EQUALITY IS NOT GOOD ENOUGH: SHIFTING BOUNDARIES IN WOMEN'S HEALTH CARE [1]

Feminist health care

In general, feminist health care is characterized by a gender-sensitive, politicizing, client-oriented and sometimes holistic approach. This explains why sex or gender, and oppression and domination are prominent concepts (1).
The developments in feminist therapy are of interest in two respects. Firstly, as an example of the struggle to stay in touch with a changing environment. If the feminist health care movement is to continue in existence beyond the year 2000, it must work on self-renewal (2). Secondly, the feminist health care movement is of interest as a pilot project in negotiating equality and differences in Europe. Its lessons apply not only to gender, but also to other types of oppression that will be all too plentiful in our European future.

Equality and feminist therapy.

For almost a decade equality was a central concern of feminist therapy, and that concern gave rise to many narratives.
One narrative concentrated on the equality of treatment within therapy. It assured that the same respect and attention would be paid to women as was already paid to men participating in a traditional therapy. It sought to end the traditional tendency to pathologize or trivialize women's problems.
In addition, there is a narrative about an egalitarian therapeutic relationship. It speaks about a relationship `structured to move toward an equality of power, in which artificial and unnecessary barriers to equality of power are removed. In this relationship, there is an equality of value and of respect for each person's value. At the same time some necessary asymmetry is maintained in certain aspects of the exchange. This is partly designed to empower the less powerful person but primarily required to define and delineate the responsibilities of the more powerful'(3).
Another narrative focuses on equivalence in treatment as a means of guaranteeing a therapeutic path towards social and political equality for women. The standards for healthy functioning should be similar for both sexes and feminist therapy should provide for the missing elements (skills, self-reliance, political action etcetera). In this way, women should be enabled to attain the autonomy and independence men already possess.

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[1] Beyond the Modernism/Postmodernism Debate: Sexual Difference, Gender Identities and Equality Principles. Gunning, dr. M.J., and drs. T. van den Ende (eds) III, 78

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The most radical narrative speaks about feminist therapy as the motor of a social revolution, and about sex equivalence in a fundamentally otherwise organized society.
Thus, the concern with equality served to analyze the origin of clients' problems. Moreover, it standardized the therapeutic relationship that should be stripped from unnecessary power differences. It depicted as its ideal outcome the woman who was capable of living a man's life. In short, it constructed the therapy process as a school in which women could become equal.

These narratives were not unproblematic and several developments have exposed their limitations.
In the first place, feminist therapy has had to admit that its relevance for specific groups of women was limited. The original focus had been on white, middle class, heterosexual women from the contemporary west; typically they were seen as professionally occupied, to be pitied for their housekeeping and mothering duties, and as needing to be rescued from violence. But, what insights and training could this perspective offer to lesbian women, women of colour, or from ethnic minorities, with chronic illness or being childless? Feminist therapy merely obscured these categories of women, and their experiences. Attempts to remedy these failures through concepts like `double or even triple oppression' were not very satisfactory.
In the second place, the limited utility of current feminist health care was exposed with its integration into the regular health care system. Thus, questions were raised about the appropriateness of the principles of feminist therapy for the less-abled clients in health care: the adolescent, elderly or handicapped women, female addicts and psychiatric patients who do not see their problems as woman-specific.
Subsequently, and in the third place, several principles of feminist therapy have given rise to debate. One line of criticism contests the desirability of cultural and social gender equality: what is its use if it does not challenge the valorization of autonomy and the division of labour in the family and marketplace? Would it not be better to promote connection and in this way proclaim women's moral equality or even superiority? That claim - it was argued - would better serve the interests of working class women, of less westernised groups and of care dependent people. Another debate focuses on the victimization of female clients: by placing the emphasis on violence against women are we not encouraging an image of women as powerless instead of furthering gender equality? (This suspicion was fuelled by evidence that regular health care institutions would willingly assist incest victims but were reluctant to make provision for autonomy groups).
Furthermore, the validity of assumptions about psychological similarities between the sexes has been doubted. The differences in women's cognitive, emotional and moral development (4) might be essential instead of temporarily and contextually determined. The egalitarian view of the therapeutic relationship has been challenged as naive in its presumption that clients would not be inclined to employ strategic behaviour in order to take advantage of the therapists' power, for example to procure resources. And of course, the differences in oppression required a solution.
Little-by-little, these disputes exposed the limitations of the original narratives on equality, autonomy and anti-domination. Equality was not good enough. But what was the alternative? At this point postmodern women's studies appeared to be helpful.

