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dissertation entitled

CLIENT SEX AND DEGREE OF DEPENDENCY:
RELATION TO PSYCHOTHERAPISTS'
JUDGEMENTS OF CLIENT MALADJUSTMENT

presented by

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has been accepted towards fulfillment
of the requirements for

Ph.D. degree in Counseling Psychology

Major professor

Date 2/25/87

CLIENT SEX AND DEGREE OF DEPENDENCY: RELATION TO PSYCHOTHERAPISTS' JUDGEMENTS OF CLIENT MALADJUSTMENT

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A DISSERTATION

Submitted to
Michigan State University
in partial fulfillment of the requirements
for the degree of

DOCTOR OF PHILOSOPHY

School of Health Education, Counseling
Psychology and Human Performance

1987

ABSTRACT

CLIENT SEX AND DEGREE OF DEPENDENCY: RELATION TO PSYCHOTHERAPISTS' JUDGEMENTS OF CLIENT MALADJUSTMENT

By

Randall Lee Wolthuis

The purpose of the current study was to investigate the effect of client sex and client behavior (dependent vs. independent) in therapy on the assessments of psychotherapists. Since dependent behavior is more congruent with the traditional female stereotype and independent behavior with the traditional male stereotype, it was expected that clients whose behavior deviated from the expected stereotype would be more harshly judged than their opposite-sex counterparts.

Two-hundred-thirty-one psychologists and clinical social workers (59% rate of return) responded to a written vignette in which a client was described. The client was described as either male or female. The client's behavior in therapy was presented as either dependent or independent. Subjects were asked to respond to a 20-item questionnaire created by the experimenter. Items required subjects to make assessments of clients' vulnerability to various symptoms of

maladjustment. The questionnaire also asked subjects to provide demographic data on themselves.

Results indicated that, as expected, psychotherapists did view the dependent male as more vulnerable to maladjustment than the dependent female. The independent female, however, was not rated as more vulnerable to maladjustment than the independent male. Psychotherapists rated the dependent male and independent male as significantly different from each other in terms of vulnerability to maladjustment but not the dependent female and independent female. In addition, more experienced and older psychotherapists gave higher maladjustment vulnerability scores than did lesser experienced and younger psychotherapists.

Results imply that some sex role stereotyping may continue to exist among psychotherapists. The dimension of client dependence/independence may be a more salient factor in psychotherapists' assessments when evaluating a male as opposed to a female. Reasons for the finding of no difference between psychotherapists' scores for the independent female and independent male are discussed both in terms of the design of the study and cultural factors. It may be that societal changes in recent years have diluted the bias against independence for females. It may also be that the severity of the stereotype violation is a factor in psychotherapists' assessments of clients. Further research is necessary to clarify these issues.

ACKNOWLEDGEMENTS

There are several people who deserve special acknowledgement for their help and support. I thank my committee members, Drs. Rochelle Habeck, Linda Forrest and John Powell for their assistance and encouragement. I am grateful to Dr. Lawrence Baer and Dr. Harry Piersma for their valuable assistance with the statistical analyses. I especially wish to acknowledge Dr. Richard Johnson, my chairperson. Dick was always available to hear my questions, to process my concerns, and to be my advocate. For this, I am very grateful.

I am thankful to my parents, Ralph and Marilyn Wolthuis, whose nurturance and encouragement were a catalyst for learning in my early years. I also wish to acknowledge Dr. William Van Eerden, a colleague, friend, and therapist. Bill helped me get through a difficult time during the past year. He made me feel welcomed and accepted. With his help, I found renewed energy.

I would like to also express appreciation to my children, Ryan and Kimberly, who always seemed to understand when their father was "too busy." Watching them mature and enjoying their growth prevented me from becoming too

TO LINDA

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consumed with myself and my task. They provided me with joy and happiness which eased my burden considerably.

A special acknowledgement is due my wife, Linda. This is where words do not do justice to the feelings felt. Linda's quiet strength and stability, her ready willingness to sacrifice, her love and companionship, and her optimistic approach to life are all valued and cherished beyond words. I am happy and priviledged to be her life's companion.

Finally, I wish to humbly thank my Creator, the One who has seen fit to provide me with the personal strength and stamina I have needed, but also the supportive people so important and valued during the past year. His faithfulness to me during my life becomes clearer and clearer to me as life goes on.

"Saving, helping, keeping, loving,
He is with me to the end."

