of women); or sexual harassment in the workplace (as many as 71% of women; McGrath et al., 1990). Studies also indicate that women are more likely than men to be sexually abused by a therapist or health care provider (McGrath et al., 1990). The physical and psychological consequences of violence against women can result in severe and long-term depression and suicide for women.

Factors that place women at risk for depression become increasingly complex when women are also members of other oppressed groups. There has been little research on depression among women who are African-American,

Latina, Asian-American, Native-American, adolescents, or elderly, and no research on depression among lesbians or women with diabilities.

Events that relate to women's reproduction, such as infertility, menstruation, abortion, pregnancy, childbirth, and menopause, may affect women's mood and behavior although the research has often contained a number of methodological flaws (see Weissman & Klerman, 1977, for a review of hormonal factors and depression). Finally, research has found a number of biases in diagnoses, including depression, when gender and race of hypothetical people were varied (McGrath et al., 1990).

In sum, feminist mental health practitioners have conceptualized women's predominance in depression as the result of sociodemographic and cultural factors. This is in contrast to traditional theories of the etiology of depression which have not accounted for the gender difference in rates of depression. The psychodynamic model emphasizes unconscious conflicts connected with grief and loss. Biological theories of depression focus on neurotransmitter levels in the brain. Cognitive theories stress the self-defeating thought processes of depressed people. Most mental health professionals are trained in one or more traditional models of psychopathology, yet feminist practitioners will add a sociocultural model to the above theoretical conceptualizations of depression.

Clearly, depression is not unusual for women. Given women's biological, psychological, and socicultural roles, we might ask why all women aren't depressed. Why do many women cope so well despite sexism in society and socialization to be passive and dependent?

What is Feminist Therapy?

Despite the clear prevalence of depression among women and the societal factors that place women at risk for depression, most theories of the etiology and treatment of depression have ignored gender. Research that has focused on the efficacy of treatment for depression has found psychodynamic, cognitive-behavioral, and pharmacological treatments for depression to be effective (see McGrath et al., 1990, for an extensive review of this literature and for methodologic constraints of treatment outcome research).

Feminist therapy was a result of the second wave of the feminist movement and women's consciousness-raising groups (see Kaschak, 1980, for a review). Many feminists viewed traditional therapy as maintaining traditional roles for women and conceptualized therapy that recognized sexism in society and women as members of an oppressed group (Brown, 1984). One of the major themes of feminist therapy has been identifying commonalities of individual female clients with women in general. Another major theme of feminist therapy has been attention to women's relative powerlessness and thus also to the role of the therapist-client difference in power. Feminist therapists view the personal as political and may also be involved in sociopolitical change outside the context of therapy (for a detailed description of feminist therapy, and similarities and differences with non-sexist therapy, traditional therapy, and grassroots radical feminist therapy, see Kaschak, 1980).

This article is not so much a description of feminist therapy as it is an illustration of how feminist therapy can be used in the conceptualization and treatment of depression among women. Feminist therapy can be used in most clinical service settings, and we, the authors, represent feminists who have worked in a variety of such clinical settings. Consequently, we wanted to portray the different routes by which depressed women may enter the mental health service sector. We will portray some of the differences, as well as the many similarities, that feminist therapists have in these diverse settings. Finally, we will describe our own process in writing this article.

Client description

We developed a description of a hypothetical client, Suzanne, who would fit our various clinical settings. Suzanne is 28, Caucasian, and lives in Vermont. Like a significant proportion of people living in northern Vermont, she is of French Canadian descent. She has completed high school and one year of a community college.

Suzanne married Ed four years ago and has been separated from him for two years. She has one daugther, Marie, age three. Ed, who comes from a rural Vermont background, provides intermittant child support. During their marriage, Ed was physically abusive towards Suzanne. She never sought legal or mental health services for this abuse, but it was the reason she initiated the separation. The family court has authorized supervised visits by her husband with Marie every other weekend. To the best of her knowledge, Ed has not abused her child. However, Suzanne worries about potential abuse of her or of Marie when Ed visits. She has considered taking legal action to terminate Ed's visitations.

