FEMINIST THERAPY AND ASIAN AMERICAN WOMEN
IN THE UNITED STATES: SELF-IN-RELATION THEORY
IN PSYCHOTHERAPEUTIC PROCESS

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ABSTRACT

FEMINIST THERAPY AND ASIAN AMERICAN WOMEN IN THE UNITED STATES: SELF-IN-RELATION THEORY IN PSYCHOTHERAPEUTIC PROCESS

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This study investigated the relationship between self-in-relation theory and Asian American women in the psychotherapeutic process. The hypothesis was that self-in-relation theory is a more effective approach with Asian American women in therapy than that of traditional psychotherapy. A correlational study measured three major variables: Effectiveness of therapy, elements of self-in-relation theory, and elements of traditional psychotherapy. Through self-report/subjective ratings, participants answered two questionnaires: The Asian American Women’s Satisfaction in Therapy Questionnaire (AWSTQ) and the Client Satisfaction Questionnaire-8 (CSQ-8). The statistically significant results indicated that there is a positive relation between self-in-relation approaches to psychotherapy and Asian American women’s satisfaction in therapy. In addition, there is an inverse relation between traditional psychotherapeutic approaches and Asian American women’s satisfaction in therapy.
Asian Americans and Mental Health Services in the United States

The Asian American population is growing rapidly in the United States, and the growing diversity within the Asian American population is challenging the provision of proper and effective mental health services and treatment to Asian Americans (Chin, 1998). As of 2000, there were over 10.2 million Asian Americans, and by the year 2020, the Asian American population is projected to reach 20 million (Kim & Atkinson, 2002; Sue & Sue, 1999). Based on these statistics, it is predicted that there will be greater demands in the future from Asian Americans for culturally sensitive and relevant mental health services. Chin also indicates that “as the ethnic consciousness of Asian Americans was raised, the literature began to reflect the unique characteristics of Asian culture and to question the relevance of ‘standard’ approaches for Asian American clients” (p. 486). Currently, there is an increasing emphasis on revising existing psychological approaches and/or developing new approaches to be more responsive and sensitive to the differences found among Asian American clients. These current trends support the need for cultural sensitivity, bilingual/bicultural mental health providers, and cross-cultural training.

Before further discussion on the diversity of Asian American women, the term “Asian American” will be given a thoughtful definition. Throughout the text in the present study, the term “Asian American” will be defined as noted in Laura Uba’s (1994) book, Asian Americans: Personality Patterns, Identity, and Mental Health. Technically speaking, those who have not become U.S. citizens are not Americans, but researchers in psychology usually include them under the term, “Asian American.” Moreover, many statistical analyses of research in psychology combine both citizens and non-citizens due to limited sample sizes (Uba). Thus, the use of
“Asian American” in the present study will include both Asian American citizens and Asian non-immigrants living in the United States because of the difficulty in recruiting participants.

**The Diversity of Asian American Women**

Despite the growing amount of research on the mental health of Asian Americans, research on Asian American women is still emerging slowly (Root, 1998). Asian American women are a heterogeneous group because there are cultural and generational factors involved; she may be a new immigrant, refugee, or American born, first or fourth generation (Root, 1995). In addition, the term “Asian American women” defines a diverse group of women representing over 30 different ethnic-cultural groups in the United States and this group has very diverse cultural values, ethnic backgrounds, and socio-economic statuses, immigration experiences and sexual orientations.

Given the diverse background of Asian groups, the self-identity for an Asian American woman is a balancing process in which gender, race, culture, class, and any other dynamic senses of self must be integrated in her daily life (Root, 1998). In this balancing act, Asian American women have to develop reference standards to be able to evaluate themselves and others. However, it is not easy to set standards which are accepted by both mainstream American culture and their own cultures of origin. Struggling with self-acceptance/identity in Western culture and the gender roles within their own cultures, Asian American women may encounter difficulties adjusting between Western and Asian cultures. The difficulties adjusting to a new environment and confronting with several psychosocial stressors (e.g., immigrants and refugees, socio-economic statuses, stereotypes against Asian American women) increase their risk for continuing psychological distress and the need for mental health services.

**The Preference of Feminist Therapy**

In the present study, the beliefs of feminist therapy are adopted to view and examine Asian American women’s experiences in psychotherapeutic process. The central tenet of feminist therapy emphasizes sociocultural factors affecting the psychology of women, a positive development to provide more effective mental health services for women of color (Espin, 1994). Particularly, the core of feminist therapy is to empower women. The process of women’s empowerment can help them to gain essential skills and knowledge, so they can have more control in their
own lives. In a way, empowerment is a form of healing and validating women’s lives (Espin). As Espin summarizes:

Feminist approaches help women of color to acknowledge the deleterious effects of sexism, racism, and elitism; to deal with negative feelings imposed by their status as ethnic minorities; to perceive themselves as causal agents in achieving solutions to their problems; to understand the interplay between the external environment and their inner reality; and to perceive opportunities to change the responses from the wider society. (p. 272-273)

Despite its initial development, which failed to acknowledge the various life experiences of women from diverse racial, ethnic, and cultural backgrounds, feminist therapy is considered highly relevant and especially helpful to the lives of women of color (Enns, 1997; Worell & Johnson, 2001). Furthermore, more women of color have developed multidimensional models and strategies that address their diverse cultures and multiple identities (Worell & Johnson).