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CHAPTER I

INTRODUCTION

During the 1970's there occurred an explosion of research which investigated the effects of a person's sex on the opinions, judgements and assessments of psychotherapists. This research was precipitated in no small part by the now classic study by Broverman, Broverman, Clarkston, Rosenkrantz and Vogel (1970) which revealed what has since been described as a "double standard of mental health." That is, males and females were described by psychotherapists as healthy when their behavior complied with commonly held sex role stereotypes. Furthermore, males were viewed as more healthy than females since psychotherapists' concept of health for a sex-unspecified adult did not differ significantly from the concept of health for a man but did differ significantly from the concept of health for a woman. At about the same time authors such as Chesler (1972) charged that therapists define mental health in terms of sex role stereotypes. Furthermore, Chesler asserted that therapists impose their stereotypes on their clients in the name of good therapy,

thereby not promoting mental health but inhibiting it. These charges, along with the Broverman et al. (1970) findings ignited a flurry of research which investigated the effect of a client's sex on psychotherapists. This research was fueled further by the Womens Movement which was gaining momentum during the 1970's.

Despite activism and legislation designed to diminish sex discrimination and increase public awareness about commonly held beliefs about men and women, recent studies have found remarkable stability in the sex role stereotypes of the general public (Ruble, 1983; Werner & LaRussa, 1985). For example, respondents of both sexes continued to view men as more forceful and independent than women. Since psychotherapists are human beings, they are products of their culture and are prone to be influenced in both overt and subtle ways by that culture. Several studies have revealed that psychotherapists also have stereotypic beliefs about men and women and invoke them when making mental health judgements (Maslin & Davis, 1975; Swenson & Ragucci, 1984). Furthermore, there is evidence that persons behaving in a manner not congruent with traditional sex role stereotypes are assessed as more maladjusted than persons whose behavior complies with traditional sex role stereotypes (Coie, Pennington & Buckley, 1974; Miller, 1974).

Since females have been traditionally stereotyped as dependent while men have been stereotyped as independent, one would expect researchers to have focused on the effect of a person's sex and degree of dependence on the judgements of practicing psychotherapists. It is interesting to note, however, that there is very little empirical research which has had as its focus the clinical judgements of therapists confronted with male and female clients exhibiting dependent or independent behavior. There exists a need for this research. Research investigating sex bias in psychotherapy has declined markedly since 1980. The gains made by the Womens Movement along with the decline in research may have lulled psychotherapists and researchers alike into believing that sex role stereotyping is not as much a factor in psychotherapy as it once was. This is unfortunate. Since there are many client behaviors within the process of psychotherapy which may invoke sex role stereotypes, the research possibilities remain abundant.

Past research involving sex role stereotyping has relied heavily on clinical analogue methodology in which subjects in the study are presented with case material, usually in written form. The investigator is then free to vary the client's sex, behavior, or other pertinent variables within the text of the written vignette. It has been suggested that analogues which describe clearly a client's behavior in certain situation may be more powerful in eliciting sex

biased responding than analogues which merely describe a client's traits (Whitely, 1979). Most studies investigating the effect of sex role-deviant behavior on therapists' judgements of mental health have used analogues in which the behaviors of interest occur outside of the psychotherapy relationship. Therapists' judgements as determined by a client's behavior within therapy have been examined in only a small number of studies. Furthermore, in no study has the effect of client sex and degree of client dependence (independence versus dependence) on therapists' judgements been examined. The present research was proposed to investigate this.

Human relationships intimately involve both dependence and independence. It is a given that life inevitably is characterized by attachments to and separations from people. Young children bond with their parents or caretakers but later in life separate from them. Adults form relationships with other adults and life's circumstances (e.g. moving away, death, divorce) dictate that the relationship must end. The process of psychotherapy also requires that a person form an attachment to another person, in this case a therapist, only to inevitably detach and disengage from this same person when treatment is finished. Traditional sex role stereotypes hold that for men being able to separate from a relationship and be independent is valued and a sign of mental health whereas for women bonding and attaching to

others is valued and a sign of mental health (Gilligan, 1982).

It might be expected that if therapists hold sex role stereotypes of mental health, they may invoke those stereotypes when confronted with client behavior in the therapy relationship which is either dependent or independent. The purpose of the present research is to investigate the effects of client sex and degree of dependence on therapists' judgements of the client's vulnerability to maladjustment. It is expected that the client's sex and degree of dependence will interact in such a way that therapists will view the male behaving in a dependent manner as more vulnerable to maladjustment than a female behaving the same way. Similarly, it is expected that a female behaving in an independent manner will be viewed by therapists as more vulnerable to maladjustment than a male behaving in like manner.

In Chapter II the pertinent literature on sex role stereotyping is reviewed. Studies will be presented in which psychotherapists' and non-psychotherapists' mental health standards for both males and females were examined. In addition, studies involving sex role-deviant behavior and its effect on the mental health judgements of psychotherapists are also presented. Since the behavioral dimension of dependence and independence is strongly sex role linked, a review of pertinent theoretical and empirical

literature on this dimension is also presented. In Chapter III the methodology of the present study is presented. The data are reviewed and the statistical analyses are presented in Chapter IV. A discussion of the results and their implication is presented in Chapter V.