Suzanne works the night shift as an assembly worker at a major electronics firm. She switched from the day shift to the night shift one year ago so that she could spend more time with Marie and also begin college. The assembly work is tedious, and Suzanne is frequently exhausted when she returns home in the early morning. Her salary is low and reflects her lack of seniority in the company. The company provides good benefits, but like many companies in New England, may lay off some workers in the near future as a result of the economic recession. Suzanne is worried about this. She has not made social contacts with any co-workers, so she is not sure how much truth there is to these rumors of impending layoffs.

Suzanne is currently enrolled in a community college where she has completed the first year by taking classes two days a week. She is interested in a special education major. Although the college has made special efforts to attract older, nontraditional students, most of the students are much younger than Suzanne. She has done well in college, but she has not made any friends among the other students.

Marie is in a private day care during the day and Suzanne's mother takes care of the child at night while Suzanne works. Suzanne's father died of cancer five years ago, and Suzanne was involved in his long-term home care before he

died. Each evening, Suzanne drops Marie off at her mother's apartment and picks Marie up in the morning. Suzanne's mother cannot drive a car.

Last month, Suzanne was involved in a car accident and sustained a closed head injury. She suffered a left temporal lobe contusion and facial lacerations. She was not wearing a seat belt at the time. She did not lose consciousness at the scene of the accident. The emergency medical technicians immediately brought her to the local hospital's emergency room. After ten days she was transferred to the hospital's rehabilitation unit to treat higher order level cognitive deficits and to improve her balance and gait. The rehabilitation unit also evaluated her ability for independent living and found her to have no difficulties returning to work and school and caring for her daugther.

Suzanne views the car accident as a major setback, because she was just beginning to feel that her life was in order. She is proud that she left her abusive husband, entered college, and moved from the day to the night shift at work. She blames herself for the car accident since she normally wears a seat belt but hadn't had it on while she had the accident. For the weeks that Suzanne was in the hospital, her husband provided some child care. Suzanne is concerned that this may help his case for increased visitation.

In the settings we will describe, Suzanne states she is depressed. She is concerned about her job security and about the stress of combining employment and time spent with her daughter. She is also depressed about her perceived inability to do well in school and to be a single parent. In addition, she claims to have been depressed "for no reason" for the past year, even before the car accident.

Description Of Mental Health Settings: Strengths And Dilemmas For Feminist Therapists

We, the authors, have worked in a number of clinical settings and would like to portray five settings that Suzanne is likely to enter as the result of her head injury and the resulting depression. Obviously, Suzanne would not come in contact with or choose to enter more than one or two of these settings, but as she is a hypothetical client, we can also speculate on how various mental health settings would provide services. For each setting, we are assuming that the provider or clinician is a feminist therapist. The settings are as follows: (1) informal social support setting; (2) inpatient medical or rehabilitation facility in which psychological support services are a component; (3) child outpatient service; (4) college counseling center; and (5) adult outpatient setting.

Informal social support setting. The majority of people do not seek therapy or mental health services for problems in living. For centuries, women have sought advice and support from family, friends, and spiritual leaders. Women are most likely to be the providers, as well as the seekers, of this kind of psychological support from members of their communities. Women are more disclosive of personal information, including personal crises, than are men, and more willing to seek informal help; they are more likely to turn to other women

in times of distress. Thus, Suzanne is probably more likely to talk to someone she knows personally, as a first resort, rather than seek out professional services.

Suzanne does not seem to have close friends, and has not connected with co-workers or with students at the college. Possibly her mother is her closest confidante. She might contact a professor or advisor at school to address academic stressors, or approach her supervisor at work about issues around her employment. In this way, she might come to our attention indirectly, rather than because one of us is her therapist. She may have heard one of us speak about women's issues on the radio; she might be a student in one of our classes and approach us because she has questions about her career or future directions, or she might write about her situation in a class assignment, as a "cry for help."

The advantage of informal sources of social supports is that they are plentiful (or potentially so, even if a woman like Suzanne does not have many friends) and can be accessed for hours at a time. Informal contacts may know their friend's or acquaintance's situation extremely well, due to similar demographic, economic, or social situations. The dilemma of contacting us (the authors) as sources of informal mental health advice or support is that we may be greatly constrained by time (we may teach a large number of students) or conflicts of interest (we cannot be both friend and teacher to Suzanne).