A key feminist theory, self-in-relation, is the center of this present study. The self-in-relation theory was introduced by feminist scholars from the Stone Center at Wellesley College. With the groundbreaking work of Jean Baker Miller, along with three other scholars, Judith Jordan, Irene Stiver, and Janet Surrey, the self-in-relation theory adopts a developmental perspective and emphasizes the mother-daughter relationship in exploring the complexities of women’s development (Jordan & Hartling, 2002; Worell & Johnson, 2001). The core ideas underlying the self-in-relation theory suggest that “all growth occurs in connection… and that growth-fostering relationships are created through mutual empathy and mutual empowerment” (Jordan & Hartling, p. 49). In other words, women’s growth occurs in connecting with others during their lives rather than separating themselves from others (Jordan, 1997).

**Asian American women and Self-In-Relation Theory**

Is there a “connection” between Asian American women and the self-in-relation theory? One of the major concepts of the self-in-relation theory emphasizes women’s interpersonal relationships as central to women’s identity development because women’s positive connections to others help them to experience personal continuing growth and well-being. For Asian American women, the interpersonal relationship also plays an essential role for their identity development and life experience. As Chin (2000) indicates, with patriarchal dominance in the Asian
cultures, cultural expectations define an Asian American woman’s social status by her marital status within the family hierarchical structure; historically, Asian American women have been expected to behave in a self-sacrificing, subordinate role. However, interpersonal connection encourages and supports Asian American women to establish a respected social status and maintain the unity of family.

**Summary of the Purpose and Hypothesis in This Study**

The purpose of the present study was to examine whether self-in-relation theory is a preferable therapeutic approach to Asian American women in therapy. This research hypothesized that Asian American women would be more satisfied in therapy if the therapeutic process included the components of the self-in-relation approach, sense of connection, and mutuality. Also, it was anticipated that Asian American women would have less satisfying experiences if the elements of traditional psychotherapy were used in therapy (e.g., blaming clients for their mental problems, hierarchical relationship between therapist and client). In addition, the relationships among client’s satisfaction, the elements of self-in-relation theory, and traditional psychotherapy were examined.

In the present paper, four major issues will be reviewed. First, the critiques of traditional psychotherapy from feminist perspectives will be discussed. Second, the Asian cultural values (14 value dimensions), how these cultural values can affect Asian Americans’ perception of psychotherapy, and why Asian Americans underutilize the mental health service will be examined. Third, a brief overview of feminist therapy will be discussed, including its historical background and principles of feminist therapy. Finally, I will go into details of the self-in-relation theory, which is the main theme of this study.

**Critiques of Traditional Psychotherapy from Feminist Perspectives**

Traditional forms of psychotherapy are open to several critiques from feminist perspectives. Traditional models of psychotherapy are based on some or all of the following components: Therapist objectivity, therapist as an expert, emotional disconnection from clients, mental problem as an illness (medical model), and intra-psychic dynamics (Greenspan, 1983; Worell & Remer, 1992). Four major critiques of traditional psychotherapy will be discussed: Intra-psychic, therapist as expert, mental problem as an illness, and stereotyped views of women (S. C. Turell, personal communication, February 5, 2001).

*Intra-psychic.* Theories that ascribe all problematic behavior and emotional
distress to intra-psychic causes tend to ‘blame the victims’ for their psychological problems. With the emphasis on unconscious intra-psychic element, it implies that people, unconsciously determine or have control over our lives. The solution to one’s problems, therefore, rests inside the individual. Besides, the foci of intra-psychic and past experience overlook the present external environment, and this emphasis has been criticized by feminist therapists (Benjamin, 1984). As Unger (1984) states, the focus on the intrapsychic self can easily lead one to blame the person. Traditional therapy concentrates on the client’s internal conflicts without considering the influence the client’s external environment contributes to her/his issues. Such external factors may include oppression and/or abuse. If one overlooks the need for possible changes in the environment as solutions to a client’s emotional problems, it can lead the therapist to blame the client for her/his problems (Greenspan, 1983; Worell & Remer, 1992).

Therapist as expert. Another critique of traditional psychotherapy is the notion of “therapist as expert”. The concept of “therapist as expert” imposes a rigid and hierarchical structure of power over the client during the therapeutic process, and it manifests a sense of directing and controlling therapy with the client. As experts, traditional therapists are in a higher position over the client, with power to make diagnosis and provide treatments for the client. Clients have little choice but to accept the diagnosis and treatments from their therapists. This hierarchical relationship distances the therapists from their clients in therapy, and also prevents the therapists from sharing themselves with the clients. The justification from the traditional therapy perspective is that if therapists reveal themselves to their clients, they are seen as unprofessional; emotional withholding by traditional therapists is considered essential in order to be neutral with clients in therapy. Neutrality is a fundamental element in traditional psychotherapy.

From a feminist perspective, clients and therapists are considered to have equal value and respect as people, and the clients are considered to be experts about themselves. Self-disclosure (e.g., sharing information about their life experiences) and self-involving skills (e.g., sharing their feelings/reactions) are utilized by many feminist therapists to replace the notion of therapist as expert in therapy (Worell & Remer, 1992). Many feminist therapists believe that interpersonal relationships, such as the client-therapist relationship should be as egalitarian as possible to empower clients. They believe that most women in American society do not have
equal status and power compared to men, and many oppressed groups also have less power and are considered of lower status. It is important to establish an egalitarian relationship between client and therapist for two reasons. First, an egalitarian client-therapist relationship can lessen the controlling/directional aspects of therapy. Second, egalitarian client-therapist relationship would not reconstruct the power imbalance/different women have experienced in society (Worell & Remer).