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The equality-difference trap

One of the first to deconstruct the opposition of equality and difference, was Joan Scott (4). She was followed by others. So, the relationships with additional dichotomies such as domination-oppression were revealed. Tronto, for example, argues that inequality gives rise to unequal relationships of authority, and to domination and subordination (5), but also that oppression can arise out of the denial of equality.

equality	difference
similarity	dissimilarity,
resemblance	contrast,
equivalence	unequivalence,
symmetry	a-symmetry,
non-distinguished	distinction
commonality	inequality
sameness	otherness
uniformitydiversity	

Obviously, the terms themselves are not unequivocal. Moreover, as Scott has argued, the opposition between equality and difference is in itself improper. It structures an impossible choice, as the notion of equality includes, even depends upon, the existence of differences. As she puts it (p. 142): `Equality is the deliberate indifference to specified differences'. Consequently, equality must always lead to a query about the qualities or aspects that are being compared, and the answers will vary with the particular context and purposes that are involved.
In addition, questions of equality have been differentiated into separate realms as they touch upon politics, morality, law, the body and the mind. Within the related disciplines feminist scholars have engaged in a number of profitable and interesting debates on gender equality. Again and again, the conclusion of Scott seems to be reinforced (p.142): As feminists we can neither give up `difference' as it is one of our most creative analytic tools, nor can we give up equality as long as we want to speak to the principles and values of our political system.

Equality debates

In political science, Joan Tronto (p.15) confirms and develops Scott's conclusion when she writes: `In trying to make a persuasive case, the powerless have only two options available to them to try to change the distribution of power. The two options are: to claim that they should be admitted to the center of power because they are the same as those already there, or because they are different from those already there, but have something valuable to offer to those already there.'

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In her opinion there is no logical way to escape from the many dimensions of the difference dilemma unless the logic of the outsiders' situation is rejected. By this, she refers to three boundaries that shape current western morality: the boundaries between morality and politics; the boundary established by the `moral point of view' which requires detached judgment by disengaged moral actors, and the boundary between public and private life. Together, they have effectively excluded women's experience from and prevented women participating in the spheres of morality and politics. That is also why the idea of care has remained undervalued in moral deliberations.
After rejection of this outsiders' logic Tronto reveals how the notion of care functions ideologically to maintain the privileges of those in power. Subsequently, she demonstrates how care as a political concept helps to prescribe an ideal for a more democratic, radical and pluralistic politics (6), and how it helps us to rethink humans as interdependent beings - with a variety of needs (7) that should be cared for.
Tronto's line of thought has been further elaborated by Sevenhuijsen (8) who argues for an ethic of care (although she maintains the opposition between care and justice that Tronto declares to be false). This ethic includes an open process of interpretation (9) of and moral deliberation on people's needs: their origins, the questions why and how they should be met (especially if needs compete), the allocation of collective resources, and - inevitably - the meaning of equality and inequality.

In psychololology, the debate about gender equality and differences has been articulated as the difference between beta and alpha bias (10). The beta bias denotes the inclination to ignore or minimize differences; in case of gender it results in women who are thought to be almost equal to men. The alpha bias is the exaggeration of differences; as a result, women are seen as totally different from men.
Both biases have their advantages and disadvantages. However, neither escapes from taking the male as the standard of comparison. But how to go beyond? At this point, mainstream psychology is not of very much help.