Medical setting. As a result of her car accident, Suzanne arrived at the emergency room of a hospital. Suzanne's head injury, particularly the resulting memory loss and difficulty concentrating, will most likely bring her in contact with neurological services in the hospital. A mental health professional (in the case of a hospital setting, usually a social worker, psychologist, or psychiatrist) may be called in because Suzanne is showing symptoms of depression such as sadness, poor appetite, lack of sleep, and tearfulness. Suzanne will most likely be referred to a rehabilitation setting staffed by medical, mental health, and rehabilitation professionals to address functional and psychological issues.

In the hospital setting, Suzanne is likely to have immediate and practical concerns, such as her inability to go to work and to complete her school assignments. She may have questions about the amount of health coverage provided by her employer. Since her mother cannot drive, Suzanne may not be able to have regular contact with her mother and daughter. Suzanne may erroneously suspect that the hospital staff have blamed her for the car accident, and this may exacerbate her own self-blame.

The hospital setting is likely to have more men than women as accident-related patients, since men predominate in accident-related injuries. A common scenario is to treat a male patient for medical reasons (e.g., head injury) and to meet female family members (primarily patients' wives) as they visit the patient or need to be instructed in long-term home care of the male patient. These women often have a great deal of difficulty coping with these demands on top of their regular roles. Women may be overwhelmed and distraught because they need to make decisions traditionally made by men and also because they are in

need of support themselves. It is possible to work with women patients in this setting, and one of us has formed a support group for patients' family members. However, it is difficult to find the time and resources for this activity. When it did happen, it worked very well since women were able to see the commonalities between them and also formed some connections with other women in similar situations.

There may be pressure in a medical setting to provide medication in addition to therapy. Thus, one of us might be expected to recommend antidepressant medication for Suzanne.

Child outpatient service. Women often come to the attention of the mental health profession in the process of seeking advice or services on behalf of a family member, often a child. Thus, we wanted to portray child services as one avenue in which Suzanne may enter the mental health system.

Suzanne's daughter, Marie, may be referred for therapy because she is showing symptoms of anxiety related to separation from her mother during Suzanne's hospitalization following the car accident. Marie may begin having sleep problems and show signs of distress when her grandmother leaves her at day care or even leaves the room at home. Marie may begin having nightmares. Alternately, Marie may begin withdrawing from her mother, may become noncompliant to Suzanne's requests and may turn to her grandmother for support and attention. Suzanne may seek services because she feels that Marie no longer loves her. When Marie is brought for therapy, she may be extremely fearful of the therapist or may comply with all requests from the therapist but not with those from her mother.

During this initial assessment session of Marie, Suzanne may show evidence of depression by sad or flat affect, obvious fatigue, or tearfulness. She might state that she blames herself for Marie's distress, in that her accident as well as her busy schedule and difficulty in coping have affected her daughter. Suzanne may not be reassured by the therapist's statements. If she is asked directly, Suzanne may describe her husband's abuse of her and her worry that Ed might abuse Marie or abuse Suzanne again in the future.

One constraint of working with women indirectly as the result of child referral is that, in many service systems, the focus of therapy must relate directly on the child in order to be reimbursed. The parent (usually the mother) is bringing the child in to be "fixed." Even if the mother is clearly depressed, there may be little we can do for the mother in the context of such a child service clinic that does not relate directly to her child's problem. We also have to consider what it means when we develop an intervention for the child that the mother then needs to explain to the father who wasn't present in the therapy session. Is this putting the mother in a bind? Certain therapies aggravate symptoms, at least initially. How do we support the mother through this period? In this case, our intervention for the child may actually increase the mother's stress and exhaustion level and possibly contribute to her depression.

Academic counseling setting. Suzanne may decide to seek counseling at a college counseling center since it is usually free to students enrolled in college. Suzanne might seek counseling for a variety of reasons: she is finding it difficult to find the energy to attend classes and is considering quitting college; she may find it difficult to make friends since she is older than most students; her job may not be quite what she wants it to be, and the night shift is disrupting her sleep and overall life style. Our role would be determined by the expectations of therapy. If her depression is interfering with her school work, we may explore ways to cope with the demands of school.