Mental problems as illness. Furthermore, mental health problems are seen as illness in much of traditional psychotherapy. The notion of medical model suggests that mental problem is just like physical illness; people can either have or not have (Morris, 1997). The view of “medical model” in psychotherapy indicates that an individual’s emotional suffering/distress is a medical problem and sickness, and her/his emotional problems can be ‘cured’ in the same way as she/he has physical problems. The medical model contributes a person’s emotional suffering or pain as the result of individual pathology; the diagnosis focusing on medical model tends to de-contextualize problems by overlooking the client’s social/cultural context. The medical model approach pathologizing/naming client’s psychological problems is especially problematic for feminist therapists/theorists while they try to understand client’s problems in her/his social/cultural environment in addition to client’s inner psyche (Morris).

Therapists who utilize the “medical model” can be prone to bias in evaluation/diagnosis of client because a client’s social/cultural position is frequently excluded in diagnosis and treatment (Wyche, 2001). According to the examples of eating disorder and attention deficit disorder, therapists using the medical model tend to infer that the client’s behaviors are maladaptive. Traditional therapists view client’s characteristics of these disorders are fixed entities inside the client and are not influenced by socio/cultural context (Marecek, 2001). The focus of the medical model is on the client’s inner psyche, and at the same time ignores the influences from client’s socio/cultural environment. However, diagnostic bias can also intertwine in complicated ways with other biased assumptions about social classes and various groups, such as racial, ethnic, age, ability, and sexual orientation.

Stereotyped views of women. For many years, traditional psychotherapy, particularly, psychoanalysis seems to be influenced by the values of male psychotherapists. For example, Freud’s concepts have been criticized for devaluing aspects of women’s roles, such as “castration anxiety” and “penis envy”. Horney
(1967) criticized Freud’s view of penis envy, noting it indicates that women are inferior/subordinate to men. Many feminist therapists claim that psychoanalysis devalues women and their roles because traditional therapists often adopt the principle that women and men should behave in traditionally stereotyped gender roles. Also, they may diagnose and label female and male clients differently based on gendered stereotypes. Thus, many traditional therapists with these approaches may differ in their treatment goals from female and male clients, based simply on the client’s gender. The structures of traditional psychotherapy also reflect many patriarchal assumptions about women (Morris, 1997). Traditional therapists with gender-biased stereotypes tend to believe that for women to be mentally healthy, they should be submissive, nurturing, and fulfilling their roles as wives and mothers; on the other hand, traditional therapists consider that men should be aggressive, independent, competitive and unemotional in order to be mentally healthy (Worell & Remer, 1992). Because of these stereotyped views of women, traditional therapists can misunderstand their clients and also provide improper treatments for them.

**Asian Cultural Values: 14 Value Dimensions**

As described in a study by Kim, Atkinson, and Yang (1999), there are 14 identifiable Asian value domains based on their extensive literature review (i.e., journal articles, books/book chapters, and dissertations) on Asian cultural values. The 14 value dimensions empirically identify the Asian cultural values as perceived by Asian Americans in the United States. The following brief description of Asian values is derived from the study by Kim, Atkinson, and Yang in 1999 (as described in Kim et al. 2001).

First, the “ability to resolve psychological problems” is one of the 14 value dimensions, which suggests that an individual is expected to use her/his inner power to resolve psychological problems; asking other for help is a sign of weakness. Second, each individual should not disgrace her/his family because family’s reputation is a crucial concern and a top priority. Also, Asian Americans are expected to be successful in both academic and work. The issue of “losing face” or “bring shame to family” is something that Asian Americans will try to avoid because the concept of “face” is often salient for Asian American clients. On the other hand, the issue of “face” also involves the notion of respect, in which Asian American clients show the respect towards professionals/authorities, and expect respect in return. Thus, any interaction that may result in a loss of respect is considered a loss of face.
Asian American clients’ satisfaction may be strongly influenced by their expectations and experiences concerning respect in therapy. In some cases, clients may also be reluctant to reveal their satisfactions or dissatisfaction to their therapists because they want to avoid causing loss of face of others (Zane & Yeh, 2002).

Third, the nature of “collectivism” plays an important role in the lives of Asian Americans. An individual should have a sense of bonding/attachment to a group where they belong to, and she/he should place other’s requests before personal needs. Also, Asian Americans are encouraged to be interdependent with other people of the group, and they should work with others instead of working by themselves. Many Asian cultures focus on the fundamental connectedness of human beings to each other and to the external environment. This concept is very different from the central belief of Western culture that emphasizes on individualism. Fourth, “maintaining interpersonal harmony” is another important dimension as well. While having argument with others, an individual should make effort to maintain harmony instead of fighting back; each person should not say something or express her/his feelings that might offend others or cause others to feel uncomfortable or losing face. Additionally, Asian Americans are expected to hold their emotional pain or anger rather than to express them to others. Also, the ability to restrain emotions and sufferings is a sign of strength.

Importantly, some of the Asian cultural values identified in the 14 value dimensions may have great impact on how Asian Americans perceive the psychotherapy and why Asian Americans underutilize the mental health services. Are these cultural values helpful to Asian American clients when they deal with mental health problems? Or would these cultural values put them in an uneasy situation?

First, the ability to resolve psychological problems without seeking help from therapists is expected in the Asian culture. Traditional Asian culture encourages the suppression of emotional conflicts and discourages the expression of emotions. Many Asian Americans are taught to have self-control and emotional restraint when experiencing psychological problems. They are expected to resolve their psychological problems on their own. Therefore, asking others for help means that they are weak and incapable to deal with their own psychological problems.

