“THE GOOD WOMAN”:
SOCIOCULTURAL APPROACHES IN THE TREATMENT
OF WOMEN WITH DEPRESSION

BY
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The undersigned certifies that she or he has read and recommends to the Faculty of Graduate Studies and Research for acceptance, a final project entitled “The Good Woman”: Sociocultural Approaches in the Treatment of Women with Depression submitted by Karoline Sandhurst in partial fulfillment of the requirements for the degree of Master of Counselling.

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November 21, 2006
Faculty of Graduate Studies and Research

The undersigned certifies that she or he has read and recommends to the Faculty of Graduate Studies and Research for acceptance, a final project entitled "The Good Woman": Sociocultural Approaches in the Treatment of Women with Depression submitted by Karoline Sandhurst in partial fulfillment of the requirements for the degree of Master of Counselling.

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ABSTRACT

Depression is one of the most commonly diagnosed mental illnesses and has a rate in women that is two times that of men. In this project, a feminist sociocultural perspective was utilized to develop a handbook for counsellors treating depression in women. An extensive literature review formed the foundation for the project, in which the cultural messages women receive about what it means to be a “good woman” was the prominent theme. A handbook was developed that offered both process-oriented information about feminist approaches, and content-oriented information with suggestions for specific interventions to address depression. Themes identified in the literature review that formed the framework of the handbook included deconstructing goodness, emotional awareness and expression, behavioral activation, and building connections. The project was synthesized with consideration of its utility, strengths, and limitations. Offering a unique, woman-centered approach to treating depression, this handbook is aimed to provide practical and useful information for counsellors.
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CHAPTER I
Introduction and Procedures

Introduction

Depression in one of the most commonly diagnosed mental illnesses, with 8% of all Canadian adults expected to experience it at some point in their lives (Health Canada, 2002). Health Canada indicates that, during any 12 month period, between 4 and 5% of the population will experience a major depressive episode. Depression is a condition characterized by symptoms including depressed mood, loss of interest or pleasure in daily activities, significant weight change, sleeping problems, fatigue, feelings of guilt or worthlessness, decreased ability to concentrate, and/or recurrent thoughts of death and/or suicide for a duration of at least two weeks (American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders, 2000).

The rate of depression in women is approximately two times what it is in men. In the most recent Canadian National Population Health Survey, 7.1% of women reported an episode of major depression, compared with 3.3% of men (Stewart, Gucciardi, & Grace, 2003). Factors such as differential reporting, physiological vulnerability, and relational and cognitive styles have commonly been used to account for gender differences in the diagnosis of depression (Mazure, Keita, & Blehar, 2000). Mainstream researchers have explored risk factors in women such as hormones, genetic vulnerability, poor social support, and ruminative coping styles (Wells, Brack, & McMichen, 2003). Feminist researchers such as Stoppard (1999) have staunchly criticized this research, stating that these accounts have served to medicalize and pathologize women’s
experiences. Instead, feminists have advocated for approaches that take into account the gender-driven social and cultural factors that underlie depression (see Jack, 1999).

The goal of this project is to develop a handbook that bridges sociocultural theory about depression in women with interventions useful for counsellors. My interest in this subject came from previous graduate course work and extensive reading, where I noticed that the theme of cultural imperatives related to goodness pervaded feminist research about depression in women. My interest was also piqued as a result of my previous counselling work with marginalized women, many of who were depressed (either self-described or formally diagnosed). The vast majority of my clients were single women. My reaction to their distress was that it seemed natural given their circumstances, as most of these women lived in poverty and had lives marked by trauma and abuse. Many were labeled with various diagnoses, which struck me as pathologizing what I thought was a normal psychological reaction to very challenging life circumstances. When I later began my graduate studies, I wondered why so few psychological theories addressed the social and cultural realities that in my view clearly influenced psychological well-being. Once I was introduced to feminist theory, I embraced these ideas, and focused much of my graduate work on increasing my understanding of feminist approaches to depression.

In exploring feminist researchers and therapists’ work related to depressed women, a clear theme emerged. Time and again, research participants across various studies described trying to live up to a certain standard of behavior, and the feelings experienced when they fell far short of their aspirations. I wondered about the origin of these standards, how they influenced depression, and how to best address them therapeutically. For this reason, I have chosen to highlight the role that cultural messages
and standards play in the development and maintenance of depression, hence the title “The Good Woman.”

For the purposes of this project, sociocultural factors describe elements influencing depression that are rooted externally to women. These factors are located in the social and cultural landscape and interact with women at the individual level to construct depressive experiences. Examples include social rules and norms, social expectations, social locations (such as ethnicity and socioeconomic status), and social structural conditions (such as violence against women, poverty, and abuse). Cultural narratives that convey shared ideas about what it means to be a woman are key sociocultural conditions. Often, these narratives are played out in “practices of femininity”, or the domain of gendered activities that are culturally rooted (Stoppard & McMullen, 2003), which will also be discussed.

“Discourses of femininity”, or the social messaging that describes what it means to live and act as a woman in our society today (Stoppard & McMullen, 2003) will be a focus for this project. Of special importance are the messages women receive and internalize about what it means to be a “good woman.” Here, the word goodness describes the moral standard of behavior that women aspire to in their various social roles as mothers, wives, daughters, employees, and community members. Each of these roles is associated with implicit and explicit standards for thinking, feeling, and behaving. Feminist researchers (e.g. Mauthner, 1999) have found that many depressed women have internalized social messages and struggle with behaving in a way that adheres to rigid social norms. Depressed women may lose themselves in an effort to achieve standards of goodness in their roles as wives and mothers (Jack, 1991; Simonds, 2001).
Developmental transitions that interact closely with feminine expectations and ideals, such as adolescence, marriage, and motherhood, can be critical periods of vulnerability for depression (McGrath, Strickland, Keita, & Russo, 1990). The belief that cultural expectations of goodness underlie depression provides the foundation for the development of a handbook for counsellors.

*The Relevance of this Project.* There are three primary factors that underlie the relevance for this project. First, ignoring social and cultural factors in depression can be blaming and damaging to women, particularly in the failure to take into account social conditions such as poverty, marginalization, and victimization. In fact, it has been argued that traditional approaches have served to further oppress and disempower women (Stoppard, 1999). With this in mind, there is a need for a resource for counsellors that is sensitive to the oppressive experiences of many women which formed the impetus for this project.

Second, while depression impacts women disproportionately, few women-centered approaches have been developed to address it effectively. Stoppard (1999) recommended combining mainstream and feminist research to enrich our understanding of depression. While this has been done in a piecemeal way, for example, by combining feminist strategies with cognitive behavioral approaches, or by describing specific elements of feminist therapy that enhance work with depressed women, ideas have not been brought together in a thorough or comprehensive manner. In this project, I will build on existing research about women and depression to present a comprehensive, women-centered approach.
Third, although broader sociocultural perspectives on depression have been advocated by feminists, methods of translating this research into meaningful counselling interventions has been slower to materialize (Worell & Remer, 2003). Existing research is primarily theoretical in nature, while the practical implications of these findings are less clear. My goal is to bring feminist theory together in a comprehensive way to create clear guidelines for practice. Then, these guidelines will be used to explore and draw on existing interventions that hold promise for depressed women. As a practitioner, I wanted to be able to use feminist research to plan intervention approaches with depressed women, and to find and apply practical therapeutic strategies to support women in alleviating depression and meeting personal goals. I suspected that this work would also be valuable to other practitioners, and set out to develop a handbook that could be shared with others.

**Overview and Structure of the Project.** The procedures section that follows describes in detail the steps that were taken in this project. Within Chapter II, I present the theoretical foundations for the project and go on to synthesize the research related to sociocultural factors in depression in women. The comprehensive literature review provided in Chapter II formed the basis for the handbook, which is included as an appendix. The handbook is intended as a resource for counsellors who are working with women in a one on one format. It provides information about strategies and interventions that can be applied to address depression. However, in line with feminist practice, empowerment (versus simple symptom reduction) is a key goal. A hypothetical case study is utilized to demonstrate how various approaches might be applied. Within Chapter III, I explore the synthesis and implications of the project, followed by a
reference list. Strengths, limitations, and potential applications are included at the conclusion of the handbook.

_procedures_

This project began with a comprehensive literature review. PsycINFO was the primary database utilized. Academic Search Premier and CINAHL provided some supplemental resources. A number of searches were performed, depending on the area of focus. I began with a broad search, and then I narrowed my focus for more detailed information. The initial search included terms such as “major depression” and related terms such as “depression (emotion)” and “postpartum depression.” The results of this search were combined with terms such as “human female”, “sociocultural factors”, and “feminism.” Reading in this area began to suggest major themes, and subsequent searches were conducted that combined “depression” with “gender role”, “sex roles”, “socialization”, and “victimization.” The ancestry method, as described by Mertens (1998) was used extensively in reviewing this research to identify key authors and sources. Peer reviewed journals were the primary sources for data, supplemented with information from books.

My approach to the development of this project was first, to explore and review evidence in the literature of social and cultural causes to depression and second, to translate the theory gleaned from this evidence into practical information for counsellors. In developing the literature review, I presented various arguments for the validity and strength of feminist sociocultural theories of depression. Further research indicated themes in promising treatment practices that sprung from these theories, which I later used to develop the handbook.
As I reviewed the literature, I looked carefully for emerging themes that related to treatment approaches. There is a significant body of work related to feminist therapeutic principles and strategies for enacting feminist theories in practice such as addressing issues of power, considering cultural differences, and the feminist therapeutic relationship. To me, these practices are the essence of feminist therapy, and would lay the foundation for any intervention that I considered for inclusion in the handbook. I utilized this information within the body of work related to depression to develop the handbook section called “Utilizing Feminist Strategies in your Work with Depressed Women.”

As I reviewed the feminist depression literature, some articles specifically discussed particular intervention methods. In those cases, I went on to do a secondary review, searching for related articles and critiques. This review included terms such as “brief psychotherapy”, “cognitive therapy”, “interpersonal psychotherapy”, and “gestalt therapy.” The research I found doing the secondary search began to form the background information for the section of the review dedicated to healing from depression. Given the vast amount of research that exists related to depression treatment, a critical decision was made to limit research presented to those methods that have been utilized or critiqued from a feminist perspective. This decision was made based on the theoretical underpinnings of this project, which is grounded in feminist theory. For example, some approaches to depression, such as interpersonal therapy, are widely researched, but have not been critiqued from a feminist standpoint or utilized within a feminist framework. These treatments were excluded.

In the development of the handbook, the key themes identified in the literature review were revisited. Feminist therapeutic strategies formed the backbone of the
handbook, followed by the integration of other therapeutic techniques. In creating the handbook, I compiled additional reference materials (such as handbooks and treatment manuals) related to specific intervention strategies used to address depression. These sources were gleaned for practical information for counsellors about how to use specific techniques in one on one therapy.

The creation of the handbook centered around four main guidelines. First, the handbook is based in key feminist principles of practice outlined in the theoretical orientation section. Second, the handbook builds on theories of depression that are rooted in social and cultural causes. Third, the handbook provides a practical resource for counselling professionals in which intervention approaches are outlined in a clear and useful way. Finally, the handbook offers a range of strategies and approaches that can be integrated and adapted depending on a practitioner’s setting, skills, experience, and client population.

A hypothetical case study was developed to demonstrate how various approaches could be applied within a feminist sociocultural framework for depression. I based the case study on a composite of clients I have encountered in my own work as a practitioner. I also made a decision to use the same case study across all interventions, to allow for consistency for the reader, and to show how the same issue might be handled differently.

To summarize, depression is one of the most common mental health issues impacting women today. While research in this area is profuse, there is a lack of attention to how our cultural environment has contributed to this problem. Feminist researchers have offered an alternative theoretical view to mainstream research however; practical strategies that counsellors can arm themselves with have been slower to materialize. With
this in mind, this project and the resulting product fill an important gap in counselling service provision to women.
CHAPTER II

Literature Review and Theoretical Considerations

In this literature review, I will explore various sociocultural bases to depressive experiences in women. I will begin with theoretical foundations, including background relating to feminist theory, and how feminist therapeutic principles were used to guide this project. Then, the sociocultural elements in depression will be explored, including social structural conditions, gender socialization, women’s relationships, and practices of femininity. Cultural imperatives and the “good woman” are highlighted in a subsequent section, in which I draw attention to social messaging women receive throughout the life span. I will go on to identify four main themes related to healing from depression, and outline a variety of intervention approaches that may be employed to facilitate change.

While the focus of this review will be on culturally produced factors influencing depression, the purpose is not to negate or discredit the existing body of research relating to women and depression. Instead, offering alternative perspectives will help to broaden current understandings. For the purposes of this literature review, many of these sociocultural elements are teased apart for discussion purposes; however, to do so is artificial, since they overlap and intertwine.

Theoretical Foundations

This project is grounded in feminist theory. A substantial portion of the research exploring sociocultural influences on depression has followed in the feminist tradition. Feminist researchers were the first to examine the social and cultural backdrop to women’s depression and provide alternate conceptualizations to the mainstream biological and psychological theories (Evans, Kincade, Marbley, & Seem, 2005). In the
following section, feminist theory will be briefly discussed as it relates to principles of practice. I will discuss how these principles relate to depression in women, and how they guided this project.

Feminist Therapeutic Principles

The women’s liberation movement of the 1960’s and the subsequent feminist movement began a new faction in psychology. Unlike other psychological traditions, the feminist movement emphasized the need for social change to alter the conditions of women’s lives. Gender was viewed as a central organizing feature of women’s lives, and it was recognized that women’s problems occur within a context of the larger social environment (Greenspan, 1983). Feminist therapeutic approaches were initially developed as a way to correct the negative effects of sexism and bias in psychological theory, diagnosis, and practice (Corey, 2001). Feminism formed the framework for what would become feminist therapy, in which a wide variety of theories and practices are integrated within a number of central guiding principles (Enns, 2004) which will be discussed below.

Principle 1: The personal is political. The most familiar credo of feminist therapy, this principle conveys the belief that individual problems have social and political roots (Worell & Remer, 2003). Some of the social conditions that have found to impact depression in women are poverty, discrimination, victimization, and marginalization (McGrath, Keita, Strickland, & Russo, 1990). When viewed from this perspective, depression is not an individual problem, but a symptom of larger social issues. In this way, women are doing the best they can to deal with oppressive conditions. This reframing of pathology is also a central tenet of feminist therapy. Symptoms of
depression are a natural response to oppression, but may also be viewed as a way of communicating pain, or a coping behavior that has had some survival value (Enns, 2004).
**Principle 3: Reducing the power differential.** This principle stems from the observation that women in most societies do not have status and power equal to men, and that various minority groups are even more subordinate in their status (Worell & Remer, 2003). The ways in which power structures and the inherent hierarchy involved in the counselling relationship are addressed are important considerations in feminist therapy. Minimizing the power differential through striving for a more egalitarian counselling relationship is one way feminist therapists attempt to provide a different experience for clients (Enns, 2004). Contratto and Rossier (2005) believed that traditional counsellors were agents of social control who imposed their values on clients. In this regard, in feminist therapy, the client-counsellor relationship should not reproduce the power imbalances that subordinate groups experience. An important way that feminist therapists enact this principle is through the demystification of the counselling experience. Feminist counsellors offer information, provide choices, and treat the client as a competent person whose expertise is affirmed (Enns, 2004).

**Principle 4: Empowerment and social change.** From the perspective of Worell and Johnson (1997), the overall goal of feminist therapy moves beyond symptom reduction to help clients see themselves as active agents of change, both in their own lives and in the lives of others. As such, empowerment involves helping women become aware of the power dynamics inherent the context of their lives, develop skills to exercise personal power where feasible, and support others to do the same (McWhirter, 1991). Furthermore, change, as opposed to adjustment to oppressive conditions, is emphasized (Enns, 2004).
In guiding this project, the powerlessness that many women experience as victims of rape, abuse, battering, and harassment will be carefully considered as they relate to depression (McGrath et al., 1990). The feelings of worthlessness and hopelessness associated with depression will be viewed as natural response to experiences of victimization in women’s lives. Providing counselling practitioners with tools to address depression that acknowledge these issues will be a key consideration. In addition, feminist therapy exists not only to support individual clients, but also to create cultural change (Schreiber, 2001). Hill (2005) believed that small individual changes eventually accumulate to begin a larger shift. In this way, this project is an example of a micro change that helps to create momentum toward larger social action.

Criticisms of Feminist Theory

Although it is beyond the scope of this review to critique feminist theory at length, a number of important criticisms should be mentioned. First, feminist theory has been criticized as being by and for White women, a privileged group compared to other, more subordinate women (Brown, 1994; West, 2005). It has only been recently that the diverse experiences of women have been included, for example, in the development of cultural feminist theory, women-of-color feminisms, and lesbian/queer feminisms (see Enns, 2004).

Second, there have been definitional problems relating to whether feminist theory is a philosophical orientation or a theory, and how this translates into feminist practice (Corey, 2001). Rather than a prescription of technique, feminist therapy is interwoven into different approaches to treatment, ranging from cognitive behavioral, to
psychodynamic, and family therapy. Worell and Johnson (1997) have recognized that theory building over the last decade has begun to address this criticism.

Third, there is little evidence to suggest that therapists are able to effectively combine feminist therapeutic practice with social activism (Evans et al., 2005). Some have argued that putting together the words “feminist” and “therapy” is inherently contradictory because feminism is concerned with changing the societal structure of women’s lives, and therapy focuses on individual women. Stoppard (2000) has argued that what began as women meeting as equals in an informal setting in consciousness-raising groups has now become regulated by the imposition of professional training programs, codes of conduct, and debates on theoretical issues. It is debatable whether contemporary feminists have resolved this criticism successfully.

Lastly, feminist therapy has been criticized as ignoring the social and cultural forces influencing men’s lives (Evans et al., 2005). However, contemporary feminist theory highlights that both women and men are affected by being raised in a culture where the genders are differentially privileged (Corey, 2001). More recently, feminist therapy has been used to explore issues of power, violence, and gender role socialization in men’s lives (Evans et al., 2005).

Sociocultural Theories of Depression

In this section, a number of factors that influence the development and maintenance of depression will be briefly explored, including conditions inherent in the social structure, gender socialization, women’s relationships, and practices of femininity.