As feminist therapists, we need to be acutely aware of the link between education and empowerment which, in turn, has implications for long-term emotional well-being, thus, we have a responsibility to assist or support Suzanne in the completion of her studies. Given all the issues that Suzanne is confronting, school may be the first to fall by the wayside since it has less of an immediate impact upon her situation. The vocational and career counseling resources may be of assistance to Suzanne if she chooses to explore her career options.

The greatest drawback in such a setting is the fact that access to services is contingent upon enrollment in school. If Suzanne were to stop being a student, even for a semester, she would have to seek therapy from other sources, or go without it.

Outpatient setting. Suzanne may directly seek services at an outpatient setting, which can range from a community-funded mental health center to a private practice setting. The cost of therapy can range considerably.

Suzanne might come to this setting because she just can't go on. She has lost contact with friends during her marriage and now has few social supports. Her mother feels that Suzanne should have stayed with her husband. Suzanne is concerned about Marie's safety when her husband has visitation and feels like a bad mother for being unable to protect Marie during these times. Suzanne is angry with the courts for having given her husband visitation rights. She is tempted to flee across the border to Canada with Marie in defiance of the visitation situation. Consequently, Suzanne may bring up some issues that are approaching a crisis level and others that are more chronic.

In an outpatient setting, staff have enough independence to behave as free agents in terms of the philosophy of their therapeutic approach. Thus, feminist therapy is one of many available approaches. Nevertheless, colleagues may feel that therapists should not force their agenda (i.e., feminism) on the client. Despite the independence of individual therapists, there is still an assumption of certain shared values among professionals, and this may result in feminist therapists feeling marginalized. If we don't have experience in feminist therapy, most therapy settings will not provide this training.

Another issue in outpatient settings is that group practices survive by changing fees for services, and so there is a limit in how much free or reduced-fee services an outpatient center can provide. Because Suzanne has both access

to transportation and child care, she is better off than many women who cannot evens seek such services.

Feminist therapy: Conceptualization and interventions

Given this diversity of potential clinical settings, what are some issues that may arise in feminist therapy? In all settings, we viewed feminist therapy as a comprehensive approach, that examines both societal factors as well as individual issues. Regardless of the client's stated problem, we do not look at the problem in isolation. Instead, we wanted to focus on women's realities and sources of stress.

We all agreed that Suzanne has more resources than do many women in Vermont. She has health benefits at work, and her job, at least for the time being, is relatively secure. She is doing adequate work in college. She has a car, and she has her mother to provide day care. On the other hand, Suzanne is facing a number of obstacles. Her time off due to her hospitalization and recovery may threaten her job if the company begins to lay off workers. Young women are also among the first to be let go if companies give preference to long-term employment.

What makes Suzanne's situation a women's issue? Our society has very few supports for women bringing up a child while working or going to school. Suzanne's company has some benefits, but not for child care or time off from work for child-related problems. Suzanne's feelings that she is a bad mother are certainly supported by society's expectations that women need to make a choice between childrearing and paid employment.

It is also important to examine Suzanne's history of physical abuse. How is it impacting on her current functioning and on her feelings about herself? Physical abuse is another arena that contributes to powerlessness, both in terms of the threat of actual abuse from her husband and the threat of perceived abuse in the future. In either case, therapy will need to focus on ways Suzanne can understand the individual and societal dynamics of abuse. Suzanne, like many women who have been abused, may have feelings of guilt for not leaving the relationship sooner or for the potential of "exposing" her daughter to an abusive father. Individual or group therapy must emphasize that abuse does not occur because women provoke it and that Suzanne is not alone in being battered.