Second, Asian Americans are not encouraged to reveal mental health problems because they will disgrace their family. Asian Americans are expected to avoid
bringing shame and loss of face to their families; manifesting psychological problems can ruin their family’s reputations. Many Asian Americans consider mental disorder as a stigma because they think that revealing problems by seeking help from professionals are signs of personal incapacity, weakness, and a lack of self-discipline (Uba, 1994). Thus, the issue of “loss of face” can be a salient factor that indicates why Asian Americans are more likely to have the “highest premature termination rates and shortest treatment stays in mental health systems” (Zane & Yeh, 2002, p. 134).

Third, the ability to have self-control and emotional restraint is considered a sign of strength. Many Asian Americans are taught to mask their emotions rather than to express them. To maintain interpersonal harmony is very important for Asian Americans. Traditional Asian values are largely based on Confucianism and Buddhism. Confucianism is a philosophy that encourages the values of maintaining harmony in relationship, knowledge and acceptance of one’s place in the family and society, obedience, and orientation toward the group (Kim et al. 2001; Uba, 1994). The Confucian value of interpersonal harmony plays a significant role in Asian Americans’ communication style and interpersonal behavior (Kim et al.). Furthermore, the way of expression and interpersonal behavior can be salient factors that influence Asian American clients in their relationship with therapists. For instance, therapists need to understand the communication style (e.g., emotional restraint) of Asian American clients so that therapists are able to lead (but not in a hierarchical way) Asian American clients to talk about their feelings and concerns in therapy. As one can see, these Asian cultural values may have a great impact on how Asian Americans perceive/solve their psychological problems and why Asian Americans underutilize the mental health services.

*Asian Americans’ Perception of Psychotherapy*

How do Asian Americans perceive psychotherapy? It is crucial to recognize and understand that the mental health profession (e.g., psychotherapy) does not have a structured system or even does not exist in many traditional Asian cultures; mental health services are still limited to the medical practice of psychiatry (Hong, 1993). In many instances, Asian American clients will first complain about their physical pains to the medical doctors because they do not realize that the symptoms of their physical pains are caused by their emotional distress and suffering. When the medical doctors comprehend the reasons for their clients’ physical pains, they tend to provide treatments in a “medical” way. Normally, people in many Asian countries
will see their physicians first for treatments, and oftentimes the physicians tend to either prescribe medications directly to the clients or refer to psychiatrists for further consultations. It is important to note that the psychotherapeutic process in many Asian countries starts from seeing psychiatrists, and then “maybe” combining therapists/psychologists with the whole process; apparently, the therapeutic process is in an opposite order as compared with Western mental health systems.

**Asian Americans underutilize Mental Health Services**

**Cultural conflicts.** The discrepant expectations and perceptions of psychotherapy can contribute to misunderstandings between therapists and Asian American clients, as can cultural conflicts/expectations and interaction styles of many Asian Americans in therapy. These cultural conflicts can result in underutilizing the mental health services. One of the cultural conflicts is that Asian American clients expect the psychological evaluation or diagnosis to occur quickly and expect therapy to be brief. For instance, many Asian Americans, especially foreign-born or new immigrants, expect a quick diagnosis without the necessary time for evaluation (Uba, 1994). The reason is that the healing practices back to their home countries do not require a lengthy evaluation sessions for diagnosis. They tend to have the expectation that the therapeutic interventions are short and the psychological problems/symptoms can be relieved by the therapist quickly.

Asian American clients tend to ask their therapists at their first therapy session how many therapy sessions are needed to “heal” their problems. Moreover, they usually assume that if they just tell the therapist what their problems are, the therapist will direct them to the solution because of their “authority” status. However, the therapist may need extended discussions with clients to carefully comprehend the underlying problems. It can be a time-consuming process. In the case of extended therapy sessions, Asian American clients will feel frustrated by not being able to receive direction/advice for their problems. When they do not acquire “solutions” from the therapist, they may drop out of therapy early. Asian American clients are discouraged from seeking help because of the cultural expectations.

**Style of interpersonal communication.** The different styles of interpersonal communication, such as indirect and nonverbal expression, and deference to authority figures have to be considered while doing therapy with Asian American clients (Hong, 1993; Chin, 1993). The expressive/interpersonal behaviors of Asian Americans tend to be restrained and reserved, and they may tend to avoid being confrontational.
Asian Americans often use non-verbal/passive communication, including gesture and facial expressions, to convey feelings nonverbally while communicating with others. The interaction styles of many Asian American clients are likely to be misinterpreted by therapists who are not culturally sensitive and have no experience with Asian American clients (Uba, 1994). For example, Asian Americans rarely disclose information about themselves because of cultural values. A therapist who is not culturally sensitive might misinterpret this as the clients are quiet, oppressed, resistant, defensive, or in denial.

Therapists usually want clients to discuss their feelings and concerns openly. However, it is unusual for Asian American clients to express their feelings, especially in front of therapists who they see as an authority figure. Deference to authority figures is one of the cultural values that encourage Asian Americans to respect the authority figures and not question a person in a position of authority. On the one hand, many Asian American clients are hesitant to discuss their feelings and problems in front of the therapists because that would be disrespectful, and on the other hand, many Asian Americans tend to defer to authority figures for assistance with problems. As Kim et al. (2001) indicate, this deference to authority is based on the cultural expectation that a person in a position of authority has special expertise or knowledge in her or his field.