It seems that the `becoming subject' is the best we can have. It is a mixture of philosophy, developmental psychology and psycho-analytic insights. In short, the `becoming subject' focuses on a stream of identities that is produced within an inherently dynamic context of cultural, social, psychological, biological, sexual, and genetical developments. It assumes a flexibility of outcomes, stresses the interaction with the political and historical context, and highlights the identification of an emerging `I' with the collective memory of a `we'. In fact, `the subject' is a self-construction in retrospect, and is always in transition. (11)
For the original feminist therapy narrative, this conception of the subject leads to a greater diversity in the identities of women. It includes the probability that not all women give priority to the gender side of their identity, or that its ranking may vary during one's life.
The `we' a becoming subject may identify with, can be an oppressed group as well as a privileged

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group. Sometimes, it will alternate. Recurrently, the group itself will have both characteristics: being oppressed as well as in some way privileged.

Please, note that this is also a rather new way of conceptualizing oppression. The dichotomy `oppression versus domination' is no longer taken for granted. `Being privileged' offers a more dynamic and less absolute opposite for oppression. It makes it possible to understand the contradictions in and meanings of a combined privileged and oppressed group status (biracial, bisexual or bicultural people, for instance, but also successful feminists) and how these contribute to physical and mental malaise. Similarly, it may be understood how persons having a dominant group status possibly feel oppressed by their own internalized domination of silenced `otherness'. Think, for example of men suppressing the feminine in themselves, or feminist therapists who cannot accept the ageing, vulnerable and dependent woman in themselves (3,12). Even more differentiation is provided by differentiating oppression into a family of concepts and conditions. Iris Young (13), for instance, has distinguished five `faces' of oppression that may reinforce each other: imperialism in the cultural realm (negation or trivialization alongside stereotyping of differences), exploitation and marginalization in the socio-economic realm, disempowerment by professionals and owners of information (one could say epistemological violence), and systemic violence (that allows for physical and mental brutalities). These categories may be very productive for the understanding of the commonalities and differences between western women and men, and between clients and therapists. It would enable the comprehension of genderbased oppression or privileging as it is interwoven with otherlocated types of oppression. As such, it will sustain the possible openness of feminist therapy to a diversity of people who could benefit from its antidomination attitude and empowering capacities.(14)

Self-renewal of feminist therapy

In my opinion, feminist theorists provided a series of concepts that can support the self-renewal of feminist therapy. Together, these define a new and enlarged linguistic space for feminist therapy.
The language of `commonalities and differences' allows us to make analyses of at least three types of gender difference: not only the commonalities and differences between men and women, but also among women (and men), and within women (and men) personally.
Within this space equality could better be replaced by diversity. Diversity means the appreciation of differences. It proclaims respect for what is different, and abstains from suppression or trivialization of `otherness'. As such, it prevents dissimilarities being overlooked, but also avoids their disfunctional celebration.
Thus, the original space of feminist therapy is opened up. Firstly, for perceiving all sorts of commonalities and differences in cultural images, types of behaviour, feelings and cognitions that may be relevant for understanding internalized cultural, social and physical oppression or privileging. Secondly, for seeking the combinations that are therapeutically relevant in the sense that

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they offer an outlook on healing.

Notes

(1) In the Netherlands an extensive "women's health care movement" exists, encompassing physical as well as mental health care. Feminist therapy is considered to be a part of the last; it is thought to be confined to the psychotherapeutic help frequently offered in an individual setting. However, as the six components by which Laura S. Brown identifies feminist therapy, anno 1994, are valid for the whole Dutch women's health care movement, I will use the term feminist therapy as a synonym for women's or feminist mental health care.
Brown's components are (p.23): 1. an understanding of the relationship of feminist political philosophies to therapeutic notions of change; 2. an analysis and critique of the patriarchal notions of gender, power, and authority in mainstream approaches to psychotherapy; 3. a feminist vision of the nature and meaning of psychotherapy as a phenomenon in the larger social context; 4. concepts of normal growth and development, distress, diagnosis, boundaries and relationships in therapy that are grounded in feminist political analysis and feminist scholarship; 5. an ethics of practice tied to feminist politics of social change and interpersocal relatedness; 6. a multicultural and conceptually diverse base of scholarship and knowledge informing this theorizing.