Suzanne has chosen a traditionally female major in college and one that is underpaid. Unless she has the freedom to look for work outside Vermont, she will have difficulty finding work in this state, which is currently experiencing cuts in the school and mental health systems. Suzanne is likely to be the first person in her family of origin to go to college, and women in her family may not have been encouraged to obtain higher education. She may see college as a goal in and of itself and have few plans or ideas of what to do after college. It is important for women to understand how education and income are paths to reducing powerlessness even though they may not always have the opportunity

to act upon them. Powerlessness is not only in women's heads but also in their wallets and in their resumes. During the course of therapy, it is essential that we not ignore such issues and their impact upon our clients.

Suzanne's mother is providing an important avenue of social support. Yet by relying on her mother, Suzanne may be perpetuating the role of caretaker or may be increasing her mother's burden. We need to explore how this relates to her history of her relationship with her mother. Even if Suzanne has no other options for childcare, it would be helpful for her to examine the role that her mother plays in her life.

Although it may be necessary for Suzanne to attend college while making an income, her night shift is likely to be a major stressor in reducing her well-being. Night shifts may promote sleep difficulties, and lack of sleep may contribute to Suzanne's depression. The night shift may also impact on Suzanne's social relationships since many social events take place late in the day or evening. Suzanne seems isolated and may need to connect with people in order to increase her resistance to depression.

Exploring Suzanne's work environment might offer clues about the presenting situations. If she works in a traditionally male job, is she being harassed in subtle ways? Are there ways she can reach out to other women at work? Is Suzanne being put down or supported for working in a man's world? Is anyone in her work environment contributing to Suzanne's feelings of helplessness or powerlessness? In seeking to understand Suzanne's feelings, we must examine their source. Is Suzanne being paid equitably? Women are often underpaid relative to men performing similar jobs and may not be aware of this inequity. When women do realize these pay inequities, they may experience outrage, anger, or a drop in morale. Is Suzanne trapped in her current position, or are there opportunities for advancement? Since Suzanne works for a large company, are there opportunities for child care or for educational advancement? Companies may be reluctant to publicize these benefits, assuming that employees are already aware of them, when in fact employees may not be aware of such benefits.

These issues we have outlined may be reframed as aspects of Suzanne's ongoing development rather than merely crisis-oriented events.

What would we do in working with Suzanne? After a full assessment of Suzanne's cognitive functioning, we would try to normalize her experiences and also focus on her self-esteem. All of us mentioned women's groups for Suzanne. Support groups may be general in scope (for women, for students) or more specific (for single parents, for survivors of abuse). Suzanne needs to recognize her own strengths and acknowledge this rather than perpetuate a self-blaming mode.

Working with women in therapy more often seems to involve the entire family system than does working with men. Men's sense of self is less tied in with others, including family members. Men are also less likely to seek therapy through their involvement with their children. Women are more likely than

men to be primary caregivers for support in relationships. Thus, therapy with Suzanne may involve sessions with her mother or with her daughter.

Therapy would focus on ways in which Suzanne could gain control over her life. We would also elucidate the messages that Suzanne carries about herself and would ask her to evaluate whether her expectations are realistic or unrealistic. We would normalize the external circumstances but also examine how Suzanne could change some of these circumstances. For example, Suzanne might want to change jobs. She needs to decide whether to stay in college.

We would ask Suzanne to rank order her various roles and reflect back on her life events that contributed to her depression. Her depression is the result of various situations, some under her control and some not. She has a number of choices in how she can cope with the depression, and it is important that the mental health professional encourage Suzanne to examine these coping patterns and identify ways in which they are helpful. Suzanne needs to realize that there are both internal and external factors that contribute to women's feelings, thoughts, and behaviors, and that her own understanding of what is internal and what is external may be different than the therapist's understanding. We would work on how the two processes meet and what can be done to change either one.

There are also a number of issues that Suzanne has not mentioned directly that may be additional issues facing women in our society. Suzanne is not in an intimate relationship, yet lives in a society that stresses the importance of such relationships, particularly for women. Women are often expected to juggle the stressors of motherhood and employment. Suzanne has the additional role of student to juggle as well.

Travel is another common problem for women. "Treatment" is often defined as taking place in a specific place, so that home visits may not be reimbursable. Women may have limited transportation and be dependent for rides during certain hours of the day or to certain locations.