Moreover, Asian American clients expect the therapeutic relationship to be hierarchical and to obtain direct instructions from the therapists (Hong, 1993; Chin, 1993). Many Asian American clients assume that therapy should be focused on problem solving, not talking about feelings and emotions (Hong). It is important to note that this cultural value can affect the expectations from Asian American clients toward their therapists (i.e., perceive therapist as an expert, expect to receive direct instructions or advice from the therapist). Furthermore, this specific Asian cultural value (deference to authority figures) may reinforce one phenomenon of traditional psychotherapy, “therapist as an expert,” where a power differential/hierarchical relationship can be created between clients and therapists.

Language barrier. A language barrier can also play a crucial role in therapy because language discrepancies between clients and therapists can affect diagnosis, frequency of misunderstandings, and treatment effectiveness (Uba, 1994; Yamamoto, Silva, Justice, Chang, & Leong, 1993). The language discrepancies can have an impact on how Asian American clients communicate with their therapists, and also
can hinder the effectiveness of therapy with Asian American clients (Porter, 2000). When the clients are not proficient in English, they tend to have difficulty conveying their feelings and concerns in English. Another limitation is if the clients can only use simple English to express complicated thoughts and confused feelings, they sometimes feel very frustrated by not being able to tell therapists their real concerns and problems in their preferred language. Moreover, the language discrepancies between the Asian American clients and the therapists in understanding nonverbal behavior might result in misinterpretation and miscommunication. The clients may feel that their feelings have not been heard or may feel rejected by the therapists.

Use of interpreters. Overcoming language discrepancies between the client and therapist is never easy because the cultural differences underlying the languages can be presented in very different ways (Lee, 1997). Although the clients can have interpreters to help them to communicate in therapy, there are still many problems associated with using interpreters in therapeutic process. For instance, the use of interpreters can cause the length of therapy to be longer than usual. A second problem is that many interpreters are not properly trained in the mental health setting, and sometimes they lose subtle distinctions in what the clients intend to express themselves (Lee, 1997; Uba, 1994). As Lee defines:

A “cultural interpreter” is an active participant in a cross-cultural/lingual interaction, assisting the provider in understanding the beliefs and practices of the client’s culture and assisting the client in understanding the dominant culture, by providing cultural as well as linguistic links. (p. 478)

When interpreters try to explain the client’s statements that they think are too obscure/problematic, they might distort what is said rather than interpret the original statements.

Another problem is that the Asian American clients may feel uncomfortable when the interpreters are present due to fear of breach of confidentiality (Lee, 1997). The clients might not want to discuss their psychological problems in front of the interpreters (e.g., the interpreter can be a family member) because they do not feel comfortable. Under this situation, the therapists must inform the interpreters of the importance of confidentiality. The fourth problem is “role conflicts” in therapy when therapist, client, and interpreter are all present. Interpreters are required to interpret in a three-way dyadic communication in two languages by three individuals (Lee). A problem will emerge when there is a “shifting of power” from the
therapists to the interpreters. The presence of interpreters might increase distance between the therapists and the clients. Thus, it is important for the therapists to build a relationship of trust with the interpreters and to communicate with them in a respectful and mutual manner. In conclusion, therapists should be aware of the different cultural assumptions between themselves and clients, and also use the interpreters as the cultural connector to prevent cultural misunderstanding and miscommunication in therapy.

**Model minority.** In addition to language, Asian Americans have historically had the burden of being the “model minority”. The American media started noticing the tremendous success of many Asian Americans in the early 1980s. The term “model minority” was used as the headline for Newsweek in 1982, and the title of this commendatory story was, “Asian-Americans: A ‘Model Minority’ ” (Kitano & Daniels, 2001). This phrase “model minority” was first coined in 1966 by sociologist William Petersen, and it was originally applied to Japanese Americans only. Unhappily, this term has become a new stereotype toward all Asian Americans and it has failed to recognize the real needs of diverse Asian American groups. The portrait of Asian Americans has gone from “lower class (e.g., cheap labors) to ideal minority groups (Kitano & Daniels). Several terms such as “hardworking,” “disciplined,” and “intelligent,” are oftentimes applied to Asian Americans. For instance, an analysis of census figures in 1994 indicates that of those individual over 25, 40% of Asians/Pacific Islanders had at least a bachelor’s degree. The data show a proportion one and one half times higher than that of the White population (Sue & Sue, 1999).

The image of “model minority” Asian Americans represents will give wrong impression that they do not have difficulties in society; the myth and stereotype about Asian Americans must be discarded. Another issue needs to be pointed out is that even though Asian Americans are considered as “model minority” in the United States; Asian Americans continue to be seen as foreigners (or so-called “Permanent Aliens”). It is very ironic to see that Asian Americans carry both the perfect image as model minority on one hand, and on the other hand they are seen as foreigners. A revealing example is that “during the 1998 Olympics in Nagano, MSNBC reported the gold medal outcome skating between U.S. competitors Michele Kwan and Tara Lipinski as “American beats Kwan” (Sue & Sue, 1999, p. 260). In conclusion, this image leads to two circumstances; one is that Asian Americans tend to underutilize the mental
health services because they might not be aware of their psychological problems, with respect to the burden of being model minority. Another circumstance is that Asian Americans might actually feel the pressure and acknowledge their own problems, but they tend to “maintain” the status quo. They will try to deny their psychological problems in order to not bring shame to their family.