(2) Mens-Verhulst, J. van & Schilder, L. eds. 1994. Debatten in de vrouwenhulpverlening. Amsterdam: Babylon/de Geus.

(3) Brown, L.S. 1994. Subversive Dialogues. Theory in Feminist Therapy. New York: Basic Books, p. 104. Chodorow, N. 1978. The reproduction of mothering: Psychoanalysis and the sociology of gender. Berkeley: University of California Press. Gilligan, C. 1982. In a different voice. Psychological theory and Woman's Development. Cambridge, Mass.: Harvard University Press. Jordan, J. 1993. 'The relational self. A model of women's development', in J. van Mens-Verhulst, K. Schreurs and L. Woertman eds. Daughtering and Mothering: Female Subjectivity Reanalysed. London/New York: Routledge. Miller, J.B. 1978 Toward a new psychology of women. Harmondsworth: Penguin. Surrey, J. 1984. 'Self in Relation: a Theory of Women's Development', Work in Progress 13. Wellesley, MA: Stone Center for Developmental Services and Studies.

(4) Scott, J.W. 1990. Deconstructing Equality-Versus-Difference: Or, the Uses of Poststructuralist theory for Feminism. Hirsch, M. & E. Fox Keller eds. Conflicts in Feminism. London: Routledge: 134-148.

(5) Tronto, J.C. 1993. Moral Boundaries. A Political Argument for an Ethic of Care. Kondon: Routledge, p.80 and p.135.

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(6) This pluralism is labelled radical because it does not recognize the public-private boundary. And it is labelled democratic because it gives access to all parties involved, care-receivers and care-givers included.

(7) Tronto points to the cultural determination of needs and rejects the possibility of postulating universal needs. She contrasts `needs' with `interest' and `project', and writes: `to use "needs" is necessarily intersubjective, cultural rather than individual, and almost surely disputed within the culture. [..] How one arrives at a need is a matter of social concern, how one arrives at an interest is not.'(p.164)

(8) Sevenhuijsen, S. 1996. Oordelen met zorg. Amsterdam: Boom.

(9) Sevenhuijsen has added the adjective `communicative' to Frasers `politics of needs interpretation'. Fraser, N. 1989.Unruly Practices. Power, Discourse, and Gender in Contemporary Social Theory. Minneapolis: university of Minneapolis.

(10) Hare-Mustin, R.T. & Marecek. J. 1990. Making a Difference. Psychology and the Construction of Gender. New Haven & London: Yale University Press.

(11) Braidotti, R. 1989. The politics of ontological difference. Brennan, T. (ed) Betweeb Feminism & Psychoanalysis. London: Routledge. pp 89-105. Flax, J. 1991.Thinking Fragments. Psychoanalysis, Feminism, and Postmodernism in the Contemporary West. Berkeley: University of California Press. Mens-Verhulst, J. van 1992. De autonomie voorbij: over conceptuele, praktische en morele verschuivingen in de vrouwenhulpverlening. Sociale Interventie 1/4:188-196. Mens-Verhulst, J. van, Schreurs, K. and Woertman, L. 1993. Daughtering and Mothering: Female Subjectivity Reanalysed. London/New York: Routledge. Nicolai, N.J. 1992. Vrouwenhulpverlening en psychiatrie. Amsterdam: SUA.

(12) Brown, L. & Root, M.P.P. eds. 1990. Diversity and complexity in feminist therapy. New York: Haworth. Pheterson, G. 1986. Alliances between women: Overcoming internalized oppression and internalized domination. Signs: Journal of Women in Culture and Society 12: 146-160.

(13) Young, I.M. 1990. Justice and the Politics of Difference. Princeton N.J.: Princeton University Press.

(14) Mens-Verhulst, J. van 1996. Vrouwenhulpverlening: Diversiteit als bron van zorg. Utrecht: University for Humanist Studies. Inaugural Speech.

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