*Sociocultural Conditions*
Social theories of depression implicate a number of structural conditions in society that are contributing factors. Some of this evidence will be discussed broadly here, as it relates to victimization, poverty, and non-dominant populations.

*Victimization.* Specific traumatic life events have been correlated with depression in both genders, but are much more likely to be experienced by women (McGrath et al., 1990). In this sense, gender operates in an indirect manner, by channeling women through social contexts that create a greater risk for depression. A number of methods have been used to determine the prevalence of victimization in women. For example, some researchers suggest that sexual abuse and assault has been experienced by 38% to 67% of women before the age of 18, and that violence is reported by 31% of married women (Koss, 1990). Though some critics have argued that definitional problems plague this research, other researchers have discovered that that whether or not women describe themselves as victims, the distress that is experienced is not reduced (Harned, 2004).

Victimization in interpersonal relationships has been found to be a risk factor for depression (McGrath et al., 1990). Though presenting with depression, women may be experiencing long-standing responses to trauma, such as childhood sexual or physical abuse, marital or acquaintance rape, battering, or sexual harassment in the workplace (Koss, 1990; Stein & Kennedy, 2001). The mechanisms by which these experiences contribute to depression have long been neglected, often because standard procedures of psychological history-taking have historically failed to include questions related to victimization (Koss, 1990). While the rates and mechanisms between victimization and depression may be contested, there is little question that women’s lives commonly
include experiences of victimization, and that these experiences have been found to be a pathway to depression.

*Poverty.* Researchers who focus on social explanations for depression have investigated social conditions that increase vulnerability. Higher levels of depression have been found to be more common in those experiencing poverty, and may include those who are unemployed, have less education, have low income, or are of a low socioeconomic status (McGrath et al., 1990). As result of their lower status in society, and their roles as caregivers within the family, these individuals have been found to be more likely to be women (Mazure et al., 2000). Worell and Remer (2003) have suggested that single parenthood is particularly problematic for women, as they are more likely to be engaged in low-paying, low status jobs, and often have difficulty supporting themselves and their children. Stoppard (2000) acknowledged that structural conditions such as pay and employment inequities and lack of adequate, affordable childcare services contribute to conditions that may become a source of depressive experiences. Researchers such as Mazure et al. (2000) have further acknowledged that poverty can lead to depression for women because it is associated with uncontrollable adverse life events, and may include increased exposure to crime, violence and inadequate housing.

*Non-dominant populations.* While it is beyond the scope of this review to discuss in detail the sociocultural forces that oppress members of non-dominant groups, the impact of racism, discrimination, and oppression should not be underestimated. Non-dominant groups, such as visible minorities, immigrants/refugees, lesbians, or those of differing physical or cognitive abilities are at risk of internalizing the messages given by the dominant society. This contributes to feelings of self-blame, inferiority, and low self-
esteem, and is a major source of psychological distress (Arthur & Merali, 2005). Discrimination has been identified as contributing to depression, anxiety, and some personality disorders (Guindon & Sobhany, 2001; Sheppard, 2002). In addition, non-dominant groups anticipate and frequently experience a reenactment of societal discrimination when accessing mental health services (Worell & Remer, 2003).

Gender Socialization

It has long been recognized that the central features of depression are similar to stereotypical female traits such as guilt, helplessness, low self-esteem, passivity, and dependency (Formanek & Gurian, 1987; Ruble, Greulich, Pomerantz, & Gochberg, 1993). There is evidence to suggest that the extent to which girls identify with these stereotypical gender traits is a predictor of later depression (Obeidallah, McHale, & Silbereisen, 1996). This section will discuss the ways that, from a young age, girls are socialized to behave in a manner that makes them more vulnerable to depression.

There is a tremendous body of work that identifies the ways in which boys and girls are treated differently right from birth (Atwood, 2001). Atwood suggested that gender bias manifests itself within families and disadvantages girls in both subtle and overt ways. In addition, social learning practices tend to teach girls to attend to relational processes, especially the opinions and evaluations of others (Ruble et al., 1993) Atwood found that the devaluation of girls undermines self-esteem, feeds feelings of powerlessness and self-blame, and contributes to depression in adulthood. The closer control and surveillance that girls receive compared to boys has been found to reduce self-efficacy and may lay the foundation for later depression (Ruble et al., 1993).
While it is a simplification to assume that depression is caused by gender socialization, social learning in the family can be an important factor in later depression. Jack (1991) noted that when parents reinforce cultural patterns of male superiority and female inferiority, strong patterns are established that are difficult to break in later life. Atwood (2001) commented, “a mother who grew up denigrating herself as a female tends to infer that her daughter, as a female like herself, is less important than males in the family and to act accordingly” (p. 27). Observing parents’ marital roles is a powerful socialization experience that provides a blueprint of acceptable gendered behavior. For example, Obeidallah et al. (1996) showed that girls who come from families where parents exhibited traditional marital roles were more vulnerable to depression. Together, this research points to compelling roots for depression in women that is based in gender socialization and social learning processes.

Women’s Relationships

Some feminist theorists (e.g., Jack, 1991; Stiver & Miller, 1997) have viewed depression as a loss of authentic self that occurs when women are unable to participate fully and honestly within close intimate relationships. This belief is founded on the theory of women’s development called the self-in-relation, and stipulates that women’s sense of self is created and formed in the context of close relationships (Nelson, 1996; Surrey, 1997). Characteristics such as empathy, cooperation, and relational mutuality are valued as unique and intrinsic feminine traits. This belief stands in opposition to traditional developmental theories that stress the importance of separation, autonomy, self-reliance, and self-actualization. The self-in-relation model assumes that aspects of the self, such as
creativity and assertion develop within the context of relationships, and that there is no inherent need to separate in order to grow (Surrey, 1997).

Relational theory is included in a sociocultural framework for depression because it has been suggested that this loss of self occurs because women are socialized to inhibit anger, defer to others, and to prioritize the needs of others over themselves. This makes women more vulnerable to depression because they are thwarted from forming the close relationships in which they thrive. Through the lens of the self-in-relation, “disorder becomes less about the individual and more about what happens in the relationship. Disorder emanates from a breach between rather than within” (West, 2005, p. 108).

In Jack’s (1991) “silencing the self” theory of depression, women must stifle the expression of true feelings in the marital relationship in order to secure and maintain the marriage. Women become alienated from their own wants, desires, feelings, and selves in an effort to nurture, please, and look after others. When this occurs without reciprocity, they may feel disconnected, unsupported, and angry. However, these feelings are shut out of awareness through the internalization of cultural scripts related to goodness. The dominant North American cultural messages women receive about how to behave in intimate relationships play an important role in depression. Jack (1991) stated that:

When being ‘selfless’ in relationship is linked in the woman’s mind with ‘goodness’ (morality), with femininity (out of identification with a mother who was ‘selfless’ in relationship), and with intimacy (providing safety from abandonment), a woman must deny whole parts of herself, including negative feelings and direct self-assertion (p. 49).
Cultural standards that value stoic emotional expression also contribute to depressive symptoms (Stiver & Miller, 1997). These cultural messages will be discussed in a later section devoted to cultural imperatives related to goodness.

**Practices of Femininity**

Practices of femininity refer to tasks and responsibilities that have become socially prescribed parts of the female role, such as caregiving, child rearing, and housework (Stoppard, 2000). There is a body of research that has drawn a direct relationship between these tasks and depression. Housework, for example, is frequently viewed as a low status activity that is not valued, is often taken for granted, and is contrasted with the “real work” of paid employment (Sheppard, 2002). Despite advances in the women’s movement, women continue to perform the overwhelming majority of household tasks, regardless of employment (Bird, 1999). In a well-controlled study of nearly 1300 subjects, Bird found that equity in the division of household labor was directly related to measures of depression. This echoed the previous work of Lennon and Rosenfeld (1994) who found that perception of an unequal situation as unfair impacted women’s psychological well-being. This was even more prominent for women who perceived other alternatives to a traditional division of labor.

For employed women, the expectation to complete household tasks and look after children has been dubbed the “second shift” or the “double day” and may speak to the higher rates of depression in married women compared to unmarried (Simon, 1995). When the division of household labor is equal, women have the same rate of depression as employed men (Rosenfeld, 1989). There is an irony to research findings in which women reported that feelings of depression interfered with the ability to perform their
household responsibilities. When these women experienced role strain, they were found to reduce work hours or give up schooling in order to prioritize the maintenance of the home and care of the children (Gammell & Stoppard, 1999; Scattolon & Stoppard, 1999). This finding speaks to the centrality of childcare in women’s lives, and the social messaging that promotes the image of the “good woman” as one who makes sacrifices and copes for the good of her family (Scattolon & Stoppard, 1999). This social messaging will be discussed extensively in the following section.

Cultural Imperatives and The “Good Woman”

Feminist writers have been prominent in uncovering the myriad implicit and explicit cultural messages women receive about how to think, feel, and behave in socially acceptable ways. Many of these messages carry with them a moral undertone of goodness, implying what a woman “should do” in order to be a good wife, good mother, or good woman. A number of researchers (e.g. Jack, 1991; Mauthner, 1999) have made a direct connection between these cultural discourses and depression, which will be discussed here. I will also examine how these messages are acted out in heterosexual relationships and in relation to women’s bodies and lives over the life span.

Feminist use of the term “discourse” describes the cultural language that includes ideas, symbols, rituals and gestures related to femininity (Dunlap, 1997). One of the ways that feminist researchers have uncovered how cultural discourses become internalized is by using qualitative methods to examine themes in language. Researchers including Jack (1991), Gammel and Stoppard (1999), Mauthner (1999), McMullen (1999), and Schreiber (2001) have found that depressed women consistently use moral language such as “should,” “ought,” “good,” “bad,” and “selfish” to describe themselves and their
behavior. The finding that women with depression frequently use common language to judge themselves against a standard of behavior has been used to demonstrate how cultural messages are translated to the individual level.

The conflict between what women feel they should be doing, thinking, or feeling and what they are actually experiencing creates dissonance. This is manifested as a struggle between different parts of the self; one that reflects cultural ideals, norms, and values, and another that is informed by the woman’s actual, concrete experiences (Jack, 1991; Mauthner, 1999). While standards of goodness may vary with cultural group and social context, listening to moral language and the meanings it conveys provides important clues as to how a woman defines herself (McMullen, 1999).

When examining research related to cultural imperatives, the following themes emerge that convey the messages women receive, including: (a) the necessity to prioritize nurturing and care of others to the extent of being selfless and self-sacrificing (Gilligan, 1982; Jack, 1991; Schreiber, 2001); (b) to be cheerful, strong, and productive while avoiding conflict and the expression of anger (Brown, 1986; Schreiber, 2001; Simonds, 2001); (c) to be autonomous and independent, not smothering others with emotional neediness and not showing vulnerability lest it be interpreted as weakness or failure (Mauthner, 1999; McMullen, 1999); (d) to ensure that a husband is attracted and held and that his emotional and physical needs are met, always prioritizing marital and parenting roles over vocational goals (Brown, 1986; Jack 1991; Scattolon & Stoppard, 1999); and (e) to maintain a youthful, slim, and attractive appearance (Dunlap; 1997; Jack, 1991). For many women, goodness also includes norms and attributes of the achieving, competent superwoman. Imperatives related to this role often act in direct opposition to
the traditional values related to femininity, and encourage women to be self-reliant, aggressive, carry themselves with integrity, and have high self-esteem (Jack, 1999). As a body of work, the principle that emerges is that social and cultural messages limit how fully a woman can express herself because the range of acceptable behaviors is limited.

Messages about femininity are often most strongly acted on in the context of relationships with men. Beginning in childhood, females are taught socially sanctioned way to interact with men to show love and caring that provide a powerful template for acceptable behavior (Atwood, 2001). Women’s strong desire to create closeness and attachment are acted out in relationships by helping, pleasing, and compromising. When there is no reciprocity, a woman may stifle her own needs and wants further in an effort to maintain the relationship (Jack, 1991). This leads to a silencing of one’s voice that can translate into depression and a sense of alienation from the self. Some have speculated that this mechanism is behind statistics indicating that married women are more likely to be depressed than both single women and married men (Stoppard, 2000). In an effort to simultaneously navigate the roles of wife and good woman, and to meet their wishes for attachment, the groundwork for depression is laid.

*Women’s Bodies*

It would be impossible to discuss cultural discourses of femininity without acknowledging the myriad messages women receive about their physical bodies and appearance. There are four main ways that I found in my review of the feminist literature in which cultural attitudes towards women’s bodies impact vulnerability to depression. First, patriarchal culture views women’s bodies as a commodity, a concept highlighted by Wolf (1990) in The Beauty Myth. The beauty myth is a fallacy perpetuated on women
wherein “the quality called ‘beauty’ objectively and universally exists. Women must want to embody it and men must want to possess women who embody it. This embodiment is an imperative for women but not for men” (p. 12). Second, our culture encourages women to be fixated with physical aspects of their bodies. Focusing on every diminutive aspect of personal appearance leads to a distorted image and intense dissatisfaction with the self, which is often found in depressed women (Simonds, 2001). Third, women’s bodies are subject to male control through violence and the threat of violence, including sexual abuse, rape, battering, and harassment. This has been found to contribute to a woman’s belief in her powerlessness, which is a hallmark of depression (Dunlap, 1997). Finally, the physiological and biological experiences of menstruation, pregnancy, and menopause interact with personal and social meanings of the female body to create vulnerability to depression. It is not the physiological changes themselves that create depression, but the need to navigate complex imperatives at each stage. Although there is little empirical support implicating female biological factors such as hormones in depression (e.g. Whiffen, 2004), it is theorized that over the life span women experience bodily changes, each with its own set of cultural messages and meanings. These imperatives will be explored in the following section.

_Depression throughout the Life Span_

Certain cultural values and messages become more prominent at different times in the life span. Adolescence, the transition to motherhood, and later life have been identified as key developmental periods. A number of these values will be discussed as they relate to vulnerability to depression.
Adolescence. Differential rates in depression between males and females first appear in adolescence, a finding that has been underscored as having particular importance for understanding depression in women (Stoppard, 2001). From a sociocultural perspective, it has been argued that adolescent girls are faced with dominant cultural narratives of womanhood, and challenged with how they will navigate and make sense of these messages for themselves (Compitello, 2003). Pipher (1994) argued that depression in adolescence is often related to factors such as physical appearance, peer relationships, and pleasing others.

As they enter adolescence, girls encounter the impossibilities and contradictions of cultural expectations, nowhere more apparent than as they relate to body image and the thin ideal (Compitello, 2003). Peer acceptance of physical appearance is an important factor in adolescent distress (Pipher, 1994). Themes of objectification, shame, and embarrassment have been associated with adolescents’ stories of how they experience their bodies (Stoppard, 2000). Compitello found that the physical changes associated with puberty interact with peer group behavior, normative standards of one’s grade level and cultural prescriptions to influence the emotional and psychological well-being of adolescent girls. In addition, cultural discourses related to menstruation and premenstrual experiences provide powerful messages about the nature of women, often portraying them as emotional and unpredictable (Stoppard, 2000).

At the same time, Compitello (2003) highlighted how distress is mediated by peer relationships, with those that reinforce rigid role stereotypes having a toxic effect on young women. For example, Pipher (1994) highlighted how issues related to popularity, cliques, social status, and the construction of the social world of girls have been
implicated in depression. In addition, during adolescence, girls begin to identify with what has been referred to as a “romantic discourse” (Stoppard, 2000). This involves finding the right man and falling in love, followed by a wedding and children. A heightened awareness of cultural norms as they relate to heterosexual relationships develops.

During adolescence, girls can be vulnerable to playing out cultural scripts about niceness, including pleasing and deferring to others. As in adulthood, depression in adolescence is commonly conceptualized as a loss of self (Pipher, 1994, Stoppard, 2000). This loss occurs as girls try to follow rigid narratives and fit feminine expectations for goodness. This may mean denying the self in an effort to be socially acceptable. It is notable that the bulk of research about adolescents and depression relates to dominant groups, with little attention to how culture, race, ethnicity, and sexual orientation interact with known risk factors to create vulnerability for depression (see Compitrello, 2003).

Motherhood. Few experiences in a woman’s life parallel the adjustment required in the transition to motherhood. Women vary greatly in their experience of pregnancy and motherhood, with 20 to 30% reporting some depressive symptoms in the postpartum period (Stern & Bitsko, 2003; Terry, Mayocchi, & Hynes, 1996). There is a tremendous body of research focused on postpartum depression, both from feminist and traditional perspectives. While it is beyond the scope of this review to discuss this research in detail, salient aspects related to discourses of femininity will be discussed here.

Cultural norms create an assumption that all women want to become mothers. Motherhood is taken for granted as part of a natural role in a woman’s life that requires little justification (Chrisler & Johnston-Robledo, 2002). Stoppard (2000) noted that
marriage and motherhood also offer escape from what has become a culturally devalued role, that of the single woman. Stoppard noted that long before a woman has a child, cultural messages have begun to shape how she will form her identity as a mother, and how this fits in with her identity of herself. Mauthner (1999) found that women who experience postpartum depression experience dissonance between the mothers they expected to be and the mothers they have become.

There are deeply ingrained cultural myths related to motherhood. Moral standards of “good” versus “bad” mothering resonate throughout the research related to depression. Traits associated with good mothering include being soft-spoken, patient, receptive, nurturing, and enjoying their children (Chrisler & Johnston-Robledo, 2002). Mothers who do not inherently enjoy infant care, do not experience positive bonding, or who feel ambivalent tend to hide this reality from others, lest they be labeled a “bad mother” (Mauthner, 1999). Prevailing norms expect that good mothers consistently organize their lives with their children as a priority (Stoppard, 2000). Partners, friends, and health professionals may also reinforce rigid mothering beliefs (Mauthner, 1999). Feminist researchers have argued that the bulk of the responsibility for children’s growth, development, and behavior rests on women, and that mothers are often blamed for any behavior problems or faults in their children (Sommerfeld, 1989). The experience of becoming a mother is wrought with social messages. Women who constantly strive to meet rigid cultural expectations may find themselves struggling with feelings of inadequacy (Mauthner, 1999).