**Brief Overview of Feminist Therapy**

*Historical background.* In the early 1970s, the criticisms of psychotherapy from feminists urged a re-examination of the field of psychotherapy. The growth of feminist therapy arose from the re-evaluation of psychotherapy. Feminist therapy originated from the theories of feminist politics, philosophy, and principles; the ideology of feminism scrutinized the social inequality between women’s subordinate position and men’s dominant status (Greene, 1994). Although feminist therapy has existed as an important approach in psychotherapy in the past three decades, defining feminist therapy is a difficult task because of its variations and complexities. Feminist therapy is not connected to or founded by a particular person, model or method of psychotherapy, but integrates the ideology of feminism into many theories/models of psychotherapy instead (Enns, 1997; Kaschak, 1992). Yet, Brown (1994) gives a comprehensive definition of feminist therapy that summarizes its great complexity:

Feminist therapy is the practice of therapy informed by feminist political philosophy and analysis, grounded in multicultural feminist scholarship on the psychology of women and gender, which leads both therapist and client toward strategies and solutions advancing feminist resistance, transformation, and social change in daily personal life, and in relationship with the social, emotional, and political environment. (p. 21-22)

The political philosophies of feminism in which feminist therapy is rooted combine many principles that undertake to subvert patriarchy by fighting inequities based on gender. The different frameworks of feminism address how the inequalities based on gender or other status-related issues (e.g., race, sexual orientation) are problematic, in which many inequality of treatments need to be changed by cultural transformation and social change (Brown, 2000). Feminist therapists express their concerns with the psychological influences of social forces toward an individuals’ psychological well-being, and they also note that patriarchal oppression can bring different forms of distress in people’s lives. Thus, feminist therapy challenges the
patriarchal approaches of traditional psychotherapy that treat women’s psychological distress/suffering as illness, and also criticizes the goals of traditional psychotherapy that reinforce women’s traditional gender roles in the society, such as subordination and dependency.

Consequently, feminist therapists seek to reconceptualize the goals of therapy, collaborate with different theoretical approaches of therapy, and redefine the role of therapists in order to establish a unique feminist therapeutic approach that differs from traditional psychological theories (Espin, 1994). The lack of consensus concerning the constructs of feminist therapy results in numerous philosophical and theoretical feminist approaches that have been included in the broad definition of “feminist therapy” (Juntunen, Atkinson, Reyes, & Gutierrez, 1994). As a result, most feminist therapists utilize the feminist therapy approaches with other theoretical approaches in therapy. In the therapeutic process, feminist therapists have developed techniques that they integrate with other theories that recognize the importance of political and social factors on individuals and also value women’s perspectives. The goals of feminist therapy are to make changes in one’s own personal life and institutions in the society.

*Principles of feminist therapy.* Feminist beliefs are applied to the process of therapy with clients through different means. Several essential principles that construct various feminist approaches in therapy will be discussed: the personal is political, egalitarian relationships, valuing the women’s experiences, and women’s personal/sociocultural identities. First, the personal is political, mirrors the core of different feminist thoughts and beliefs. This principle demonstrates issues of oppression toward women, institutionalized discrimination (sexism), and gender-role socialization/stereotyping from many circumstances (Worell & Remer, 1992; Worell & Johnson, 2001). Applied to feminist therapy, this principle emphasizes the importance of helping the clients to identify their problems from a social and political context, instead of focusing on intra-psychic cause. By examining the social/political contexts of the client’s experience, feminist therapists raise issues on how gender role stereotypes, discrimination, and oppression can impact a client’s life.

Second, striving toward an egalitarian relationship addresses the power differential between women and men in the society and the inequality of women of color in the dominant culture (Worell & Johnson, 2001). Brown (2000) provides a clear definition of an egalitarian relationship:
In an egalitarian psychotherapy relationship, a primary goal is for clients to come to know and value their own needs, voice, and knowledge as central and authoritative to their lives. Therapists are not to supplant this knowing with their own authority but rather to use their skills to reflect and engage the clients in their own process and to help them learn how such self-knowledge and self-value are obscured by patriarchal processes and institutions. (p. 371)

Further, feminist therapy strives toward an egalitarian relationship based on mutuality; feminist therapists minimize the imbalance of power in therapy by emphasizing empathy, sharing experiences, and affirming the client’s strength in therapy.

Third, women’s perspectives are valued, and they are encouraged to validate their own experiences, believe their own strengths, and accept for who they are. Feminist therapy reevaluates stereotypes against women because the devaluation of women’s characteristics results in a “double bind” situation for women. Women are taught to behave in certain ways. Conversely, they are also devalued for being the expectation of nurturing and subordination to men (Worell & Remer, 1992). Thus, the validity of women’s experiences has to be recognized. Feminist therapists believe that clients should trust their own experiences, identify their own strengths, and nurture/care for themselves. Finally, emphasizing socio-cultural factors in women’s lives is crucial because women’s personal and socio-cultural identities are interdependent. Women’s different identities can not be separated because all identities are coexistent and interactive. In order to explore a woman’s identity from the larger socio-cultural perspectives, feminist therapists raise awareness of an individual’s “location” according to their gender, race, ethnicity, social class, sexual orientation, and ableism (Worell & Johnson, 2001). Thus, integrating essential principles with the practice of feminist therapy empowers women’s lives and also encourages women to believe their own strengths.

Awakening: Changes in Feminist Therapy

Feminist therapy first emerged from re-thinking/evaluating traditional psychotherapy in the early 1970s, and it affirms the belief that social inequities based on gender oppression manifest an explanation of mental health problems in women. However, the presumption of gender oppression as the main focus of oppression for women has been considered too simple because this assumption does not mirror the various life circumstances and experiences of women (Greene, 1994). Apparently, the presumption of gender-based inequity/oppression becomes problematic. For
instance, women of color may comprehend gender-based oppression differently than White women because women of color experience different childhoods while growing up with respect to racism or cultural stereotypes. Thus, feminist therapists need to address not only the issues of gender oppression, but also the impact of culture, social class, race, sexual orientation on clients in the process of therapy.