Money is another dilemma in feminist therapy. What female clients most want or need may not bring in the most money. What feminist therapists most want to do may not bring in enough money to a therapy setting and thus be discouraged. When feminist therapists provide services for free or at reduced fees, the income of other therapists who are charging a higher fee for these same services may be threatened. Even when a clinic or service becomes known as focusing on women (let alone as feminist or lesbian), this woman-focus may discourage some clients from seeking services or threaten some colleagues.

Feminist therapists need to know about legal recourse that clients may need to pursue and about ways to facilitate legal services. Thus, Suzanne's situation may involve future legal action against her husband.

The work setting itself can provide a supportative or unsupportive atmosphere for women as clients or therapists. Seeing artwork or posters that are degrading to women or just seeing few other women in the setting can send the message that women are not important to the setting. Women may prefer collaborative styles of working rather than hierarchical styles. Settings can foster

competition or cooperation in very subtle ways. For example, therapists may receive subtle rankings for the prestige of the clients with whom they work. Or staff in some settings may meet to discuss ways of encouraging more male clients, thus giving the impression that men are more important than women or that women are problematic for the setting in some way. The demands of the setting may provide little time for process, resulting in clients described primarily by their diagnosis.

In a teaching and training setting, we have allegiance to our peers and colleagues while also having allegiances to other women (even if these women are subordinates - students and trainees). This results in dilemmas.

We realize how often women have less power than men in a system, yet we also understand how much power we have over clients and trainees. Our diagnostic and treatment decisions have tremendous influence over people's lives. Adult clients and parents of child clients may not be aware of how much information may get transcribed into their records and may eventually be reviewed by several others.

People assume that feminist therapy means women working with women. We could ask why so few men are depressed, given the horrors of our society, or why men predominate in other areas of mental health problems, such as substance abuse and illegal behavior. Some feminists have understood this gender difference as women hurting themselves and men hurting others. Clearly, feminist therapy can be used with male clients as well.

Our client is white, generally able-bodied, young, and heterosexual. The complexity of our interventions would increase as clients are members of more than one minority group.

Clients in crisis may not have the luxury of long-term therapy. This is particularly true for less affluent clients, and women are overrepresented in this group. Thus, therapy needs to reflect short-term, immediate care. This means that only one or a few goals can be addressed. We cannot hope to change a number of areas, and we need to be realistic about change.

Middle-class therapists may be horrified at the idea that Suzanne may need to drop out of school since we are aware of the role of education in long-term independence. Nevertheless, leaving school may be the only way to decrease the tremendous role overload that women are under, and therapists should not preclude this even if they want to urge clients to consider it a last resort. Access to services are often tied to such roles, however, if Suzanne drops out of college, she will probably be unable to receive free counseling at the college.

Had we conceptualized Suzanne's situation from a more traditional perspective, we might have administered antidepressant medication to affect neurotransmitter levels and, thus, to improve some of Suzanne's depressed symptoms, such as her mood and sleep. If we used traditional psychological therapy, we might have focused therapy on helping Suzanne achieve insight into unconscious conflicts, or worked on altering her negative thought patterns. As mentioned earlier, feminist therapists are usually trained in traditional therapy and may combine feminist therapy principles with traditional therapy strategies.

The way in which we conceptualized and wrote this article also reflected feminist process. We began by discussing the scope and complexity of feminist therapy for depression. We spent several hours discussing feminist issues, long before we were clear what this article would be about. We ended this discussion (which we audiotaped) by deciding that the article would focus on how each of our clinical settings provides both opportunities for and dilemmas about feminist therapy. We then met a second time to discuss these clinical settings (beginning with the dilemmas). Finally, we came up with a description of a hypothetical client, taking care that she was someone who might seek services at any one of our clinical settings. In other words, we discussed this topic in the exact reverse order in which it was eventually written up.

Throughout the process, there was a tremendous spirit of collaboration and enthusiasm. We, the authors, represent four graduate students and one faculty member in clinical psychology and are from diverse cultural backgrounds. We realize that we speak only for feminist therapists of our particular demographic backgrounds and training styles. We encourage readers to discuss their understanding of feminist therapy for depression and publicize their own unique approaches.

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