Later life. Developmental changes in social roles have been found to be an important element in depression in older women. Stoppard (2000) stressed that the
centrality of childbearing in women’s identities is an important consideration in exploring depression in midlife women. This was echoed by McGrath et al. (1990) when they found that women who experience the most distress at menopause are often those who draw on their childbearing and child-rearing roles for status and self-esteem. Socially constructed meanings play an important role in depression in these life stages; however, these explanations are often downplayed and an emphasis placed on biology (Stoppard, 2000).

Negative connotations of women’s aging are embedded in a focus on biological (particularly menopausal) changes. Kurpius and Nicpon (2004) found that cultural values related to attractiveness are apparent, even for women with healthy lifestyle habits, who still struggled with feelings of bodily shame and poor body image. Changes in the body that accompany menopause often involve weight gain and are distressing for most women, who feel less attractive and desirable as a result. However, the relationship between menopause and depression is largely misunderstood, with some questioning whether depression is a precursor to symptomology or a result of biological changes (McGrath et al., 1990). As in other stages of a woman’s life, the interplay between cultural norms, self-perception, and intimate relationships must be recognized when considering mood.

Healing from Depression

Traditionally, research related to exploring treatment for depression has involved empirical testing of a variety of approaches using positivist scientific methods. Feminist standpoint theory has countered this emphasis by inviting women to share their understanding and experiences, from which new perspectives can be generated (Scattolon & Stoppard, 1999). As I reviewed the literature, I found four key themes that emerged
from the work of standpoint researchers that provide important information about the healing process.

First, the work of feminist standpoint theorists suggests that recovery begins when women question the messages they have received about themselves throughout their lives. Reflection, inner questioning, and attentiveness to the origins of personal standards of behavior can begin an important process of re-defining the self (Jack, 1991; Schreiber, 1998). Change occurs as women weigh the evidence for and against the messages they had received in their families of origin, partners, and friends. Jack described this as examining cognitive schemas that represent beliefs about the self, particularly as they relate to what it meant to be “good enough.” Healing involves discarding messages that have reinforced a woman’s worthlessness, and making a conscious decision to pave a new way. This new way involved rejecting the behavior that was associated with being a “good wife” or “good mother” and beginning to re-define the self, even if this meant losing the approval of others (Jack, 1991; Mauthner, 1999; Schreiber, 1998).

While changes at the cognitive level were shown to be important to recovery, knowledge about the self that comes from emotional awareness was also found to be necessary (Schreiber, 1998). This leads to the second theme, which relates to recognizing and expressing emotions in an authentic way. This can be a painful process of descending into loss, grief, or anger, as women acknowledge long-repressed or hidden feelings (Stiver & Miller, 1997). Women frequently described a sense of being split into different parts of the self; the part they show to others, and the part that remains hidden (Gammel & Stoppard, 1999; Jack, 1991; Mauthner, 1999). Jack further added that healing involved resolving this split by attending to the emotions associated with hidden parts of the self.
Emotional awareness was a catalyst for creating new frameworks for living that were related to honoring the authentic self.

The third theme relates to women reinvesting in themselves and the action that is associated with this goal. For many women, this began with reevaluating the priorities shaping their everyday lives (Gammell & Stoppard, 1999). Women recounted stories of asking for what they needed from others, deciding not to tolerate physical or emotional abuse, setting new boundaries, and not trying to control everything in their environment (Mauthner, 1999; Schreiber, 1998). Taking action also involved reexamining taken-for-granted responsibilities and beginning to rediscover themselves and their own interests. Women in these studies chose to spend time involved in pleasurable activities away from home and children (Azocar, Miranda, & Dwyer, 1996; Scattolon & Stoppard, 1999).

Finally, connecting with others, especially other women, was an important way to normalize experiences and access support. Building connections helped to reduce isolation and encouraged women to learn coping strategies from others who shared their experiences (Azocar, Miranda, & Dwyer, 1996; Scattolon & Stoppard, 1999). Female friendships allowed women to test out new ways of being in the safety of a trusting relationship (Jack, 1991).

In summary, the way that women recover from depression has been conceptualized as a developmental transition where old ways of being are challenged and new frameworks are built. Key to the successful navigation of this transition is a movement away from internalized messages about goodness; and a movement toward a way of being that honors the authentic self. Qualitative research that has examined the process by which women heal from depression has important implications for counselling
practitioners. The themes emerging from this research provide critical avenues for intervention approaches that will be effective when working with depressed women, to be discussed in the following section.

*Intervening to Address Depression*

In this section, therapeutic approaches and strategies that show promise in helping depressed women are discussed. The approaches described are not exhaustive. Instead, they follow from a belief that depression is caused and maintained by sociocultural conditions, and that cultural imperatives related to femininity and goodness are key factors. Following in the feminist tradition, existing intervention approaches from other therapeutic approaches can be utilized, providing they are grounded in feminist principles. In developing this section, only those approaches that have specifically been critiqued from a feminist perspective were included.

*Feminist approaches.* Feminist approaches to depression occur in the context of a therapeutic relationship in which the counsellor constantly strives to reduce the power differential. The nature of the feminist counselling relationship not only empowers the client, but also acts as a model of healthy relational mutuality (Brown, 1994). A number of interventions that can be used to address depression in women are considered uniquely feminist. For example, the feminist strategy of demystifying therapy means that knowledge about tools and approaches are shared openly and the client is not only fully informed, but participates equally in making therapeutic decisions (Worell & Remer, 2003). One approach that lays the foundation for therapeutic work is the depathologizing of depression. Depression is reframed as a healthy, normal, or adaptive reaction to difficult or depressing circumstances, or resistance to an oppressive situation (Avis, 1991,
Framing depression in this way is believed to reduce self-criticism, increases self-empathy, and pave the way for new coping (Simonds, 2001).

The hallmark of feminist therapy is gender and/or power role analysis, which serves to reframe a woman’s problems as rooted within her social and cultural context. Gender analysis involves the exploration of the meaning of gender in light of personal values, family dynamics, life stage, cultural background, social experiences, and current environment (Brown, 1994). Feminist power analysis can also be used to help a woman understand how unequal access to resources can influence personal choices (Enns, 2004).

Feminist therapists may use self-disclosure as a way to reduce the power differential, normalize the client’s experiences, convey feminist values and promote the client’s consciousness (Enns, 2004). An important difference between feminist therapy and other approaches to depression is that it seeks to move beyond symptom reduction to promote client empowerment. This leads to greater resilience by supporting the knowledge and skills that promote effective coping (Worell & Remer, 2003).

It is important to mention that women who struggle with depression frequently mention the difficulties of trying to cope with multiple stressors. For low income or marginalized women, these stressors have been found to relate to financial problems, childcare responsibilities, abusive partners, and employment challenges (Scattolon & Stoppard, 1999). Dealing with practical issues and finding ways to alleviate stressors is an important way to support recovery. Azocar et al. (1996) have highlighted the need to address financial, vocational, and legal needs by advocating on behalf of marginalized women with government and community agencies.
Feminist therapy is used as a framework for the integration of other models and interventions. Interventions for depression that have been used within the framework of feminist therapy will be examined thoroughly in the handbook, but will be briefly introduced below.

_Cognitive-behavioral approaches._ A number of general concepts of cognitive-behavioral therapy (CBT) overlap with feminist principles, including the consultative role of the counsellor, the assumption that problematic behavior is learned, and that clients can take control of their lives (Enns, 2004). Cognitive behavioral strategies such as self-monitoring, modeling, cognitive restructuring, assertiveness training, and stress inoculation can be integrated within a feminist model to promote achievement of goals. While the feminist emphasis on socialization differs from the intrapsychic orientation of CBT, this approach can be used to help women understand how their thoughts are socially-derived (Hurst & Genest, 1995). Simonds (2001) illustrated how CBT can be used to deconstruct templates related to feminine ideals of goodness, particularly those related to being a “good mother”, “good wife” or “good woman”. Simonds noted that the more social roles a woman fulfills, the more idealizations of goodness a woman has, dovetailing cognitive techniques with gender and social role analysis.

An important strength of CBT is the considerable empirical support for its effectiveness with depression (Hurst & Genest, 1995). Nevertheless, one caution voiced by feminist therapists in the use of CBT is that it promotes androcentric values such as personal mastery of the environment without acknowledging the cultural limitations on women (Enns, 2004; Hurst & Genest, 1995).
Gestalt approaches. Gestalt approaches have much to add to feminist therapy, especially when dealing with goals related to defining the self and owning personal power. Developing awareness of unexpressed emotion and using it constructively, and generating new behavioral alternatives are goals of feminist gestalt therapy (Enns, 1987). Techniques gestalt therapists use, such as using assertive language, guided fantasy, and use of the empty chair technique to express difficult emotions can encourage women to become more aware of their personal power (Enns, 2004). Gestalt approaches lend themselves to encouraging women to outwardly express the inner dialogue that occurs between conflicting parts of the self. For example, a therapist might encourage a two-chair dialogue between the authentic voice, and the voice of the good woman.

Gestalt approaches that facilitate women connecting with the intense sadness and loss that underlie depression have been advocated by feminist therapists such as Stiver and Miller (1997). They have recommend emotion-focused strategies to cultivate and bring awareness to painful feelings that were evoked when relational needs were not met. Recently, emotion-focused therapy, developed by Greenberg (2002) has been shown to be successful with women who survived child abuse (Paivio & Nieuwenhuis, 2001) and with couples where the woman is depressed (Dessaulles, Johnson, & Denton, 2003). Schreiber (1998) noted that Gestalt approaches could assist depressed women in moving toward wholeness and authenticity. However, Enns (2004) cautioned that the Gestalt focus on personal autonomy and responsibility underemphasizes the importance of relationships and does not recognize the environmental factors that serve as barriers to growth.
Postmodern approaches. The constructionist belief system that underlies postmodern approaches such as solution-focused and narrative therapies shares considerable common ground with feminist principles. De Shazer (1985) is generally credited with being a founding member of solution-focused brief therapy (SFBT) in the 1980’s, while White and Epston (1990) founded narrative therapy in the 1970’s and 1980’s. Central to the overlap between postmodern approaches and feminist approaches is the narrative principle that people’s identities are actively created within popular cultural discourses related to issues such as gender and individuality (Gremillion, 2004). In this perspective, people’s problems are situated within the context of social and cultural inequality rather than within the individual, and are acted out through cultural scripts (Lee, 1997). Narrative therapy emphasizes the use of language to deconstruct identity, explore dominant stories, create meaning, and reconstruct new stories (Prouty & Bermudez, 1999). Solution-focused therapy encourages the reframing of problems such that women can capitalize on their strengths and expertise (Dermer, Hemesath, & Russell, 1998).

One significant difference between postmodern approaches and those mentioned thus far is the espousal of a single true “self.” Instead, several selves exist within an individual, all which develop different roles (Prouty & Bermudez, 1999). Utilizing this model, a feminist therapist might work with a client to deconstruct the various roles she plays, such as wife, mother, and daughter. Ideas about power and gender are examined within each of these roles to understand their collective contributions to her identity (Lee, 1997; Prouty & Bermudez, 1999). Cultivating the expression of dominant narratives, externalizing the problem, emphasizing exceptions to problems, therapeutic documents,
and reflecting teams are all strategies used by narrative therapists (see Lee, 1997).
Solution-focused approaches are founded on presuppositional language that fosters an internal locus of control and assumes people have the ability to change (Demer et al., 1998).

Both narrative and solution focused approaches share the principle of collaborative and empowering client-therapist relationships with feminist therapy and also discourage the use of pathologizing language and diagnostic labels (Demer et al., Enns, 2004). However, it has been argued that the postmodern emphasis on subjectivity of experience threatens the unifying power of the feminist movement, which has placed value on universal feminine experiences (Lee, 1997).

**Couples and family systems approaches.** Given the emphasis in the feminist literature about relational factors in women’s depression, there is a surprising scarcity of literature in this area. A notable exception to this is Bergman and Surrey’s relational model (1999), in which they employed feminist relational theory to address depression as a symptom of relationship disconnection. This model of couples therapy takes into account how power and gender are played out in a couple’s relationship, acknowledges cultural context, and capitalizes on a woman’s desire for connection in the relationship (Mirkin & Geib, 1999). Bergman and Surrey have used the model extensively in their own practice; however, this approach has yet to be researched.

Family therapy models of addressing depression rest on the assumption that interactional patterns in the family create or maintain depressive episodes. Carter (1991) noted that women with traumatic interpersonal histories may find themselves reenacting these dynamics in their current family, and suggests gender-sensitive object-relational
family therapy to address depression. For feminist family therapists, recognizing unequal power and gender imbalances is critical (Worell & Remer, 2003). This is in contrast to traditional family systems therapy, such as the modality developed by Bowen (1974) where no particular situation or person is considered the cause of problematic interaction. Instead, each action or individual is seen to influence problems in a circular way.

While theoretical models of addressing depression from a feminist couples or family approach exist, further writing exploring their practical application has been slow to develop. This is clearly an area where more research is needed. In addition, approaches that assume that relationships issues underlie depression, such as interpersonal therapy (IPT) have not yet been critiqued or utilized within a feminist framework, and warrant examination.

Summary

Many sociocultural factors contribute to depression in women. The social realities of women’s victimization, poverty, and marginalization all contribute to an increased vulnerability that has, by and large, been ignored by traditional models of depression. Gender socialization researchers suggest that certain female traits that are reinforced socially can lay the groundwork for later depression. This combines with the realities of the feminine role, which often involves caregiving, household responsibilities, and self-sacrifice. These risk factors are laid against a backdrop of strong cultural messages that dictate socially acceptable thoughts, feeling, and behavior for women. Cultural scripts related to goodness weigh heavily in depressed women’s minds, and, when played out in the context of intimate relationships, lead to self-silencing and a loss of authentic self that is detrimental to identity (Jack, 1991; Simonds, 2001).
Given these realities of women’s lives, feminist models that take into account social and cultural factors in depression across the life span are essential. It has been suggested that healing from depression involves questioning cultural scripts and redefining the self in a way that honors women’s authentic feelings and experiences. Feminist therapy can be used flexibly to promote this healing, and can be combined with cognitive behavioral, gestalt, and post-modern approaches to address depression. The research presented in this literature review will be used to develop a handbook that will contribute to counselling practitioners’ knowledge. It is anticipated that the handbook will build on what is known about depression to encourage the use of methods to alleviate it in ways that support, empower, and encourage the well-being of women.
CHAPTER III

Synthesis and Implications

Feminist researchers have done important work in drawing a connection between cultural imperatives and depression, but less has been done to translate this knowledge into practice. The need to recognize both the influence of culture on depression, and the heterogeneity of women’s experiences was acknowledged at a summit of women and depression by the American Psychological Association (Mazure, Keita, & Blehar, 2002). Furthermore, Worell and Remer (2003) have noted that research has been slow to move beyond symptom reduction and into more holistic measures of well-being. In particular, they have called for “more research on feminist interventions with specific diagnoses and presenting problems” (p. 286). In this project, I set out to speak to one of the gaps in the feminist literature by investigating specific interventions that could be used to address a specific problem within a feminist framework.

As a counsellor, researching and developing this project has been an important experience in my development. Throughout the research, I reflected on my own work with clients and considered how this information contributed to my identity as a counsellor. I was fortunate to be completing my practicum while working on this project and had the opportunity to begin to integrate some of the ideas I was exploring with clients. The more I learned and reflected, the more confident I became in my counselling work and about sharing my theoretical orientation. I was pleasantly surprised with the positive feedback that I received and the collaborative joining I was able to engage in with a number of female clients when I introduced some of the ideas I have presented in this project.
As a woman, I was also impacted by the research I encountered. Throughout the development of the handbook, I reflected on the cultural messages I had received throughout my life, and how these had influenced my own decisions, relationships, and psychological well-being. As I developed the handbook, I speculated on what it would be like to be a client working with a counsellor who took this approach. Immersing myself in feminist research over the past year has done much to strengthen and challenge my identity as a feminist and feminist counsellor. I took opportunities to discuss my work with friends and colleagues, both male and female. Initially, when people asked about my final project work, I was not sure how they would react to the kinds of theories I was presenting given their less-traditional nature. Women in particular seemed to be very interested; and often asked me questions, recounted their own experiences, or made comments that related to how empowering this approach seemed. I was very encouraged by the positive reactions I received, and this served to motivate me further in my work.

In addition to enhancing my own development and identity as a counsellor, the most gratifying part of this project for me was being able to begin to address, in my own small way, one of the areas of needed development in feminist research. My own experience of feminist writing about depression is that it is hugely theory-oriented. With the notable exceptions of work by Worell and Remer (2003) and Simonds (2001), it would be very difficult for practitioners to know how to address depression from a feminist perspective in practice. Being able to “fill in some of the holes” and offer interventions that are strongly rooted in the literature was very satisfying. My subjective impression is that, given the strong utility of this handbook for myself, it would also have
considerable value for other practitioners, a point which will be discussed further in project utility section, to be found at the conclusion of the handbook
References


Appendix:

“The Good Woman”:
Sociocultural Approaches in the Treatment of Depression in Women

A Handbook for Counsellors

Karoline Sandhurst
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Counselling practitioners in a variety of settings are likely to encounter women who report depression as their primary presenting problem. In the most recent Canadian National Population Health survey, completed in 2003, 7.1% of women reported an episode of major depression, compared with 3.3% of men (Stewart, Gucciardi, & Grace).

While a large number of treatment strategies are available to counsellors, very few approaches acknowledge the social and cultural realities that women experience. In addition, counsellors who wish to utilize a sociocultural conceptualization in their approach to depression treatment may be unsure of how this can be applied in practice. In this handbook, practical counselling strategies are provided to demonstrate how this approach might be applied. Counsellors who wish to reflect on their current practice will find treatment approaches in this handbook that move beyond intrapsychic causes for depression.

This handbook is rooted in feminist theory, research, and practice, in which the salience of sociocultural factors in the development and maintenance of depression is central. Cultural ideals and socially constructed standards about what women “should” do to be “good wives”, “good mothers”, and “good women” are significant in the experience of depression, and will form the focus for this handbook.

What does it mean to be a “good” wife, mother, or woman? How do these themes resonate with depressed women? How can a counsellor work with these themes to help women heal? These are the central questions that this handbook will address.

Sociocultural Influences on Depression

Much of the current depression research focuses on physiological and intrapsychic factors in depression. However, this approach marginalizes the social and cultural factors that contribute to depression. For example:

- Women are more likely to experience traumatic life events, such as childhood physical or sexual abuse, martial or acquaintance rape, battering, or sexual harassment in the workplace (Koss, 1990).