**Women of Color and Feminist Therapy**

The second wave feminist movement arose in the 1970s, and was mainly a White, middle-class women phenomenon. During the same period, feminist therapy grew as an approach to psychotherapy (Enns, 1997). However, only few references of feminist therapy in the literature remarked on oppression that women of color experienced (Enns, 1993). As Brown (1990) indicates, several frequently cited writings in feminist therapy are largely based on the life of White women only, with occasionally references on women of color, women living in poverty, or women with disabilities. In Greenspan’s book, *A New Approach to Women and Therapy*, the author points out several important issues regarding the problems with traditional approaches in psychotherapy, but the “women” the author refers to are mainly White women. Furthermore, Worell and Remer’s book, *Feminist Perspectives in Therapy: An Empowerment Model for Women* (1992), combines the issues of ethnic minority women and lesbian women in just one chapter with approximately 10 pages of discussion for each theme; with diverse groups of women (either women of color or lesbian women). However, in the second edition of their book published in 2002, these authors rename the book title to *Feminist Perspectives in Therapy: Empowering Diverse Women* wherein they discuss the diverse issues in depth.

Moreover, White writers on feminist therapy have tended to develop theories based on women of European heritage and then simply note that those theories might apply to people from marginalized groups as well (Brown, 1994). In fact, women of color often have different life and cultural experiences than those of White women. Even when the diverse experiences of women of color are considered, they have often been compared with White women’s experiences. Feminist therapists use a White standard to define experiences of women of color. This standard is not based on the values, different cultures, and diverse backgrounds of diverse groups.

It has been a challenge for White and/or middle-class feminist therapists to acknowledge that issues of women of color can not be considered only with this White standard in mind (Brown, 1994). When most White/middle class feminists
argue that women are considered as “others” to men (i.e., gender-focus), women of color in feminist analysis are also being represented as “others” in feminist therapy during the 1970s and 1980s. Audre Lorde (1984) noted, “As White women ignore their built-in privilege of Whiteness and define women in terms of their own experience alone, then women of color become ‘other,’ the outsider whose experience and tradition is too ‘alien’ to comprehend” (p. 117). Apparently, the visibility of women of color in feminist therapy is unclear and this invisibility creates another power imbalance between White women and women of color.

As feminist therapy has matured gradually, many feminist therapists have expressed their concern about the overlooking of feminist therapy and feminist analysis to the issues of women of color (e.g., Brown, 1990; Comas-Diaz, 1991; Espin & Gawelek, 1992). It is important to note that the issues of women of color are not only defined by different race or ethnicity; they also broadly include variables of class, socioeconomic status, culture, age, disability, sexual orientation, religious belief, physical appearance, and language. The homogeneity assumption of women of color has been argued in several feminist analyses (e.g., Brown, 1994; Enns, 1997; Wyche, 2001). They all raise important issues on the emergence of diverse groups of women.

Race is a salient factor that affects many women of color because skin color is believed to be an immediate manifestation of an individual’s own racial/ethnic identity. The gendered oppression of women of color involves culture, class, sexual orientation, and immigration status. As Wyche (2001) points out, “for minority women, the experience of racism and discrimination in the United States filters the salience of gender, culture, ethnicity, and race” (p. 335). Indeed, women of color are generally more oppressed on the basis of race than of gender. This view does not overlook sexism, but raises the issue that women of color have to struggle with racism and sexism (Kliman, 1994). Thus, feminist therapists need to understand and respect the diverse experiences of women of color, and also to acknowledge how women of color have obstacles placed in their lives by race, ethnicity, gender, and sexuality.

The Self-In-Relation Theory: Women’s Lives in Connection

The beginning of a theory. The self-in-relation theory is the feminist therapeutic approach that emphasizes interpersonal connectedness in women’s lives (Comas-Diaz & Greene, 1994). This theory is originated from the work of Jean Baker Miller, who proposed a new comprehension of women’s development in her
The main theme of this book is that “women’s sense of self becomes very much organized around being able to make and then to maintain affiliations and relationships” (p. 83). In 1977, Miller, along with three other psychologists, Judith Jordan, Irene Stiver, and Janet Surrey, began meeting regularly to discuss and reexamine women’s psychological development and clinical practice with women in the field of psychology (Miller & Stiver, 1997). Their meetings began to form a collaborative theory-establishing group that led to this important approach of psychological development.

Furthermore, it is important to note that the theory was initially known as “self-in-relation” theory; however, the theory was renamed recently. As Jordan and Hartling (2002) indicate, “ongoing conversations with collaborating scholars suggested that the original name continued to overemphasize an individualist, separate-self perspective” (p. 55). Consequently, the self-in-relation theory was renamed “Relational-Cultural” theory. Throughout the text, the “self-in-relation” theory will still be used instead of relational-cultural theory. The reason for maintaining the previous name in the present study is to minimize the confusion since most references used in the text are still referring as the ‘self-in-relation’ theory, and also the core concepts underlying this theory remain unchanged.