- Women suffer more frequently from poverty or impoverished situations, such as substandard housing, employment inequities, and lack of safe, affordable childcare (Currie, 2005; Stoppard, 2000).

- Discrimination and oppression are contributing factors to depression, especially in non-dominant groups such as visible minorities, lesbians, and the differently abled (Guindon & Sobhany, 2001).
• Overwhelmingly, women continue to perform the vast majority of household tasks, regardless of employment. Inequity in the division of household labor has been directly linked to depression (Bird, 1999).

• Female gender socialization encourages devaluation, feelings of powerlessness, and self-blame. Women are socialized to inhibit anger, defer to others, and prioritize the needs of others over themselves (Atwood, 2001).

Current treatment practices to address depression are often built on the assumption that something is wrong with the woman. This can range from irrational perceptions, distorted thinking, passive behavior, or inappropriate affect. Counselling is often viewed as a corrective experience to support a woman to reduce her depressive symptoms.

This handbook takes an alternate approach, founded on the following assumptions:

(1) Women experience oppression in many forms, including victimization and marginalization. For many women, depression is the aftermath of these experiences. Counsellors must be sensitive and aware of these realities and integrate this knowledge into treatment practices.

(2) Women receive strong cultural messages that dictate how they should think, act, and feel in socially acceptable ways. The messages vary across the unique cultures and traditions of diverse women. Striving to achieve these standards of behavior in their roles as mothers, wives, and women is a mechanism that underlies depression. Counsellors must help women deconstruct these messages and help them create new standards in order to heal.

(3) The conditions of many depressed women’s lives are very stressful. Poverty, single parenthood, caregiving, and balancing work, home, and family demands are a reality for many women. Counsellors must move beyond symptom reduction to empower women to be resilient in the face of these demands.

(4) Until the social conditions of women change, depression will continue to be a problem. Counsellors must seek to find ways within their own practice, their own counselling settings, and their larger communities to advocate for changes that will improve the lives of women.
Overview of this Handbook

- This handbook presents a way to conceptualize depression that focuses on the social messaging a woman has received and internalized. While it may not be appropriate for all depressed women in all situations, counsellors may find particular ideas, resources, or strategies of value. Feminist counsellors will be most familiar with this approach and this handbook may confirm what they already know. The information in this handbook may be very new to counsellors from other theoretical orientations. It is hoped that the information provided here will offer new perspectives and considerations.

- This handbook is designed for counselling practitioners working in private practice, community, or institutional settings. The strategies presented are intended for use with adult female clients who report mild to moderate depression. Severe depression may require the mobilization of other services and resources.

- This handbook is intended for use as one part of a holistic treatment approach. It provides ideas and resources for counsellors who wish to bring a broader focus to treatment. It does not replace the need for a full assessment that includes history taking, risk assessment, and referral to other appropriate resources and services.

- The ideas presented herein are intended for use in one on one counselling sessions, recognizing that individual women are the most frequent consumers of counselling services. However, this does not preclude the fact that, for many women, couples or family counselling that is aimed at improving relationships in the couple or family context may prove necessary or effective.

- The information in this handbook is based on an extensive literature review, of which the contributions of feminist researchers were central. Feminist practice is based on recognizing social and cultural roots to problems, highlighting women’s unique voices and strengths, and practicing in ways that promote egalitarian relationships and empowerment. These beliefs formed the cornerstone of this handbook. It is often assumed that feminist counsellors must be women. While this handbook was designed with female practitioners working with female clients in mind, it may also be a useful resource for male practitioners who are working with depressed women.

- In the feminist tradition, other therapeutic modalities are drawn upon in counselling, with the proviso that they must be compatible with feminist beliefs. The toolbox-style approach that is provided in this handbook allows counsellors to use techniques that fit with their theoretical orientation, practice setting, skills, and limitations on practice. The strategies are not intended to be used together (as in a treatment manual), but to provide ideas, concepts, and techniques that can be integrated within responsible practice.
How the Handbook is Organized

Following the introduction, Part II begins with the presentation of feminist therapeutic goals and how they can be applied to working with depressed women. Part III lists strategies and techniques specifically related to feminist therapy and their application to depression. For each strategy, an overview is provided, followed by tips, ideas, or considerations in applying the strategy in counselling practice. Throughout the handbook, references and resources for both clients and counsellors are presented for further learning.

Part III begins with an introduction to a hypothetical case study. The case study will be followed throughout the section, which presents four central healing themes and related strategies. The four themes were derived from a thorough literature review that investigated factors that help women heal from depression and was derived from the contributions of feminist qualitative researchers. Part III focuses on the practical application of the theories provided in current feminist research. Counsellors may find that only one of the four themes is relevant in their work with a particular client, or that multiple themes are relevant.

Although the case study was used to illustrate the application of particular counselling strategies, it was recognized that a single case study could not possibly contain the diversity of backgrounds and experiences of depressed women. The case study was used to demonstrate how different techniques might be applied in a practical way, but not to convey in a formulaic manner how each approach should be utilized. Counsellors must still take into consideration the unique considerations in working with depressed women from special populations, such as women of color, immigrants/refugees, lesbians, or women with physical, medical, or cognitive challenges. Counsellors are advised to consult pertinent literature when working with depressed women who have diverse social locations.

A Note About Social Action

Ultimately, the position I have put forth by this handbook is that the rates of depression in women would be reduced if the social and cultural conditions of women’s lives changed. This implies that the “solution” is at the societal level, and not at the individual level. However, counsellors will continue to work with women on one on one settings and this handbook offers a potential framework to consider in their work with clients.

Counsellors may wish to reflect on the role of social action in their own practice. Social change has a continuum of levels, from large, macrolevel to smaller, microlevels. Counsellors may find ways to engage at the microlevel in their individual practice, agencies, or communities. Action and advocacy that changes the conditions of women’s lives at social and cultural levels combat the problem of depression at a different level.

Public policy such as access to social programming, availability of safe, affordable childcare, and access to affordable housing are just a few pertinent issues. Preventative community programs that address family violence, abuse, and victimization are another example of changes that ultimately benefit women and reduce depression. Counsellors are encouraged to reflect on the role they might play in improving the social context of women.
**Feminist Therapeutic Goals**

The conceptualization of depression promoted in this handbook is aligned with the following central goals of feminist therapy:

1. **Supporting Empowerment**

   Empowerment describes a process by which an individual becomes aware of power dynamics in her life, develops skills, and increases her capacity to exercise reasonable personal control without infringing on others (McWhirter, 1991). The emphasis in this goal is on building personal competence rather than symptom reduction.

   When working with depressed women, counsellors are encouraged to support their clients to mobilize internal and external resources to create change in their lives. This approach promotes resilience by accessing the client’s own knowledge and skills, which in turn encourages current healing and future coping (Worell & Remer, 2003).

2. **Promoting Social Consciousness**

   This goal reflects the understanding that individual problems are related to larger social issues and not a consequence of personal inadequacy. Women are encouraged to become aware of the psychological impact of powerlessness and devaluation. Depression can be a result of powerlessness, victimization, marginalization, discrimination, or environmental circumstances, such as poverty and inadequate access to resources.

   Inner change is important, but so is larger change in relationships, communities, and societies. Counsellors are encouraged to help their clients discern the invisible forms of inequality that have contributed to depression. This can be achieved through techniques such as gender role or power analysis, which will be discussed in later sections.

3. **Egalitarian relationships**

   The nature of the help-seeking situation makes it impossible for power between a client and counsellor to be equal. However, the counsellor strives toward a relationship that is as egalitarian as possible. Power is shared without denying the inherent power imbalance of the counselling situation.

   The therapeutic relationship is an opportunity to model a healthy relationship where limits are negotiated. It is both an outcome and a condition of feminist therapy that promotes healthy mutuality (Enns, 2004).
Using Feminist Strategies in your Work with Depressed Women

While feminist therapists integrate techniques from various therapeutic styles, there are a number of strategies that are seen as foundational in feminist therapy. They are summarized here, and specifically offered in the context of working with depressed women.

1. The Therapeutic Relationship

Beyond the creation of a safe atmosphere for expression, the therapeutic relationship is also a form of intervention that can act as a model for egalitarian relationships in general. The counsellor offers what may be a new experience for a woman, that of being accepted, respected, and understood (Simonds, 2001).

The counsellor models genuineness, confrontation, self-disclosure, empathy, and congruence, offering a template for healthy relationships (Enns, 2004). The counsellor becomes a positive model of self-acceptance, self-nurturance, strength, and empowerment (Laidlaw & Malmo, 1990). This atmosphere also provides an environment that promotes the client’s authenticity, an important consideration with depressed women.

The client is treated with nurturance and empathy, while respecting the unique expertise she brings to the relationship. The client is the best judge of what is right for her. This contrasts with models that are based on emotional distance and the counsellor-as-expert. Treating the client as a valuable expert is a way of undoing “patient identity” and is a forum in which weaknesses can be turned into strengths (Greenspan, 1983). In this way, the relationship has its own curative function.

Counsellor Considerations in Building a Healthy Relationship

- Be alert to issues of trust and mistrust (such as previous victimization, or negative experiences with mental health professionals). Let the client know you can handle her feelings of distrust which are a natural and healthy result of previous experiences.
- Acknowledge the courage it takes to come to counselling and the barriers that may have been present (e.g., financial, time, people).
- Avoid making decisions for the client. Allow her time to think and process things in her own time.
- Communicate confidence in the client’s abilities to make decisions. In taking control of their own therapy, clients begin to trust in themselves, which translates to other areas of their lives.
- Share honest feedback with the client about goals and directions of counselling. Encourage the client to do the same.
- Do not ignore power differences or blur boundaries. Acknowledge what each party brings to the table in terms of skills, expertise, knowledge, and openly discuss how power influences counselling.

Sources: Enns (2004); Malmo & Laidlaw (1990); Simonds (2001).
“It is the client who has everything she needs inside her to find the answers that are meaningful to her, to express herself fully, to recognize her worth, to heal” (Laidlaw & Malmo, 1990, p. 8).

Empowerment is a central goal of the approach presented in this handbook and should be reflected in all interactions between client and counsellor. Some suggestions for creating this environment are presented below.

### Suggestions for Creating an Empowering Therapeutic Relationship

- Communicate an empowering attitude and belief system regarding women.
- Prepare for respectfully challenging a woman’s belief system as a way to expand her range of choices, supporting her to take greater control of those areas of her life where she does have power.
- Support a woman to take action in her own life, on her own behalf, according to what she deems best for herself.
- Facilitate the woman in articulating her own needs, wants, and desires. Consult and trust her personal expertise. Help her find her inner voice.
- Avoid over-helping, taking over, or taking charge.
- Affirm the client’s reality by validating her perceptions, feelings, ideas, and experiences.
- Allow the client to proceed at her own pace. Affirm her need to go slowly or be reluctant.
- Plant the expectation of change by choosing to use language that implies that change will occur, using terms such as “when” instead of “if.”
- Encourage and enable the client to set limits within the therapeutic environment. Give her opportunities to say “no” and reinforce her for doing so.
- Energize the client to mobilize her skills in areas she can take control.
- Provide the client with alternative information through psychoeducation or bibliotherapy.


While empowerment and the therapeutic relationship are important factors in working with any woman, they have great relevance in working with women experiencing depression. In particular, this approach directly addresses feelings of worthlessness, powerlessness, guilt, inadequacy, inactivity, and low self-esteem that are characteristic of depression in women.
2. Analysis of Social Locations

The terms and labels people use to describe themselves are important markers of identity. What categories does your client use to describe who she is? What roles does she occupy? (e.g., caregiver, homemaker, single woman, single mother, etc.)

Different social environments require women to adapt and conform in different ways to address prevailing expectations. Expectations may spring from family, peers, the media, the community, and workplace, as well as political, public, religious, or educational institutions (Worell & Remer, 2003). Over time, these roles and categories form an important basis for personal identity.

### More Privileged Social Locations
- Male
- White/light-skinned
- European in origin
- Heterosexual
- Able-bodied
- Professional, educated
- Young
- Attractive
- Upper and middle-upper class
- Anglophone
- Fertile
- Christian

### More Oppressed Social Locations
- Female
- Non-white/dark skinned
- Non-European
- Lesbian, gay, bisexual
- English as a second language
- Working class, poor
- Unattractive
- Older
- Nonliterate, poorly educated
- Disabled
- Non-Christian

Adapted from: Worell and Remer (2003)

In order to assess social locations, consider the nature of privilege or oppression associated with your client’s various roles. Some questions for exploration with the client are: In regard to each social location, how privileged or oppressed is this client? What are the client’s most salient social locations? How does this vary in different environments? How might these factors be influencing the client’s depressive experiences or well-being? How do the client’s social locations compare with your own? (This is an important consideration in working with power differences).

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**Counsellor Considerations in Working with Disadvantaged Women**

- What barriers to treatment are present? How will you address them?
- How do you intend to address issues of cultural competence?
- What other systems is the client involved in (e.g. social welfare, child welfare, medical system?) To what extent is advocacy needed?
- What additional resources would support this woman to address psychosocial stressors? e.g., housing supports, financial aid, childcare, vocational, legal supports. Is there a need for case management?
- How flexible are you in the way your services are provided? If transportation or child care is a challenge, are you able to provide home-based sessions? Babysitting and transportation may make the difference in attending sessions.
- Research shows that some low income women are more amenable to a short term, psychoeducational approach.

3. Valuing Diversity

An important aspect of feminist practice is respecting and valuing the diversity of individual women. Enns (2004) highlighted the importance of learning about the culture and traditions of diverse groups of women and not overemphasizing gender at the cost of other elements of identity. Comas-Diaz (2000) has suggested that asking clients to tell their personal and cultural stories, including their ethnocultural group’s origins, migration, and identity can be helpful in reinforcing healthy personal identity.

In addition, for counsellors from dominant groups, the ability to self-evaluate how her own White privilege, heterosexual status, and/or class privilege have shaped her own values, beliefs, and assumptions is key (Worell & Remer, 2003). Furthermore, counsellors must be aware that certain therapeutic practices, for example, emphasizing an internal locus of control, assertiveness, or individuality, may be an inappropriate focus with some cultural groups (McGrath et al., 1990).

Counsellors must be cognizant of the fact that the ways in which symptoms are presented, various cultural factors, and explanatory models of illness will influence depressive symptoms and treatment (Brown, Abe-Kim, & Concepcion, 2003). For example, a client may emphasize somatic symptoms of distress and be more likely to seek care within a medical setting because it is more culturally acceptable.

Cultural Considerations and Depression

- How might cultural traditions be impacting this client’s depression? (e.g. what are the culturally-sanctioned norms that may be impacting the client’s depression?)
- How do you assess the client’s ethnocultural identity development and/or acculturation?
- How have racism, discrimination, or internalized stereotypes impacted her identity?
- How does the client balance the competing demands of her various identities and cultural expectations?
- What political and historical factors have influenced the client’s identity? How do spiritual or religious beliefs play a role in the client’s culture?
- How does the client perceive or explain her depression? How have these beliefs been influenced by culture?
- What cultural attitudes exist towards seeking help from professionals, or mental health issues in general?
- How are this client’s cultural traditions, practices, or beliefs a strength to draw on when dealing with depression? How is the client’s cultural community an asset?
- How do you plan to address the need for culturally-relevant treatment?

Adapted from: Enns (2004); Brown, Abe-Kim, & Concepcion (2003); & McGrath et al.(1990)
Counsellors must consider whether they are emphasizing the need to adjust to existing oppressive conditions or relationships, or create change in their lives. At the same time, the counsellor and client must carefully assess the potential positive and negative outcomes change might have on the client. Some cautions:

- Consciousness-raising about the impact of sociocultural forces on the current presenting problem can be unsettling, distressing, or cause strong emotions for some women, especially where a woman is in a situation where change is extremely difficult or potentially unsafe (Worell & Remer, 2003).

- Asserting oneself or speaking out against oppression in relationships, workplaces, or communities may have unintended negative consequences. For example, a woman might be fired from her job, ostracized from her community, or be at increased risk of interpersonal violence. Collaborating with the client to assess personal safety, creating a safety plan, and utilizing natural and community-based resources are important therapeutic considerations (Simonds, 2001).

In the following sections of this handbook, a number of interventions are presented to facilitate healing from depression. However, certain intervention approaches may be more or less acceptable to clients from some cultural groups (Brown et al., 2003). At the same time, intervention approaches that emphasize the function that culture plays in gender-role issues and depression may be particularly illuminating. For example, some authors have noted a relationship between depression in Latina women and unrealistic gender role expectations that include culturally based beliefs against expressing anger, remaining married despite marital discord, and expecting to give help but not to request it (Brown et al., 2003). Counsellors are encouraged to carefully weigh and consider their intervention approaches and to work collaboratively with the client’s beliefs to make shared decisions about treatment.

Authors such as Mazure, Keita, and Blehar (2000) and McGrath et al. (1990) have suggested that counsellors need to take a more specialized treatment approach when working together with women belonging to specific groups, including ethnic minority women, immigrants, refugees, lesbians, and the differently-abled. Women who belong to these groups often face additional barriers or challenges that may need to be integrated into counselling. For example, when counselling lesbians, Mazure et al. suggest the need to incorporate learned negative attitudes about homosexuality (internalized homophobia) as part of the counselling focus.

A number of additional references are included in the Resources section for further information about counselling women belonging to these groups.
4. Life Span Perspective

There are a number of periods in the life span during which women are particularly at risk for depression. Certain cultural values and messages become more prominent at different stages of life. Adolescence, the mid to late 20’s, marriage, motherhood, and later life (especially around menopause) can be times of vulnerability (McGrath et al., 1990). Each of these time periods is associated with its’ own unique set of cultural standards and expectations. Ways to deconstruct these messages will be suggested throughout this handbook; however, this concept is introduced here specifically as it relates to a life span perspective.

Counsellors should also be aware that developmental transitions may trigger changes in the body that can impact self-esteem. Many women experience intensified body image dissatisfaction with depression (Simonds, 2001). Counsellors may wish to examine the relationship between these elements.

Questions for Counsellor and Client Consideration

- What are the messages your client received about where she “should” be at this stage of her life?
- As a young person, what kind of life did the client envision she would have by now? Where did these ideas originate?
- Who are the client’s role models? Why?
- Role transitions can be associated with a sense of loss. In what ways might the client be experiencing grief for a lost part of herself?
- What bodily changes is the client currently experiencing? How do these changes relate to her expectations? What meaning do these changes have for her?
- What relationship does this client have with her body? What pressures does she experience related to her body at this stage of her life? What messages has she received about her body?
- How does the client make sense of depression in this stage of her life? What does she attribute it to? What meaning does it have for her?

Given that these questions may require considerable self-reflection, the counsellor may wish to utilize strategies that allow the client to reflect outside of the session, such as journaling. In addition, a genogram completed collaboratively may also be a tool to understand models of behavior in the family. Depending on the client’s attributions for depression, psychoeducation about risk factors, biological correlates, and particular issues related to her stage of life may be beneficial.
5. A Relational Perspective

Feminist relational theory highlights the centrality of close relationships in women’s development. Relational theory is relevant to a sociocultural approach to depression because; (a) Counsellors may choose to model and embody relational connection in their work with their clients (a relational-cultural model); (see Stiver, 1997; Jordan, 2000); and (b) Women are socialized to inhibit anger, defer to others, and prioritize the need of others over themselves. Within relationships, this behavior leads to a loss of authentic self and the inability to participate fully and honestly within intimate relationships. This mechanism has been proposed to underlie depression (a “silencing the self” model).

Silencing-the-Self Model

The Silencing the Self model (see Jack; 1991, 1992) is based in relational theory, and proposes that some women must stifle the expression of true feelings in intimate (e.g. marital) relationships in order to secure and maintain them. Over time, women become alienated from their wants, desires, feelings, and selves in an effort to nurture, please, and look after others. When this occurs without reciprocity, they feel disconnected, unsupported, and angry. These feelings are shut out of awareness through the internalization of cultural scripts related to goodness, laying the groundwork for depression.

The Silencing the Self Scale (STSS) is a useful tool in assessing the internalization of cultural imperatives. The STSS measures normative beliefs considered socially desirable (not the level of psychological stress or functioning). Higher scores reflect greater pressure to fulfill the norms of the good woman. The STSS is significantly correlated with depression. A link to a web-based copy is available in the Resources section.

Women are asked to rate themselves on a scale of 1 to 5 (1 is strongly disagree and 5 is strongly agree) on items such as the following:

“I don’t speak my feelings in an intimate relationship when I know they will cause disagreement”

“I find it harder to be myself when I am in a close relationship than when I am on my own”

“Caring means choosing to do what the other person wants, even when I want to do something different”

“I find it hard to know what I think and feel because I spend a lot of time thinking about how other people are feeling”

Jack’s model emphasizes carefully assessing depression within the context of the client’s close relationships. She recommends Feminist cognitive behavioral to address depression, which will be discussed in the section called “Deconstructing Goodness – Exploring and Questioning Messages Received.”
6. A Non-pathologizing perspective

A non-pathologizing perspective is important because it is respectful, non-blaming, and non-stigmatizing. Feminist counsellors avoid the use of diagnostic jargon and view depressive symptoms as an adaptive effort to cope with conflicts or difficulties.

Reframing depression is a way to normalize, empower, and honor the client’s unique experiences. Recognize the ways in which misusing or overrelying on diagnostic labels might harm the client. Understand the context in which depression symptoms are occurring. If the client has been diagnosed as depressed, what is her understanding of this diagnosis?

Possible ways to reframe depression include:

- Depression or pain in response to depressive circumstances is healthy, normal, and adaptive (Avis, 1991).
- Symptoms of depression may be viewed as signs of resistance of rebelling against untenable life circumstances (Simonds, 2001).
- Depression can be viewed as a normative developmental event that follows stressful events and precedes re-integration, typically leading to a woman’s recognition that situations in her life are causing unhappiness (Simonds, 2001).
- Depression can be conceptualized as unrecognized loss or sadness that has been dulled, numbed, or never acknowledged (Stiver & Miller, 1997).
- Depressive symptoms might reflect strategies that were role modeled by others (parents, peers, media, schools, etc.) (Enns, 2004).
- Symptoms may be serving an adaptive function, either now, or at some time in the past (Greenspan, 1993).

If depression is functioning as a form of resistance or power for the client, removing it may be disempowering. Enns (2004) stated that “when the focus of counselling is to label and remove a symptom without understanding the context in which it was shaped and the current context in which it is reinforced, clients may be deprived of the indirect influence of the symptom” (p. 14). Together with the client, carefully assessing what influence the symptoms are having on the client’s life is important.

**Points to Consider for Client and Counsellor**

- Depressive symptoms have a communicative function – what powerful messages is your inner self trying to give you?
- Depressive symptoms can be a result of trying to cope with multiple role conflict – in what ways are your roles in conflict?
- Depression is an indirect form of expression. How can this expression be refocused into a more direct or productive form?

*Adapted from: Avis (1991); Enns (2004).*
7. Demystification

Feminist counsellors are committed to promoting their clients’ rights as consumers. Encouraging clients to understand the therapy process lays the foundation for an egalitarian relationship and is empowering.

The process of informed consent provides important opportunities for demystification. Informed consent is an ongoing process that allows counsellor and client to collaborate and negotiate the terms, activities, and outcomes of counselling (Enns, 2004). Therapeutic decisions that must be made, such as how to prioritize issues, which assessment tools to use, and which interventions to try are all decisions that can be shared with the client with her full knowledge and understanding of the pros and cons. In this way, the therapeutic relationship becomes a place where a depressed woman can act with knowledge and autonomy, thus supporting her growth.

**Tips for Promoting Demystification**

- Provide clear and jargon-free information about the process of counselling, including costs and benefits. Explain possible alternatives to counselling.
- Provide clearly and simply written documentation that explains confidentiality, fee structure, rights and responsibilities of each party, etc. Carefully review and read over the document with clients. Give clients the opportunity to take it away, read it, and bring it back with their questions.
- Give the client a sense of what they can expect from you, including theoretical orientation, role, style, boundaries, limitations, background, education, and approach.
- Involve the client in all aspects of decision-making. Offer choices and encourage the client to weigh and consider alternatives.
- Make your relevant personal values known to clients early in the process, minimizing the imposition of values.
- Seek the client’s opinion at each stage of counselling. Brainstorm ideas together about how issues might be worked through.
- Encourage client to write their goals and outcomes in their own words.

*Adapted from: Enns (2004); Worell & Remer (2003)*

Seeking the client’s feedback to evaluate the process of counselling and the working alliance is an important way to promote her position as consumer. An example of a simple, empirically validated tool that encourages the collection of regular feedback is the Outcome Rating Scale and Session Rating Scale (Miller & Duncan, 2004). For more information, see the resources page at the end of this handbook.
8. Gender Role Analysis

Gender role analysis is a process in which the counsellor and client carefully examine the messages a client has received about how to behave appropriately within her gender. Exploring these gender role messages increases clients’ awareness of how the societal expectations related to their various roles impacts them on an individual level. It explores the client’s various roles as they relate to gender, the messages they have received about these roles, the consequences (costs and benefits) of role-related behaviors, and the impact of these messages and behavioral choices on the client’s well-being.

Researchers such as Israeli and Santor (2000) have suggested that gender role analysis can broaden a client’s perspective and increase both instrumental and expressive behaviors.

Steps in a Comprehensive Gender Role Analysis

1. Identify the direct and indirect gender role messages the client has experienced throughout her life. These might be verbal, non-verbal, or modeled from those around them, from media or institutions. How have personal values, family dynamics, life stage, and cultural/ethnic impacted messages received?
2. Identify the positive and negative consequences of conforming or not conforming to gender role messages. What were the benefits of conformity or the punishment for non-conformity?
3. Explore the client’s experience with regard to oppression and victimization (e.g. sexual harassment, interpersonal violence, assault, abuse, racism, sexism, heterosexism) and how these have contributed to the client’s gender-role rules.
4. Examine how the client has internalized these messages either consciously or unconsciously (e.g. examine self-talk).
5. Consider how the counselling relationship mirrors gendered relationships in the “real world” or provides insight about the client’s gender and other social roles.
6. Explore what the client wants to change about these messages. Together, consider the impact gender role has had on depressive experiences. What would things be different if the messages were different? What messages are more self-enhancing and less restrictive? How might a plan be implemented?

Adapted from: Brown (1990); Worell & Remer (2003)

The counsellor and client may wish to pay special attention to conflicts in particular identities or roles, as these can create additional stress that may be influencing depression. Listen carefully to the client’s “moral language”, including words such as “should”, “must”, “ought”, “good” and “bad.” Help the client determine the origin of these messages and the impact they are having.
9. Power Analysis

There are many similarities and much overlap between gender role and power analysis. The most significant difference is that a power analysis focuses on how unequal access to power and resources has influenced the client’s choices and distress (Enns, 2004).

The goal of a power analysis is to purposefully and systemically explore the client’s power status within important interpersonal environments, which may include family, work, and community roles. Some clients might be uncomfortable with the term “power” as their own definition of power implies “power over.” Counsellors may want to reframe or broaden this definition by examining what “power within” means to the client. Where does the client have power now? Where does she lack it?

Understanding issues of power may be a new or foreign experience for the client. Many of the power imbalances in a woman’s life are taken for granted. These questions may be better explored in the context of a particular relationship. For example, in a couple, how are childcare and housekeeping responsibilities determined? How is money earned, handled, shared, or thought about? How are decisions made? Who has the power to veto or the power to abdicate from decisions (Avis, 1991)?

Considerations in a Comprehensive Power Analysis

1. Together with the client, make a list of the various roles the client occupies in family, community, cultural, and employment realms. Consider the different kinds of interpersonal relationships the client is involved in.
2. Across roles and relationships, examine the construct of power: Who has it? How is it acquired? How is it demonstrated?
3. Encourage the client to reflect on where she learned about power. What does power mean to the client? What positive and negative associations does the client have with power?
4. Discuss the client’s experience with regard to oppression and victimization (e.g. sexual harassment, interpersonal violence, assault, abuse, racism, sexism, heterosexism) and how these have contributed to her powerlessness.
5. Initiate a dialogue about multicultural differences between counsellor and client. What systemic barriers do you share as women? What is different? How have your experiences with power differed?
6. What inequities (both systemic and interpersonal) have contributed to the client’s depressive experiences? What institutional and cultural barriers have limited achievements and well-being? What emotions arise out of this? How can these emotions be channeled to the client’s benefit?
7. Explore a time when the client felt powerful. What were the circumstances? What does being empowered mean to the client?

Adapted from Enns (2004)

“For survivors of sexual abuse or other forms of interpersonal violence and victimization, being in positions of lower status or less power may recapitulate the dynamics of their previous victimization, eliciting trauma-related affects of depression, helplessness, and hopelessness.”

(Simonds, 2001, p. 113).
10. A Focus on Strengths and Competencies

In addition to reframing pathology, a strength-based approach is an important element of feminist counselling. The client is viewed as competent, strong, and capable. Even clients who are in crisis or turmoil have often learned a great deal about coping and survival.

Women who are depressed are often focused on their inadequacies may benefit from an approach that capitalizes on areas of strength. In particular, counselling is an opportunity to emphasize client strengths that may have been previously framed negatively.

Our culture undervalues relational and responsive traits in favor of autonomy, independence, and self-actualization. Valuing and privileging relational, female traits is one way to provide an alternative view. For example, dependency might be reframed as sensitivity or responsiveness to relational cues. The concept of codependency is an example of how women are pathologized for providing nurturing and attachment behaviors that they have been taught to give to men (Worell & Remer, 2003). Focusing on strengths and deconstructing societal scripts allows personal traits to be rebalanced, modified, or redirected, instead of rejected.

Considerations in Assessing Client Strengths

- What are the skills the client has used to cope with negative or difficult experiences?
- What positive meanings has the client cultivated from negative events?
- Where has the client shown resiliency?
- What behavioral assets or problem-solving skills does the client have?
- What cognitive coping skills does this client utilize?
- What relational strengths does the client possess? (e.g. empathy, nurturance, cooperation).
- What self-control of self-management strategies does the client use?
- What environmental strengths are present? (e.g. cultural or community groups, employment, housing, etc.)
- What unique skills or competencies does this client have?

Adapted from: Cormier & Nurius (2003).

Throughout the counselling process, counsellors are encouraged to capitalize on the unique strengths and competencies of their clients and acknowledge the expertise they bring to the process. This approach facilitates the use of a larger repertoire of behaviors, encourages women to trust and value their own experiences, and promotes self-nurturing (Worell & Remer, 2003).
11. Self-disclosure

Self-disclosure is a tool that can be used to balance power, move from an intrapsychic to a sociocultural focus, and model helpful responses (Avis, 1991). However, this tool should be used with caution, forethought, and prudence to ensure it is serving a therapeutic purpose.

Worell and Remer (2003) present two types of self-disclosure; sharing selective self-disclosure, and making self-involving (here-and-now) statements. Selective self-disclosure should be well-timed, brief, and may model possible helpful responses to difficult issues. These personal statements are only helpful if they promote and support the client’s growth.

Considerations in Utilizing Self-Disclosure

- How might this be helpful to the client?
- How might this be unhelpful to the client?
- If I self-disclose, am I demonstrating my superiority or supporting a power-over type of relationship with the client?
- Will my self-disclosure nurture the client’s growth and invite her to solve a problem in a unique way or will it limit how she sees or solves the problem?


When working with depressed women, selective self-disclosure may be an effective way to move from a personal to a social explanation for depression. For example, the counsellor might choose to make general statements about women from a personal standpoint, choosing to use “we” statements to externalize the issue. For example:

“As women, we have been taught that…”
“Many women feel…”
“Most of us have learned…”
“As women, many of us have experienced”

Self-involving statements convey how the counsellor is reacting to the client on an emotional level. This is an effective approach because a client receives feedback about how she is impacting another person, models effective communication (such as the direct expression of emotion), and reduces the power imbalance by allowing the counsellor’s vulnerabilities to be present (Worell & Remer, 2003). Self-involving statements are an important part of working within a relational-cultural approach.
12. A Note about Medication

In a recent report detailing the use of SSRI antidepressant medications in women, Currie (2005) highlighted that:

- Twice as many psychotropic drugs are prescribed for women as for men.
- In the period between August 1, 2002 and July 30, 2003, almost one in five women in British Columbia received a prescription for an SSRI antidepressant.
- In Canada, depression is the fastest rising diagnosis made by office-based physicians.
- Direct-to-consumer advertising has had a significant impact on how people perceive depression and medication.

It would be impossible to discuss depression in women without touching on issues related to the use of medication. Although it is beyond the scope of this handbook to provide information in detail, some starting points will be suggested for clients and counsellors. A number of additional resources are provided at the end of this handbook.

The client’s beliefs and wishes are paramount in determining the role medication will play in treatment. As in other areas of feminist practice, facilitating the client’s role as a consumer, providing information that will facilitate decision-making, empowering the client to make decisions in her best interests, and trusting her ability to make the best decision for herself are central.

Feminist researchers and writers have explored medication use extensively. Presented on the following page are a number of pros and cons to the use a biomedical explanation for depression and antidepressant medication, for counsellor and client consideration.

Counsellors must be knowledgeable about psychopharmacology as it relates to women and depression and be prepared to work with other practitioners, such as family doctors and psychiatrists. Advocacy on behalf of the client may be part of this role.

**Discussing Medication with the Client**

- What are the client’s beliefs and assumptions about antidepressants? Where did these beliefs come from?
- Why does the client feel that medication is important for her?
- What is the client’s past experience with medication?
- Does the client understand how antidepressants work?
- Does the client understand the potential side effects?
- Is the client aware of any special issues related to pregnancy, nursing, or hormone replacement therapy?
- What is the client’s view of the relationship between medication and counselling?
- Is the client aware of the risks of discontinuing medication abruptly?
- Does the client use any herbal remedies that might interact with her medication? Has she discussed this with her doctor?
- What is the client’s plan for how long she will use the medication?

*Adapted from Simonds (2001).*
### The Biomedical Explanation for Depression and Medication Use – Pros and Cons

<table>
<thead>
<tr>
<th>Pros</th>
<th>Cons</th>
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<tbody>
<tr>
<td>• Many women feel a sense of relief when they are diagnosed with depression. Finding a physical cause for their distress can translate to feelings of reduced guilt and shame (Schreiber &amp; Hartick, 2002).</td>
<td>• Acceptance of a biomedical explanation puts the responsibility for change into the realm of a medical practitioner and out of the hands of a woman (Schreiber &amp; Hartick, 2002).</td>
</tr>
<tr>
<td>• Diagnosis can be a validating experience that provides concrete affirmation of a woman’s feeling of distress (Gammell &amp; Stoppard, 1999).</td>
<td>• A biomedical explanation and diagnosis of depression does little to change the perceptions of others in a woman’s life, including significant others, work colleagues, and social contacts, who tend to maintain negative perceptions (Schreiber &amp; Hartick, 2002).</td>
</tr>
<tr>
<td>• The experience of diagnosis and/or the use of medication can be an important catalyst for a woman to make changes in her life and re-evaluate her priorities (Gammel &amp; Stoppard, 1999).</td>
<td>• Use of medication sends the message that there is something wrong with the woman and her problems are located in her body, as opposed to the conditions of her life (Stoppard, 2000).</td>
</tr>
<tr>
<td>• Antidepressants have the potential to reduce distressing symptoms, allowing the client to be more effective in doing counselling work (Simonds, 2001).</td>
<td>• A diagnostic label can reinforce negative cultural meanings and judgments associated with mental illness, reinforcing a stigma (Schreiber &amp; Hartick, 2002).</td>
</tr>
<tr>
<td>• The efficacy of antidepressant medications has been clearly demonstrated (Mazure, Keita &amp; Blehar, 2002).</td>
<td>• Side effects may outweigh medication benefits (Simonds, 2001).</td>
</tr>
<tr>
<td>• Women with severe recurrent depression or a history of suicide attempts may require the stabilizing effects of medication (Simonds, 2001).</td>
<td>• Once women begin medication, they have accepted a biomedical explanation for depression. This explanation tends to usurp all other possible explanations for depression, and shifts attention away from psychological, relational, or situational dynamics. Opportunities for personal empowerment are precluded (See Schreiber &amp; Hartick, 2002; Gammell &amp; Stoppard, 1999).</td>
</tr>
<tr>
<td>• Women who choose to take medication are exercising personal choice and may feel as though they are taking control of their depression (Liburd &amp; Rothblum, 1995).</td>
<td>• People on SSRI antidepressants find it difficult to reduce their dose or eliminate the drug completely due to the “rebound phenomenon” whereby the symptoms that led to drug therapy temporarily become worse when trying to eliminate the drug (Saibil, 2005).</td>
</tr>
</tbody>
</table>
In this section, four central themes are presented that offer mechanisms for healing from depression: (1) deconstructing goodness, (2) emotional awareness and expression, (3) behavioral activation, and (4) building connections. The themes were derived from an extensive literature review that highlighted the contributions of feminist researchers using standpoint theory. Standpoint theorists emphasize that knowledge is based in the unique social and historical positioning of the knowers. In addition, the work of feminist researchers who accentuated the individual voices of women as central to the research process formed the foundation of this handbook. In this sense, the four central themes represent what individual women said helped them heal from depression, and what feminist therapists have found effective.