The basic concepts of the theory. The self-in-relation theory is based on a developmental perspective and focuses on the mother-daughter relationship in the women’s developmental process, and the notion of relationship-differentiation in this approach is considered as the core belief to a woman’s psychological development (Jordan & Hartling, 2002; Surrey 1991; Worell & Johnson, 2001). The self-in-relation theory also provides an alternative to traditional approach of psychological development. The traditional theories of development emphasize on separation, autonomy, independence, and self-sufficiency (Jordan, 2001; Jordan & Hartling). However, the self, as described in traditional theories of development, does not characterize women’s experiences properly (Gilligan, 1982; Miller, 1976; Miller, 1991). On the contrary, the self-in-relation theory suggests that women tend to develop their sense of identities, achieve a sense of coherence, and continuity through the context of their interpersonal relationships.

As Surrey (1991) indicates, “our conception of the self-in-relation involves the recognition that, for women, the primary experiences of self is relational, that is, the self is organized and developed in the context of important relationships” (p. 52). In
other words, the self develops through relationship rather than separation/isolation; the theory emphasizes an interaction/movement, where the interaction/movement is to empathize and also to be empathized, to empower as to be empowered. Also, Surrey defines the term relationship as “an experience of emotional and cognitive intersubjectivity: the ongoing, intrinsic inner awareness and responsiveness to the continuous existence of the other or others and the expectation of mutuality in this regard” (p. 61). Thus, mutuality, empathy, and empowerment are very valuable elements in the relationship. With these basic concepts, the discussion leads to further analysis of the elements of the self-in-relation theory.

The elements of the theory. Several major elements of this theory will be discussed: connection, mutual empowerment, and mutual empathy. The concept of “connection” is defined as “an interaction between two or more people that is mutually empathic and mutually empowering” (Miller & Stiver, 1997, p. 52). The self-in-relation approach emphasizes the importance of connection with others, especially women’s experiences and emotional growth that comes from interpersonal connection. By feeling a sense of connection, people experience increased energy and strength from the sense of connection; this connection also becomes the essential characteristic of growth-fostering interactions. The feeling of increased energy and vitality after feeling a sense of connection is defined as “zest”. The “zest” is the initial component that leads people to the energizing feeling of the emotional connection, and then leads people to the next, including “action”, “knowledge”, “worth”, and “yearning for more connection” (Miller & Stiver, 1997). Consequently, all of these connect with each other and form a continuing process for “mutual empowerment”.

The theory in practice. While putting those elements into the therapeutic context, the model of relationship and the perspectives of therapist are crucial to the impact on both client and therapist. As Jordan (1991) suggests, “there is an important feeling of mutuality, with mutual respect, emotional availability, and openness to change on both sides” (p. 95). The therapeutic relationship is like a dialogue that leads both therapist and client to grow in a mutually respectful relationship, empathize with each other, and acquire something from one another (Jordan).

Most importantly, as Jordan (1997) suggests, “mutual empathy, characterized by the flow of empathic attunement between people, alters the traditional boundaries
between subject and object and experientially alters the sense of separate self in a profound way” (p. 15). Mutual empathy is one manifestation for two people relating to one another with emotional responsiveness and appreciation of the integrity of the other as well (Jordan, 1995). In conclusion, the openness and honesty from the therapists become very crucial for clients to feel a sense of mutual respect and understanding. By the same token, if clients feel the sense of mutuality in therapy, they are more likely to risk sharing more about themselves to the therapist as a way of manifesting trust and the expression of connection (Duggan, 2000).

**Boundary Crossing: Sharing Beliefs and Experiences.**

The issues of boundary in the therapeutic relationship have been commonly discussed. In the traditional dominant mental health areas, the boundary issue should be well-defined, rigid, and unchanged. The therapists should remain neutral in therapy, and any “unrestricted connection” should not be allowed. Contrary to the dominant definition of boundary, the self-in-relation approach provides a unique and specific view. Miller and Stiver (1997) state that therapists fear to lose their “objectivity”, “neutrality” and “capacity” to function therapeutically; however, a good connection with clients can still incorporate a good boundary. In traditional psychotherapy, therapists are trained to distance themselves from their feelings; the distance also reinforces the rigid boundary between therapists and clients.

In self-in-relation theory, therapists and clients should both be involved in a “moving relationship”, therapists have to be “moved” emotionally (i.e., empathic) by the clients in order to make clients being “moved” by the therapists as well (i.e., mutuality). This is a sense of movement toward mutual empathy in the context of therapy. Generally speaking, a good/respectful boundary in therapy provides an opportunity for clients to establish trust and feel safe to deal with more personal issues. Moreover, mutual empathy can lead to mutual empowerment (Miller & Stiver, 1997). The therapeutic relationship should be mutual instead of the therapists having “power over” the clients. As Brown (1994) suggests:

Understanding boundaries is somewhat more complex in feminist therapy than in mainstream theories … feminist theorizing of the therapeutic relationship admits to a diversity of interactions of therapist and client, with race, class, culture, sexual orientation, gender, setting, and power dynamics all informing the specific and unique relational matrices present in any given therapeutic exchange. (p. 212)
Indeed, power dynamics in therapy is a complicated issue for therapists. While therapists try to empower their clients, they also need to be aware of the hierarchical relationship between themselves and clients. Nevertheless, therapists should attend to minimize the power differential in therapy and facilitate a mutual relationship instead.

Thus, while establishing the boundary in therapy, the therapists have to be culturally sensitive to prevent from violating the boundaries that are improper for clients with diverse experiences and backgrounds. In other words, therapists need to find a balance between when is appropriate to “cross the boundaries” and share beliefs and experiences, and when is improper to “cross the lines” and shatter the therapeutic relationship. In sum, the self-in-relation theory reveals the need for mutual empathy and transformative connection in therapeutic process to help clients make the “move” from their suffering, which is caused by disconnection and separation/isolation (Jordan, 1995).

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