These themes were then built upon with the addition of relevant therapeutic interventions that are a fit for each theme. It was important that the interventions presented had been critiqued, evaluated, or utilized within a feminist framework. In this sense, the strategies provided here are by no means exhaustive, but instead represent a sampling. They also represent broad theoretical origins with contrasting foundational beliefs. As such, it is not suggested that they are all used, but that counsellors chooses strategies based on their own theoretical beliefs, training, and treatment settings, along with the preferences of their clients.

Each theme is presented briefly with the rationale for its importance to healing from depression. A therapeutic goal is presented, with objectives that may be drawn upon to achieve the goal. This is followed by information about specific interventions. Interventions are presented briefly, with resources and references for follow up by the counsellor. In some cases, tools and strategies from Part I are mentioned insofar as they contribute to the effective use of the intervention. The case example is then used to illustrate how the intervention approach might be applied in practice.

**Introduction to the Case Study**

Brenda is a 36-year-old woman of Latin American descent. Her parents emigrated from Chile before she was born. She is a single mother of a 6-year-old son (Travis). She has been divorced for 2 years from her husband, who she described as “emotionally abusive.” She has lived with her mother since that time, having decided at the time of separation from her husband that this was the best option. Brenda’s mother divorced her father when she was 12.

Brenda recently returned to work as an Administrative Assistant in a real estate office. She has not worked since her son was born. She is hoping to move out of her mother’s home and into her own apartment, but has been discouraged by her change in financial status since divorcing. She can no longer afford the middle-income lifestyle she once enjoyed. Her ex-husband has been sporadic about paying child support.

Brenda reports that she cries constantly, and is plagued by feelings of guilt about her worth as a mother. She rarely sees her friends, a number of whom she has lost since the divorce, and is exhausted much of the time. She has trouble sleeping at night, and often finds herself ruminating about her choices over the past few years. She reports feeling sad most of the time, which she says set in a few months after moving out of the house with her husband. She feels exhausted, and has trouble focusing on her work. She is worried about being unable to meet the demands of her job. Brenda struggles with feeling hopeless about the future.
1. Deconstructing Goodness – Exploring and Questioning Messages Received

The word “goodness” as it is used here describes the cultural standard of behavior that women aspire to in their various social roles as mothers, wives, daughters, employees, and community members. Each of these roles is associated with implicit and explicit standards for thinking, feeling, and behaving.

Feminist researchers have encouraged the input of women who have recovered from depression by inviting them to share their understanding and experiences. This research has suggested that recovery from depression begins when women question the messages they have received throughout their lives. Reflection, inner questioning, and attentiveness to the origins of personal standards of behavior begin an important process of re-defining the self (Jack, 1991; Schreiber, 1998).

Central to this process is developing awareness of messages received and weighing the evidence for these messages, which originate in women’s families of origin, partners, and/or communities. Healing involves discarding messages that reinforce worthlessness and replacing them with personally constructed visions of the self.

The goal of deconstructing ‘goodness’ is to examine social and cultural influences on identity as they relate to personal standards of behavior. This will begin a process of replacing damaging messages with more empowering ones.

Objectives that may be utilized to support this goal include:

- Understanding how a woman defines herself and what standards she has for herself
- Exploring self-talk
- Examining cognitive schemas
- Examining origins of negative self-perceptions
- Weighing evidence for and against self-perceptions
- Reframing the origin of depressive thinking as societally based
- Increasing the client’s “critical consciousness” or the extent to which she identifies the role of social factors in distressing interpersonal situations
- Developing more flexible self-schemas
- Uncovering the “split” between the “good” woman and other parts of the self

Many of these objectives are most amenable to a cognitive behavioral approach. Some objectives may be utilized within a narrative approach. Jack (1991) found that cognitive shifts that allow changes in perception precede changes in depressive symptoms. Once schemas are challenged, behaviors and symptoms can change.
Starting Points for Counsellors in Deconstructing Goodness

- Listen for moral language. For example, how does the client use words like “good”, “bad”, “should”, or “must” to describe themselves and their behavior, thoughts, or feelings?
- Listen for statements that refer to cognitive schemas that relate to control (responsibility, instrumentality, passivity), being lovable, and perfectionism. These are particularly prominent for depressed women.
- Using information gleaned from an analysis of social locations or gender/power analysis, examine each of the woman’s salient roles. What does it mean to be “good” in each of these roles? What roles are more salient or important? Why?
- As rules and imperatives are uncovered, explore their origins with the client. When did she first notice them? How does she know when she is following the rules? What tells her that she is not? What is her reaction? What is the reaction of others?
- As she tells stories, probe for the meanings she attaches to events. How do these meanings tie into her self-regard? What are the beliefs that underlie these meanings?
- Events in the domain of relationships are central in many women’s definition and evaluation of self. What are the woman’s beliefs about herself within the context of relationships? What does she need to do to be “good enough” to be loved?
- Explore the parental relationship. What did the client learn about relationships from her parents? What about her relationship with her mother? What lessons did her mother teach her, either implicitly or explicitly, through modeling?
- Many women struggling with depression also have body image concerns (e.g. weight and self-concept). In what ways do messages about goodness relate to body image for your client? What are the standards she must achieve?
- Many women feel a “split” between the part of themselves that is “good” or outwardly acts like she feels she should, and another part of the self – a “true” self, or a part that is more rebellious, or self-nurturing, or more resilient etc. What inner dialogues do you hear within the client?
- Utilize a life span perspective to discuss the messages associated with the stage of life the woman is at. What life transitions is the woman cognizant of? How has this impacted her self-concept?

Adapted from Jack (1991); Simonds (2001).

For many women, thinking about the messages they have received may be a very new experience, often requiring considerable thought and reflection outside of the counselling hour. In addition to discussion during the session, homework assignments can be used to encourage the client work outside of the session. Homework to stimulate thinking might include:

- Journaling, directed or non-directed with prompts on topics depending on a client’s comfort with journalling
- Reviewing old photo albums and reflecting on familial messages
- Reviewing popular magazines or sitcoms and noticing messages about women
- A thought log to examine self-talk
- Bibliotherapy, or the recommendation of specific books or articles for the stimulation of reflection and further discussion
Deconstructing goodness is enhanced by feminist strategies such as psychoeducation that introduces the idea of gender socialization (i.e. how are females socialized differently than men), and self-disclosure (e.g. making “we” statements). Themes in the work of feminist researchers and therapists about the societal messages women receive show some patterns in beliefs. Women are most likely to report feeling pressure to:

- Prioritize the nurturing and care of others to the extent of being selfless and self-sacrificing (Gilligan, 1982; Jack, 1991; Schreiber, 2001).
- Be cheerful, strong, and productive while avoiding conflict and the expression of anger (Brown, 1986; Schreiber, 2001; Simonds, 2001).
- Be autonomous and independent, not smothering others with emotional neediness and not showing vulnerability lest it be interpreted as weakness or failure (Mauthner, 1999; McMullen, 1999).
- Ensure that a husband is attracted and held and that his emotional and physical needs are met, always prioritizing marital and parental roles over vocational goals (Brown, 1986; Jack, 1991; Scattolon & Stoppard, 1999).

Taking time to share some of this research with clients and inquire as to which messages resonate with them, or which messages might have been different for them, may be a useful way to begin discussions about cultural messages. For clients with diverse cultural backgrounds, exploring cultural messages about gender roles may be particularly illuminating (Brown et al., 2003).

Incorporating Cognitive Behavioral Strategies

Cognitive behavioral strategies are an effective way to examine and challenge women’s self-perceptions and encourage more empowering thinking (Hurst & Genest, 1995). A feminist approach that incorporates cognitive behavioral strategies can be used to develop women’s awareness of how their automatic thoughts and behaviors are shaped and maintained by the gender-driven expectations of others (Worell & Remer, 2003).

Incorporating cognitive behavioral strategies into a sociocultural approach is described below as having three distinct phases, including examining self-schemas, probing and reframing origins, and cognitive restructuring.

Phase 1: Examining Self-Schemas

In this phase, counsellors and clients work together to uncover rigid or self-defeating schemas. This is accomplished by first revealing a client’s automatic, negative cognitions. This can be achieved by eliciting a client’s self-talk during the session (e.g. “Tell me what is going through your mind right now”), or using strategies such as thought logs or sentence completion forms.

In the feminist tradition, and in support of later phases, counsellors may wish to use a modified thought log that also includes space to describe emotions and bodily-felt sensations. Rather than focus solely on negative events, the client can be instructed to notice exceptions, or times when they make self-statements that are positive, nurturing, or empowering. These statements can be built on and enhanced in later cognitive work. This self-monitoring tool might best be described as a “self awareness log” since it also recognizes other aspects of experience. A sample is included on the following page.
Self Awareness Log

<table>
<thead>
<tr>
<th>Date/Time</th>
<th>Situation, Triggers, Antecedents</th>
<th>Emotion</th>
<th>Thoughts</th>
<th>Body</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Describe where you were, who was there, and what was happening</td>
<td>Name the emotion you felt, rate the intensity (/10)</td>
<td>What were you saying to yourself as the event unfolded? Afterwards? Record the content of your self-talk (positive &amp; negative)</td>
<td>(e.g. body sensations, headache, pain, sleep, etc., rate /10)</td>
</tr>
</tbody>
</table>

Sentence completion forms are another strategy to elicit negative cognitions and beliefs about self (Srebnik & Saltzberg, 1994). For example, completing sentences such as “caring for others means…” and “the worst thing I can do in a relationship is…” Counsellors may prefer to develop sentences that are meaningful to their client’s individual situation.

Counsellors may also wish to build on exercises from ready-made self-help manuals, such as questionnaires that examine beliefs. A number of references are included in the Resources section of this handbook.

Women who are from non-dominant groups face more complex challenges in navigating the “good woman” role. Templates of idealized goodness from the dominant culture may conflict with goodness from her minority group or culture (Simonds, 2001). Focusing on multiple identities is an important part of this process.

Messages about femininity are most strongly acted on in the context of relationships with men. Parental modeling, women’s strong desire to create closeness, and cultural imperatives related to the roles of wives all influence women’s behavior (Jack, 1991). Counsellors are encouraged to delve into what goodness means for the client in the context of her intimate relationship.

Examining the beliefs that underlie negative or demeaning beliefs is very important. The origins of some perceptions may not be immediately obvious, but probing for critical events earlier in the client’s life is an important way for the client to normalize and empathize with her own response to difficult circumstances (Simonds, 2001).

**Phase 2: Reframe and Develop a Commitment to Change**

As clients develop an awareness of self-defeating cognitions, counsellors play an important role in helping them make sense of these cognitions. Reframing cognitions and behavior is an important way to reduce blame, depathologize, and lay the foundation for new ways of being.
Together, client and counsellor can consider the societal, cultural and familial context that facilitated the development of disempowering self talk. For example, women can be praised for how well their attitudes and behaviors meet unreasonable societal standards (Srebnik & Saltzberg, 1994).

Instead of labeling thoughts as “irrational”, negative thoughts and beliefs can be labeled “toxic”, disempowering, or thoughts that lower esteem. Negative events and experiences in the client’s life are usually depressing realities, as opposed to “irrational thinking” (Hurst & Genest, 1995). Together, probe for the origins of the thoughts and beliefs. Counsellors may wish to provide psychoeducation about social causes for behavior, gender role socialization, or use self-disclosure (“as women, we are taught that…”) to demonstrate how this thinking might have been “trained” into the woman.

Counsellors are encouraged to explore with the client what impact her thinking is having on her personal wellness, and what the repercussions might be if it continues (e.g., lower self-esteem, lack of confidence). What is the client’s preferred future? This approach is not used to blame the client, but to support her in taking responsibility for the changes she can make, and to recognize the places that she does not have control. If a self-awareness log was used, there may be opportunities to explore strengths or times when more empowering self-talk is present, and to build on these displays of resilience.

**Phase 3: Cognitive Restructuring**

In this phase, the counsellor and client acknowledge that society or family may be rigid, but women need not judge themselves by the same harsh standards (Srebnik & Saltzberg, 1994). Together, new ways of thinking and being are explored. This will involve challenging the client’s beliefs and supporting her to develop empowering, nurturing, or adaptive self-statements.

Challenging can be accomplished through a process of gentle curiosity that questions a client’s thinking or behavior. Who is she trying to please? What would happen if she chose an alternate way of thinking? What different perspectives on a difficult situation can the counsellor offer? Simonds (2001) recommends asking the client if she would judge a loved one by the same rigid standards.

Gently challenging beliefs about relationships and behaviors such as pleasing are an important part of this process. Jack (1991) highlighted that some women are following cultural scripts about how to behave in relationships when, in fact, their partners do not expect this from them at all.

Encourage the use of affirmations e.g. “I am a worthy and important person”, “I am proud of myself and my unique gifts”, “I am a strong, confident, and capable woman”, or statements that are more adaptive, such as “I am doing the best that I can in a tough situation.” Together, the counsellor and client can identify situations that trigger negative thoughts and practice the use of nurturing self-statements in challenging situations.
Cognitive Restructuring Strategies

- Carefully examine central beliefs. Work together with the client to adapt her beliefs to reflect current values and needs.
- Identify situations that trigger negative thoughts. Use in vivo practice or visualization to rehearse nurturing self-statements.
- Work together with a written self-awareness log to develop new, more nurturing self-statements.
- Have the client write a list of affirmations that can be used throughout the day, both proactively and reactively to trigger situations.
- Encourage a client’s “inner dialogue” between the voice of depression and the voice of resilience. How can the voice of resilience be strengthened, or at least given equal power? How can this voice be used to provide counterarguments?
- Offer new perspectives and new ways of thinking to broaden the client’s perspective.
- Encourage the client to reinforce and reward herself for rehearsing new self-statements.

Azocar, Miranda, and Dwyer (1996) advocate the use of a simple sentence completion technique called the “Yes, but…” exercise to encourage the client to develop counterarguments. The client is encouraged to dialogue with herself out loud, countering her own thinking by saying “Yes, but” to explore an alternative perspective.

For clients, challenging long-held beliefs can be confusing, destabilizing, and lead to self-doubt (Simonds, 2001). Counsellors can support women through this process by giving permission to clients to be patient with themselves. Clients can be encouraged to be flexible in their thinking, trying different options without the pressure of needing to commit.

Cautions in using a Cognitive Behavioral Approach

- Avoid diminishing the importance of clients’ relationships. A genuine lack of power, rather than attributional style may be the problem.
- Beware of emphasizing mastery and control of the environment. Examine control the client’s has or doesn’t have over external events and reattribute responsibility appropriately.
- Cognitive behavioral approaches may not be appropriate for all cultural groups.
- Recognize the importance of emotion and intuition. Cognitive approaches should be balanced by attention to feelings.
- Beware of using cognitive behavioral methods to encourage clients to conform to oppressive conditions.
- Cognitive behavioral interventions rely on a linear, logical style of cognitive processing. This may undermine some women’s processing styles, which may be related to intuition, spirituality, or a nonlinear or circular approach.

Using cognitive behavioral strategies with Brenda

The counsellor asks Brenda to keep a self-awareness log between sessions to track her emotions, thoughts, and triggers. She also asks Brenda to notice times when she felt good.

Over the course of the week, Brenda attends a parent-child conference for her son. She reports feeling very anxious prior to the conference, and is worried about the teacher judging her. Some of her thoughts are “I know I don’t spend enough time reading to Travis. If he’s doing poorly, it’s my fault”. She feels guilty about not being able to volunteer for field trips like the other mothers in the classroom. When she arrives at the conference, she notices how outdated her clothing looks compared to some of the other mothers. She feels worthless and is reminded about her financial situation. She thinks, “If I could have held my marriage together, none of this would be happening right now.”

The counsellor asks Brenda what it means to her to be a good mother. Brenda shares her ideas, which include spending “quality time” each day, providing “the best” for her son, showing patience and caring at all times, and ensuring her son has a stable home life. Brenda and her counsellor discuss the traditional role of the Latin-American mother, and the emphasis on selfless caregiving.

Brenda feels she is failing in most of these areas. She feels too tired at the end of the day to spend time with her son or enjoy their relationship. She loses her temper frequently, and finds herself yelling at Travis, after which, she feels guilty and remorseful. Together, the counsellor and Brenda examine how her ideas of “good mothering” were formed. Brenda reflects on her own childhood, and also the cultural messages she received within her family. Together, they consider the conflicting messages Brenda has received in her family of origin compared to dominant North American culture. The counsellor provides normalizing information about the challenges of being a single mother and a single woman in our society. The counsellor asks Brenda why she “should” be able to “do it all”, and what it means if she can’t. Together, Brenda and her counsellor discuss what assumptions many people have about single women and single mothers, and where these ideas might come from.

The counsellor actively challenges Brenda’s assumption that it is her responsibility that her marriage failed. Despite her mother also divorcing, Brenda has been influenced by her cultural community’s belief in sustaining marriage at all costs. The counsellor uses self disclosure statements, such as “As women, we are taught that we are responsible for the emotional health of the relationship”, and also uses this opportunity to discuss cultural differences between herself and her client. Framing depression as a natural response to the emotional abuse of her husband provides some relief. Viewing depression as a signal to Brenda that she needs to devote energy to herself to rebuild herself again encourages Brenda to recognize her resilience.

In her self-awareness log, Brenda shared an incident at work where she was praised by her supervisor for solving a problem with a client. Brenda felt proud of herself for doing a good job. The counsellor explores with Brenda how her self-talk in this situation might be generalized to other situations. The counsellor uses the “Yes, but…” sentence completion exercise to encourage Brenda to develop counterarguments. For example, in response to her self-statement about her marriage, Brenda says “Yes, but the decision I made was important for my emotional health.” Brenda is encouraged to keep working with her self-awareness log, using it to make counterarguments and develop self-affirmations, building on positive incidents.
Incorporating Narrative Strategies

Narrative approaches can be utilized to deconstruct goodness because they help people recognize the fragmented parts of their selves, and also the social scripts that have developed these parts (Lee, 1997). While it is beyond the scope of this handbook to discuss Narrative approaches in detail (counsellors are encouraged to refer to the work of Michael White and/or David Epston) an overview of strategies as they may be applied to a sociocultural focus on depression is offered here.

An important distinction in Narrative approaches that explore the good woman “part” of the client is the concept of multiple identities. Narrative therapists believe that each of us interacts with the world through multiple identities simultaneously, and that there is not one true “authentic self” but many selves, all which play important roles. Counsellors are encouraged to refer to Prouty and Bermudez (1999) for more information about this approach.

**Narrative Strategies to Deconstruct “The Good Woman”**

- Encourage the client to externalize her inner dialogue and recognize the different parts of herself. Ideally, she might be able to give the different parts unique labels that are meaningful to her. These parts can be mapped in a diagram.
- When did the client first notice the influence of the “good woman” part of herself in her life (or, whatever name the client chooses for the different parts)? What were the factors that contributed to her entry? How do we know when she is around? What purpose has she served? How does she undermine other parts? How does she act in relationships? How does this part feel?
- Have the client write a letter to the “good woman” part of herself. What does the client you have to say to her? Encourage the client to consider her history, her purpose, what’s helpful and not helpful about her.
- Listen carefully for stories where empowerment or resilience is present, or stories where “the good woman” was nowhere to be seen. How does the client label this part of herself? How does this part interact with the “good woman” part? What other parts are present?

*Adapted from: Carey & Russell (n.d.); Prouty & Bermudez (1999); and Lee (1997).*

Externalizing the good woman “part” may be useful in helping a woman appreciate the strengths, abilities and purpose this part has served. The goal is not to wipe out this part, but to raise awareness about how the different parts of the self can work better together.
Deconstructing narratives is central to Narrative therapy. As clients reveal the important stories of their lives, counsellors listen carefully and probe for the meanings (i.e. how the client makes sense) of the stories. Counsellors offer new perspectives (by reframing depression) on how these stories are connected to wider discourses that relate to social and cultural contexts. In this way, the story is re-positioned as external to the client, with the client being separate from it. The goal is to see the problem as not being intrinsic to her, but a result of something that has acted upon her (Lee, 1997).

Externalizing conversations can be a useful tool in deconstruction. There is no formulaic way to externalize features of the client’s experience, however, some points for consideration are offered below.

Questions that Encourage Depression to be Externalized

- How long has the depression been an influence in the client’s life? When did it come into her life? What were the factors that contributed to its entry? What are the effects of the depression? When have those effects been the strongest or the weakest? What sustains the depression? What acts as a remedy?
- When has the client resisted the depression? How is the depression itself an act of resistance?
- When is the depression not around? What is different or unique about these times? As the client tells this story of an exception, you might ask “What do you think this story tells me about you?” as this may lead to new, alternate stories.
- What does feeling depressed tell you about the expectations society has for you?, How do you think you were trained or recruited into being this way?, “What reasons can you think of to explain why depression happens more to women than to men?”
- Listen carefully for the metaphors the client uses. These metaphors describe the client’s experience of the problem, but may also present opportunities for new solutions.

Adapted from Lee (1997); Carey & Russell (n.d.); and Prouty & Bermudez (1999)

Externalizing conversations are only the first step in addressing the problem. However, this process can provide rich understandings and promote new perspectives on the problem. The next step is building on exception and reconstructing narratives. New, alternative stories must be richly described (Carey & Russell, n.d.). Other narrative strategies, such as using a reflecting team, may be an effective way to present new alternative and perspectives to the client.
Factors to consider when using a Narrative Approach

- For some clients, talking about themselves as “parts” or using metaphors extensively may seem awkward or unusual.
- This model is not suitable for clients in crisis. It does not attend to concerns such as suicide or sudden trauma.
- This approach should be used with caution with clients who are survivors of sexual abuse or violence. It is important not to shame, blame, or invalidate the survivor in any way.

Source: Prouty & Bermudez (1999)

Using Narrative Strategies with Brenda

The counsellor listens carefully for language that describes the different parts of Brenda’s identity, noticing that she sometimes uses the term “dutiful daughter” to describe herself in her relationship with her mother. Together, the counsellor and client focus on the dutiful daughter, charting her history and influences over Brenda’s life. Brenda noticed that this part of her emerged when her parents divorced when she was 12. Brenda felt it was her responsibility to be a good daughter, and not let her mother down. Brenda took over many household tasks, worked hard at school, and was obedient and respectful, avoiding conflict in an effort to please her mother. Brenda contrasted this part of herself with her “independent self” who she describes as free-spirited, taking charge, and feeling self-confident, that emerged late in her teens. As a Latina woman, Brenda feels pressure to nurture and care for her family, prioritizing the needs of others to maintain the family unit.

The counsellor and client look at the strengths each of these roles have in forming Brenda’s identity, and also their pitfalls. The “dutiful daughter” helped and supported her mother through difficult times, but also put the needs of others before herself. The counsellor introduces the idea of gender socialization and the “good girl” role that most girls are taught. Brenda discussed the strengths she gets from her cultural background and the sense of community she feels and what role her culture plays in her identity. They also discussed how her “independent self” helped Brenda make important decisions in her life that required strength, but this part also has trouble interacting in relationships. The counsellor helps Brenda determine how these parts can be utilized for their strengths in the face of different challenges, and how they can be used to keep depression at bay.

Sometimes, Brenda compares herself to a car that is “running on empty.” The counsellor uses this metaphor to explore how Brenda can “fill herself up again” and what fuel is needed. Depression is compared to a dashboard indicator light. Brenda responds well to this light-hearted metaphor, acknowledging that sometimes she needs to take herself in for regular maintenance, and describes times in her life when she has been broken down at the side of the road and has needed to call a tow truck. The counsellor points out how she still starts on the coldest mornings of the winter, and they use this analogy to highlight her strengths and resilience.
2. Emotional Awareness and Expression

While changes at the cognitive level are important to recovery from depression, emotional awareness and expression are also vital (Schreiber, 1998). Emotional stifling is often required to fulfill goodness. The stifling of authentic feelings can also lead to other negative emotions that contribute to depression, such as self-condemnation, guilt for failing to live up to standards, and feelings of anger and resentment (Jack, 1991).

Most often, women become alienated from their own wants, desires, feelings, and selves in an effort to nurture, please, and look after others, a mechanism reinforced by gender socialization. In a relationship where there is little reciprocity, women begin to feel disconnected, unsupported, and angry. Cultural scripts related to goodness, and a desire to protect the security of the relationship means that these feelings are rarely expressed (Jack, 1991). In addition, women are socialized to have an external locus of control, relying on others to dictate behavior and acceptable emotional expression, which can lead to the overmanagement of emotion (Simonds, 2001).

The more a woman silences herself in meaningful relationships, the greater her sense of loss. A woman is unable to relate fully to people in a way that encourages growth within relationships. This paradox, as identified by Stiver (1997) becomes a vicious cycle that can feed depression. Without a relationship that provides an experience of mutuality and validation of feelings, depression can be experienced as a numb or non-feeling state. In some cases, a lifetime of not listening to her own thoughts and feelings means that a woman becomes very disconnected from herself. Miller and Stiver (1997) believe that the major task of therapy is to help a client move from a non-feeling state to an affective experience where feelings can be recognized and validated.

The goal of emotional awareness and expression is to encourage a woman to connect emotionally with her authentic self, which may have been stifled by her good self. Appreciating the legitimacy and meaning of these feelings within an empathic relationship helps women recover from depression.

Objectives that may be used to support this goal include:

- Exploring the parts of the self
- Recognizing emotion
- Encouraging emotional expression

In this regard, Stiver (1997) emphasized the need for counsellors to be open to experiencing their own emotions, and to allow themselves to be moved authentically and powerfully by the client’s emotion. This belief contrasts traditional notions of the counsellor as objective or neutral. Instead, experiencing the authenticity of a truly mutual relationship provides the foundation for a woman to move forward in other relationships. Miller and Stiver’s book “The Healing Connection” (1997) is an excellent resource for describing the nuances of this kind of relationship (see resource list).
Starting Points for Counsellors in Exploring Emotional Awareness

- Explore the client’s inhibition of anger. If a woman believes she has no right or cause to be angry and her anger means she is weak and unworthy, anger can present a threat to her self-identity as a relational being. Women inhibit their own anger, leading to feelings of frustration, ineffectiveness, and powerlessness, exacerbating the anger further, and confirming feelings of badness and worthlessness.
- How did the client’s mother respond to emotion? How was emotion expressed and responded to in the family of origin? Some women learn to stifle emotional expression due to a non-empathic family context. Being disconnected from feelings is an adaptive strategy in some family environments.
- Explore threats to relationships. How is the client managing her emotion in response to perceived threats in the security of a relationship?
- How are feelings expressed in the intimate relationship? Does the woman believe that compliant behaviors, or adherence to the “good wife” role will secure the relationship? Anger and sadness
- What does her “gut” tell her? Encourage the woman to tap into her intuition and experience it more fully.

Adapted from Hurst & Genest (1995), Stiver (1997)

Strengthening a woman’s connection with herself through the development of trust in her own experience is important in recovery from depression. The counsellor’s ability to create a strong, authentic, and safe relationship with the client is foundational in this process. This can be enhanced by being present with the client in a moment-by-moment way (throughout the expression of painful emotions) and expressing acceptance and empathy for the client (Simonds, 2001).

Increasing Connection with Feelings

- Reflect and summarize the client’s affective experiences
- Ask the client to verbalize feelings related to nonverbal reactions
- Name underlying feelings
- Slow down the experiencing of emotion by encouraging the client to “stay with” the feeling for a bit longer
- Ask the client to focus on bodily sensations that correspond to emotion
- Use creative strategies such as art, poetry, or music to enhance emotional expressiveness.
- Help clients symbolize their feelings using metaphors.
- Support the client in cultivating “self empathy”. Rather than judging and criticizing her own emotion, encourage her to take a gentle and compassionate stance toward herself.
- Introduce the perspective that emotions are resources that provide us with information and offer opportunities.

Adapted from: Greenberg (2002); Simonds (2001); and Stiver (1997)
Incorporating Gestalt and Emotion Focused Strategies

Enns (1987) described how Gestalt and Feminist Therapy share many goals and aims, particularly enhancing personal power and expressing emotion. Living authentically and developing healthy boundaries are other common goals of Gestalt approaches that are relevant within a feminist approach.

Gestalt & Emotion-Focused Strategies

- Encourage the client to take greater responsibility for her feelings by using the pronoun “I” rather than “we”, “it”, and “they” or by “I should” with “I want.”
- Instead of using soft language and qualifiers (e.g, “I guess”, “maybe”), encourage the client to use more assertive language.
- Encourage a bodily sensed awareness of feelings, rather than an intellectual discussion. Direct the client to pay attention to the quality, intensity, and shape of sensations in their bodies. Encourage the client to “speak from the feeling.”
- Introduce the idea that feelings do not have to be acted on, and that painful feelings should not be avoided, but welcomed for the information they give.
- Naming emotion is an important step in developing new meanings. Work together with the client to attach words to their experience.
- Recognize primary versus secondary emotions. Core feelings may differ from initially expressed emotions.
- Work with the client’s nonverbal behavior. Bring it into awareness and highlight it as another source of emotional information.
- Beware of thoughts or self-talk that is interrupting emotional experience (e.g “I can’t handle this”). Work together with the client to reframe the emotional experience.
- Use a 2 chair dialogue to encourage the expression of feeling from different aspects of the self (e.g the good self and the authentic self).
- Use an empty chair technique to allow the client to express feelings to others who are not present.

Adapted from Enns (1987) & Greenberg (2002)

Homework related to emotions can be helpful for people who have trouble accessing emotion because they have very little awareness. Greenberg’s book “Emotion-Focused Therapy: Coaching Clients to Work Through their Feelings” is an excellent resource for practical exercises (see resource list).

It is important to acknowledge that emotional expression by itself is not enough to create therapeutic results. Expression must be used as part of a process to create new meanings, understandings, and action in order to be of benefit (Greenberg, 2002). Greenberg describes this process as the client developing awareness of what their feelings are telling them, awareness of the direction in which their emotions are steering them, reflection on this new awareness, action on reflected-on emotion, and a search for new ways of handling troublesome emotion.
Using Gestalt and Emotion Focused Strategies with Brenda

During one session, Brenda recounted an incident with her ex-husband the previous week where he promised to drop off a support payment cheque and did not follow through. Brenda spent the evening at home, waiting for him to arrive.

Brenda: …so there I sat, all night waiting for him to show up with the cheque.

Counsellor: What feelings come up for you as we talk about this?

Brenda: (sighing) Well, I guess I feel angry because he’s so unreliable…but I also feel guilty because I know he’s having financial trouble, so maybe I shouldn’t be pushing him for it…

Counsellor: Let’s focus on the anger first. Do you feel this anywhere in your body?

Brenda: It feels like a tight ball wound up in my chest.

Counsellor: Describe that ball for me…

Brenda: It’s heavy like a rock. It’s coiled up and hot.

Counsellor: I’d like to put your hand where you feel that tight ball is, and speak right from that feeling…

Brenda: (Placing her fist on her heart) I’m sick of this! Travis is his son too! Why do I have to beg for help? It’s always been this way – I’m tired at the end of the day and I can’t sit around waiting for him! Why do I have to do this by myself?

Counsellor: Let’s imagine he’s sitting in this empty chair here… what do you need to say to him?

Brenda: Why do you do this to me? It’s like you’re trying to punish me! I hate the way you treat me! Like I’m a child! I’m not going to be manipulated by you any more! You didn’t deserve what I gave you – I feel sick thinking about it!

As the counsellor empathizes and encourages the expression of Brenda’s anger, the discussion shifts to what messages her anger has for her. Brenda discusses how she usually doesn’t voice or express her anger, because she feels guilty. Brenda recalls how she often felt angry at her mother for expecting so much of her as a child, but also that she felt guilt because her mother was obviously so devastated by the divorce. She described “swallowing” her anger, something that continued in her marriage.

The counsellor offers the perspective that women often are discouraged from expressing their anger, and this can disconnect them from the important messages that this emotion is trying to give. Brenda notices anger when she feels taken advantage of or “stepped on”. Together, the counsellor and Brenda discuss the healthy and unhealthy components of anger, and how anger can be used to guide her actions in a positive way.
3. Behavioral Activation

While changes in thinking and affect are important in healing from depression, behavioral changes are also an important part of healing. Women who have recovered from depression report that reinvesting in themselves and making changes in their lives is significant to recovery. This action ranges from reevaluating the priorities shaping their everyday lives, asking for what they need from others, deciding not to tolerate abuse, or resisting the need to control everything in their environment (Gammell & Stoppard, 1999; Mauthner, 1999; Schreiber, 1998). An important part of this process is “rediscovering the self”, which includes reviving interests and engaging in pleasurable activities (Azocar, Miranda & Dwyer, 1996).

In this regard, Simonds (2001) highlighted the need to strengthen self-capacities to reduce the likelihood of recurrence of depression. Self capacities include the ability to facilitate positive affect states, which is enhanced by the ability to be alone, the ability to self-soothe, the ability to have an active coping style, and the ability to have a positive sense of self.

The goal of behavioral activation is to support the client to make active changes in her life that will sustain her recovery, resilience, and empowerment. Meaningful changes range from renegotiating household tasks to supporting her financial independence, depending on her personal goals.

Objectives that may be used to support this goal include:

- Development of self care
- Reassessing responsibilities and priorities related to daily living (e.g., housework, childcare)
- Active coping strategies to combat depression (e.g., physical activity, relaxation)
- Problem solving
- Skill-building
- Cultivating a vision of the future
- Accessing community resources to support growth (e.g., joining a group or taking a class)

A counsellor might ask “What things need to be changed in your life so that you won’t be depressed?” Behavioral activation may involve exploring career goals, accessing a financial consultant, or exploring community resources. Simonds (2001) noted that “when women feel financially dependent on others (partners, parents, a terrible job, the welfare system) they can feel trapped, scared, and disempowered, which can inhibit recovery from depression or precipitate relapse” (p. 136). In this section, self-care, solution-focused strategies, and skill building will all be discussed as they relate to recovery from depression through behavioral activation.

Many women are stressed by the so-called “double day”, or double shift of employed work plus the responsibilities of housework or child care. In fact, Bird, (1999) found that the division of household labor has been found to be directly linked to depression and indices of well-being in women. This may be an important area of discussion.
Self – Care

Enhancing self-care is an important part of any feminist approach. Female socialization encourages women to care for others at their own expense, but to view self-nurturing as “selfish.” A morality of self-sacrifice in service of the good woman role means that a woman may be focused on pleasing others, denying her own needs, and giving to others without limits (Gilligan, 1982). As a result, women lose touch with their own desires, identities, and goals. Self care involves recognizing and nurturing the self as a valuable person and gaining awareness of wants and needs (Enns, 2004).

For some women, nurturance induces guilt and reduces self esteem (Srebnik & Saltzberg, 1994), so counsellors should not make assumptions about how a woman will react to the introduction of activities related to self-care. Nevertheless, this does not lessen the importance of exploring feelings related to self-care and how to integrate these activities into a client’s life.

Enns (1992) noted that “training in self care is essential and begins by expressing feelings such as anger and resentment in a safe environment, learning to trust these feelings, anticipating that these reactions are likely to emerge, and realizing the appropriate expression of emotion does not signify loss of control” (p. 11). This can then be supplemented by activities such as identifying likes and wants, separating them from shoulds, and committing oneself to engage in specific activities on one’s own behalf (Stere, 1985).

Enhancing Self Care

- What can your client do that looks after her personal care? Facilitate the development of a list.
- What activities give the client a sense of mastery or control? How can some of these activities be incorporated into her life or increased? Engage in problem solving to determine how these activities can be facilitated.
- What activities have been given up that your client used to enjoy?
- Are there stress management strategies that are effective for the client? Does she need to reengage in positive coping, or learn some new skills?
- What personal supports can this client draw upon to free up valuable time for herself? Consider friends, family, or community resources (e.g. childcare options) that will support this woman.
- How can this client “tune in” to what she needs? Use guided imagery or fantasy exercises to facilitate this process.
- Spiritual activities that connect a person to a power or force larger than themselves can support self-care. How does your client connect with her spirituality?

Adapted from: Simonds (2001)

In her book “The Artist’s Way”, Julie Cameron (1992) offers a number of exercises that promote self-awareness, self-development, and self-care. Ranging from sentence completion to journaling and homework exercises, counsellors may find tools that enhance the self-discovery of their clients (see resource list).
Utilizing Solution-Focused Strategies

While there is still some controversy about whether feminist and solution-focused therapies can be successfully combined (see Dermer, Hemesath, and Russell, 2000), the solution-focused approach has a lot to offer counsellors and clients who are focused on behavioral activation, especially under time-limited conditions. Counsellors who actively work within a sociocultural conceptualization of depression may successfully utilize solution-focused tools to enhance behavioral activation while still recognizing the realities of women’s lives.

Solution-focused strategies recognize that the seeds of solutions to problems exist within people and their stories, and that solutions are most commonly found in the exceptions to problems (de Shazer, 1985). The essential tasks of this approach are listening for what the client wants, negotiating achievable goals, discovering how these were already being achieved in some small way (past or present), keeping track of what is happening that is useful, and doing more of it (Milner & O’Byrne).

Solution-focused strategies are used here, not to minimize the realities of a client’s problems, but to orient them towards possibilities and action. Understanding the “whys” of a problem does not necessarily lead to resolution.

Solution-Focused Strategies

- Use language to influence change (e.g., using presuppositional language).
- Look intensely for exceptions to the problem and deconstruct exceptions to understand how they can be built on. Ask the client “How did you do that?” “What does this story say about you?”
- Using language to foster an internal locus of control so that clients take full credit of change.
- What would the client be doing differently if she was happier? How can some of these activities and behaviors be engaged now?
- Notice and highlight what the client does to stand up to the problem – be it depression, depressing circumstances, or poverty. Take a focused interest in competencies away from the identified problem. Competencies can be highlighted by asking “Did you know this about yourself?”
- Express curiosity to allow the client’s strengths to surface (e.g., “I wonder how you found it in yourself to…”).
- Use the miracle question to uncover what needs to happen in a woman’s life in order for her to heal e.g. “Suppose that while you sleep tonight, a miracle happens and all the problems that brought you here are suddenly gone. When you wake up in the morning, what is the first thing you notice that tells you this has happened?”
- Use scaling questions to check in with clients and make vague goals more concrete. Identify what small, progressive steps can be taken to inch her toward her goals.
- Broaden the questions you ask to gain other perspectives on strengths and competencies e.g., What would your daughter say makes her proud of you?

Adapted from: Milner & O’Byrne (2002).
A solution-focused approach can empower a client to take control of her own counselling. For example, if aims are not being achieved, ask the client what you would be doing if you were being more helpful.

A key component of the solution-focused approach is noticing where the client is successful in her life. The skills, attributes, and competencies she brings to successful areas of her life might be transferable to the areas where she is struggling. Schreiber (1998) found that women who recovered from depression became “more whole” by gradually owning the missing parts of themselves. A solution-focused approach can be used to encourage a woman to take action to honor the parts of themselves that have been absent or depleted. For example, in relation to self-care, a counsellor might ask the client to rate herself on a scale of 1 to 10, then ask what would need to occur to move one point forward on the scale.

**Using Solution-Focused Strategies with Brenda**

In her second counselling session, Brenda is asked the miracle question. She replies that she would wake up in her own apartment, finding that she is now self-sufficient and not needing to depend on either her mother or her ex-husband. Instead of feeling guilty about leaving her mother’s home, she feels confident and positive. She rarely yells at her son, and she looks forward to each day instead of feeling dread. She enjoys time with her friends and feels her life is full. The counsellor probes for what parts of this preferred reality are happening already. Brenda feels that she took a step forward when she separated from her husband. The counsellor expresses curiosity about how Brenda found it within herself to take this difficult step, especially in the face of opposition from some extended family members. This opens up a conversation about Brenda’s strengths. Brenda remembers feeling that she could not raise her son in the kind of environment that was present in her home. Her husband put Brenda and Travis down, frequently berating and insulting them. The counsellor asks Brenda what this story says about her. Brenda responds that she knows when her limits have been reached and if she is backed into a corner, she will do what is needed. The counsellor points out that Brenda actively resisted emotional abuse, taking a stand and protecting the self-esteem of both herself and her son. Brenda comments that she has actively tried to be more supportive of her son since being a single parent. The counsellor expresses curiosity about how these skills can be used to support Brenda’s goals now.

Brenda is asked how she will know that she doesn’t have to come to counselling anymore. Brenda commented that she would not be so isolated and withdrawn. The counsellor encourages her to state this positively, by stating what she would be doing instead. Brenda comments that she would be spending more time socializing with friends, many of whom she has not seen in months. Brenda rates herself a 3 out of 10 in socializing and connecting with friends. The counsellor asks what the smallest step is that Brenda could take when she leaves the office today to move to a 4. Brenda says she might respond to an email from her friend that she hasn’t talked to in months. Brenda is encouraged to take this important small step to move her toward her goals.
Skill-Building

Assertiveness training was one of the first Cognitive Behavioral methods used for working with women (Enns, 2004). When combined with a cognitive approach that helps women recognize self-defeating “shoulds”, development of new communication skills this can be a powerful mechanism for change.

There are a wide variety of self-help resources that clients and counsellors can draw upon to enhance the development of communication and assertiveness skills, a number of which are listed in the Resources section.

It should be acknowledged that the realities of many women’s lives mean that there can be harsh consequences for standing up to others. Traditional assertiveness training relies on the unrealistic assumption that assertiveness will naturally lead to successful interpersonal interactions. Counsellors and clients are encouraged to consider the cost and consequences of changing personal behaviors. Enns (1992) advocated for the reformulation of traditional assertiveness training to encompass a more sociocultural approach. Instead of focusing on the need to for women to take individual control of their lives and their circumstances to be successful, it is focused on building self-confidence and self-esteem. This skill-building is more effective in groups, since it allows women to validate each others’ experiences. However, it can be utilized within individual counselling, providing the counsellor acknowledges the social and cultural forces that can limit choices.

In her work with skill-building, Stere (1985) identified that learning to accept personal feelings as valid and based on one’s responses to something real, developing a capacity to self-nurture, identifying and developing strengths, developing realistic expectations, and resisting perfectionism are key components to assertiveness training.

Communication and Assertiveness Skill Building Strategies

- Provide information and psychoeducation about aggressive, passive, and assertive behavior.
- Use bibliotherapy to enhance counselling work.
- Do in vivo role plays to allow a safe environment for practicing new skills.
- Help the client lower perfectionistic standards when learning new skills, and encourage self-acceptance.
- Help the client define sources of low self esteem
- Introduce a discussion about who the client admires and why. What are the traits that this person has?
- Use guided imagery to visualize feeling and behaving self-confidently

Adapted from: Stere (1985).
4. Building Connections

Connecting with others, especially other women, is a significant factor in healing from depression (Scattolon & Stoppard, 1999). Building meaningful, reciprocal relationships allow women to test out new ways of being in the safety of a trusting relationship, reduces isolation, and encourages new ways of coping (Azocar et al., 1996; Jack, 1991).

Together with your client, explore whether group work is something that would support her growth and development. In addition to personal support and development, group work offers community support for a woman to form new interpretations and evaluations of interpersonal events (Jack, 1998).

The goal of building connections is to support women in developing strong natural support systems where they do not feel the need to be “good” and can experience mutuality and reciprocity.

Socialization for some women has taught them that they cannot be honest with others about what they are feeling, and that they are responsible for maintaining relationship harmony. Simonds (2001) noted that recovery from depression involves reinforcing relationships that support the client’s authentic sense of self, restoring significant relationships that have become inauthentic, and resolving relationships that ultimately will never be healthy for the client. Given the centrality of relationship for women, counselling must help women maximize healthy connections.

Strategies to Build on Healthy Relationships

- Use an ecomap to identify current relationships, and how positive/negative, healthy/unhealthy they are. An ecomap is a visual representation of the client’s network of relationships, and the nature of the connections.
- Help the client define the markers of a healthy friendship.
- Identify relational strengths, and what your client brings to relationships.
- Support the client to identify what she needs in a relationship.
- Clarify what incidents signify boundaries have been crossed.
- Discuss the potential effects of behaving differently in relationships, including negative consequences or the efforts others might make to restore a relationship back to its prior state.
PART IV. PROJECT SUMMARY

Project Utility

The handbook created here has the greatest utility for female practitioners working with female clients in settings amenable to feminist practice, such as community based counselling centres. Although intended for use in one-on-one practice settings, many of the concepts are transferable to group scenarios. In fact, it might be argued that some suggested interventions, such as identifying messages received about being a good woman, would be even more powerful in a group setting. Although intended for an adult population, some concepts in the handbook might be a springboard for work with adolescent females.

The handbook also has utility for practitioners who might be working from theoretical positions that are not necessarily feminist, but are open to exploring feminist concepts. For example, counsellors who identify with solution-focused or cognitive-behavioral theories may find that feminist concepts enhance or contribute to their practice. The toolbox approach offered in this handbook may encourage practitioners to integrate certain concepts, strategies, or approaches that might be helpful with their clients. For other practitioners, the ideas offered here may challenge their current practices, or encourage reflective thinking about the beliefs they have about depression.

While intended for female practitioners and female clients, the handbook has something to offer male practitioners. Male counsellors who wish to incorporate feminist ideas or women-centered concepts into their work with depressed women may find useful tools and strategies. Moreover, some would argue that many of the sociocultural forces that act on women to impact depression are also present for men. More recently, feminist practice has begun to explore issues of power, violence, and gender role socialization in men’s lives (Evans et al., 2005). Perhaps this handbook might be a catalyst for a similar project aimed at depression in men.

Strengths

One of the key strengths of this project is that it takes an alternative perspective on a very significant mental health problem. Even though women more frequently experience depression, very few treatment approaches are founded in a woman-centered orientation. In terms of the handbook, it is both content and process oriented. In other words, it gives counsellors specific information about how to create an environment that builds on feminist principles and empowers women, laying the foundation for the process of practice. Then, practical information is offered about a wide variety of content-oriented strategies, which ultimately enhance the project’s utility. An additional strength is that this project draws on a number of theoretical traditions, ranging from Gestalt and cognitive-behavioral, to solution-focused and narrative. Counsellors who work from various theoretical orientations will find concepts and ideas that can be applied to their practice.
Limitations

One potential limitation of this project relates to the theoretical contradictions inherent in drawing on different theories. Although there is no specific emphasis or recommendation of eclectic practice, the variety of strategies given may imply to some that technical eclecticism is being encouraged. Some would argue that drawing on different practices can have the effect of watering down the theory from which the practice was drawn and ultimately leading to a disorganized and ineffective treatment approach (Lampropoulos, 2000). However, I would argue that the approach espoused by this handbook is more akin to assimilative integration, as described by Lampropoulos (2001). Briefly described, assimilative integration calls for the integration of techniques from different theoretical orientations while retaining the counsellor’s original theoretical principles (in this case, feminist theory). Lampropoulos highlighted that when techniques are carefully assimilated within one’s favored theory and mode of therapy, maximum flexibility and effectiveness occur.

Another limitation of this project is the lack of attention to comorbid disorders that may be found concurrently with depression. For example, symptoms of anxiety are often found along with depression, and no specific recommendations were given as to how practitioners should address this (McKee & Dingee, 2003). Although I felt that it was beyond the scope of this project to discuss comorbid disorders at any length, counsellors are likely to encounter clients who experience a variety of anxiety-based symptoms in addition to depression. In addition, the handbook does not specifically discuss the special treatment needs of women with higher risk factors, such as ethnic minority women, lesbians, women who are physically abused, women living in poverty, women with eating disorders, or women who struggle with substance abuse (McGrath et al., 1990). It must be recognized that women from these populations may have special treatment needs that were beyond the scope of this final project to discuss in detail.

Summary

In this project, my goal was to offer effective treatment strategies for depressed women that are rooted in sociocultural theory, with a focus on the cultural messages women receive. This goal was accomplished by examining and presenting the evidence for sociocultural causes of depression in an extensive literature review. The information gathered in the literature review was utilized to develop a handbook for practitioners, offering practical information in a straightforward format to promote the translation of feminist sociocultural theory into counselling practice. Offering both process-oriented information about feminist approaches, and content-oriented information with suggestions for specific interventions, the goal of creating a handbook with a high degree of utility was achieved. The use of a case study illustrated how these ideas might be put into practice, and a resource list presented references for more in-depth learning. It is anticipated that this handbook will be a useful reference in the toolbox of counsellors who work with depressed women.
Epilogue

I have been grateful for the opportunity to challenge myself by completing this final project. In addition to increasing my professional knowledge, the personal reflection that I have done throughout the duration of this project has contributed to my identity as a feminist, a counsellor, and a woman. It has allowed me the opportunity to explore my personal values and beliefs, and to further develop my theoretical orientation as a counsellor. With this in mind, I feel I have much to offer women who seek my services as a counsellor, and look forward to what the future holds.
PART V. RESOURCE GUIDE

A number of resources are offered here for further exploration by counsellors. Some potential client resources are offered. It is recommended that counsellors review and explore client resources first, to ensure it is an appropriate recommendation. Brief notes are offered below to describe the nature of the resource. Websites are from highly reputable sources and are current as of June 1, 2006. In the case where web links to handbooks are provided, permission has been granted for duplication of the materials.

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<td>A copy of the Silencing the Self Scale (STSS): <a href="http://www.ac.wwu.edu/~djack/STSS_Scale.pdf">http://www.ac.wwu.edu/~djack/STSS_Scale.pdf</a></td>
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<td>Scoring instruction and detailed information about the STSS.</td>
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<td><strong>Section: Demystification</strong></td>
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<td><a href="http://www.whatsrightwithyou.com/findingatherapist.htm">http://www.whatsrightwithyou.com/findingatherapist.htm</a></td>
<td>Dr. Barry Duncan</td>
<td>Recommended resources for clients include the articles titled “Finding a Therapist” and “7 Tips for Therapy” which promote the client as a consumer of a service.</td>
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<td>Resource</td>
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<td><a href="http://www.talkingcure.com">www.talkingcure.com</a></td>
<td>Dr. Barry Duncan &amp; Dr. Scott Miller</td>
<td>Provides information about the theory and research behind the Outcome &amp; Session Rating scales, information about how to purchase the manual, many resources for counsellors and clients, founded in solution-focused practice.</td>
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<td>Self-Care Depression Program: Antidepressant Skills Workbook, 2nd Edition: <a href="http://www.mheccu.ubc.ca/documents/publications/SCDP%5FAdult%5F2005.pdf">http://www.mheccu.ubc.ca/documents/publications/SCDP%5FAdult%5F2005.pdf</a></td>
<td>Mental Health Evaluation and Community Consultation Unit of the University of British Columbia</td>
<td>Simple, jargon-free information and activity sheets related to goal setting and self-help with a cognitive-behavioral focus. Note that the focus is very intra-psychic, however, the activities could be adapted to fit within a sociocultural approach.</td>
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<tr>
<td><strong>Section: Strengths &amp; Competencies</strong></td>
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<td><a href="http://www.authentichappiness.sas.upenn.edu/">http://www.authentichappiness.sas.upenn.edu/</a></td>
<td>Dr. Martin Seligman</td>
<td>A website dedicated to Seligman’s Positive Psychology. Recommended by Enns (2004) as complementing feminist focus on strengths and competencies. Offers a number of brief tests aimed at clarifying key strengths, including the VIA Signature Strengths Questionnaire, and a number of more specific scales aimed at measuring specific strengths, such as “grit” (focusing on perseverance), “gratitude” (measures appreciation), “transgression motivation” (focuses on forgiveness), optimism, and meaningfulness in life.</td>
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<td><strong>Section: Medication</strong></td>
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<td><strong>Women and Health Protection:</strong> <a href="http://www.whp-apsf.ca">http://www.whp-apsf.ca</a></td>
<td></td>
<td>A Canadian website founded by a coalition of community groups, researchers, journalists, and activists concerned about the safety of pharmaceutical drugs. This website has a strong sociocultural, feminist focus with publications for both counsellors and clients. Recent recommended articles include:</td>
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<td>Canadian Women’s Health Network: <a href="http://www.cwhn.ca">http://www.cwhn.ca</a></td>
<td>A national voluntary organization dedicated to improving the health of girls and women in Canada.</td>
<td>A substantial source of woman-centered health information with a focus on issues related to diverse women. Research information for practitioners, and access to publications that may be appropriate for clients, including: Anderson, D., &amp; Currie, J. (2005). <em>What People Need to Know about Psychiatric Drugs such as Sleeping Pills, Antidepressants, Tranquilizers, Anti-Psychotics</em>. Psychiatric Awareness Group: Duncan, BC.</td>
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**Section: Deconstructing Goodness**

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<td>Website of the Dulwich Centre: <a href="http://www.dulwichcentre.com">www.dulwichcentre.com</a></td>
<td>The website for key figures in narrative therapy.</td>
<td>A comprehensive resource on Narrative Therapy for practitioners.</td>
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**Section: Emotional Awareness and Expression**

A detailed account of the truly mutual therapeutic relationship.

A practical guide for practitioners, including wide range of homework assignments to support clients in developing greater awareness of emotions, and using this awareness to guide them.

**Section: Behavioral Activation – Self-Care**

Exercises that promote self-awareness, self-development, and self-care. Ranging from sentence completion to journaling and homework assignments, counsellors will find tools that enhance the self-discovery of their clients.
References