CHAPTER II

REVIEW OF THE LITERATURE

Psychotherapists are presumably trained to view each client as a unique individual with his or her own unique attributes and possessing his or her own unique strengths and weaknesses. People viewed in this manner are less likely to be categorized and described by virtue of their membership in a group. If, however, a psychotherapist responds to a client on the basis of a client's attribute and commonly held beliefs about others who share that same attribute, a problem exists. The client loses his or her individuality and effective treatment is compromised.

This study concerns itself particularly with the sex of the client. Since there appears to be pervasive and rather enduring stereotypes of the male and female, it would not be surprising to find psychotherapists sharing in those stereotypes. To the extent that this occurs, the danger exists whereby a client is viewed or treated in a particular way by virtue of his or her sex. Succummbing to the traditional stereotype obscures the vision of the therapist who sees only a "female," for example, and fails to see the

many other significant traits of the client as well as the client's unique life situation.

Pertinent research involving sex role stereotyping is presented. Since the behavioral dimension of dependence and independence is strongly associated with sex role stereotypes, a review of this relevant empirical and theoretical literature will also be presented.

Sex Role Stereotyping

Non-psychotherapists

Sherriffs and McKee (1957) employed a sample of college students at the University of California at Berkeley and found very sharp and distinct stereotypes of males and females. Fifty men and 50 women were given two cards each with 200 adjectives on them. Subjects were asked to check those adjectives which they thought were in general true of men (or women). The results revealed a clear difference in the perception of males and females along several traits. For example, men were viewed by subjects of both sexes as significantly more frank, thorough, logical, independent, and aggressive than women. Women were viewed as significantly more pleasant, social, warm, sentimental, and sensitive than men. Sheriffs and McKee summarized their findings by noting that the stereotype of men as described by subjects of both sexes seemed to encompass three notions:

a straightforward and uninhibited social style, rational competence and ability with a tendency toward being active, and a bold effectiveness in dealing with the environment. Furthermore, it should be noted that in a later study (McKee & Sheriffs, 1959), it was found that men were concerned that women not be aggressive, independent, dominant, or forceful.

About ten years later, Rosenkrantz, Vogel, Bee, Broverman and Broverman (1968) reported sex role stereotypes very similar to those reported by Sheriffs and McKee (1957). Seventy-four men and 80 women, all college undergraduates, were given what has since become known as the Sex Role Stereotype Questionnaire (SRSQ). It contained 122 items each of which described an attitude, behavior or personality trait which was believed to differentiate men and women. The items were arranged in bipolar form along a seven-point continuum. Subjects were to rate an adult male, an adult female and themselves along the continuum for each item. It was found that men were viewed in relation to women as having more competence and lacking warmth and expressiveness. Women were seen as being warmer and more expressive but lacking competence in comparison to men. Traits in the "competence" cluster included "ambitious", "independent", "objective", and "active". Broverman, Vogel, Broverman, Clarkston and Rosenkrantz (1972) found that these same stereotypes occurred independent of the age, sex, educational level, religion and marital status of the

respondents. After extensive administration of the SRSQ to hundreds of subjects who varied on the traits mentioned above, they concluded that sex role stereotypes were very distinct and very pervasive.

More recent research seems to indicate that these stereotypes continue to flourish. Ruble (1983) administered the Personal Attributes Questionnaire (PAQ) to 128 undergraduates from a midwestern university. The PAQ consisted of 54 items from the SRSQ which had been shown, through previous research, to differentiate the typical man from the typical woman as described by subjects in previous studies. Thirty-two males and 32 females were asked to rate along a six-point continuum how typical it would be for a man (or woman) to possess each trait. Independent-group t tests were performed with a confidence level of at least $p < .01$ required to indicate a significant difference. Results showed that sex role stereotypes remained very strong for that sample of undergraduates. Significant differences between the typical man and typical woman were found for 53 of the 54 comparisons. For 51 of the comparisons, differences were significant at the $p < .001$ level of confidence. The typical male was found to be, for example, more independent, aggressive, outspoken, and active than the typical female. The typical female, on the other hand, was found to be more in need of approval, more emotional, and more aware of others' feelings than the typical male.

Werner and LaRussa (1985) replicated the Sheriffs and McKee (1957) study in an attempt to determine if there were differences in the content of sex role stereotypes over time. This was an interesting study since the sample consisted of 50 male and 50 female undergraduates at the University of California at Berkeley, the same site where Sherriffs and McKee selected their sample. The same procedure was followed. Subjects were asked to check from a list of 200 adjectives those which were true in general for a man (or woman). Sixty-two percent of the adjectives significantly ascribed to men versus women in 1957 continued to be a part of the male stereotype. Seventy-seven percent of the adjectives ascribed to women in 1957 remained part of the female stereotype. Again, males continued to be viewed as more frank, independent, dominant, and determined than women. Women were viewed as more gentle, sensitive, sociable, and trusting than men. These results are of particular significance since they were obtained at a campus known for the progressiveness and activism of its students.

In summary, there is a considerable amount of evidence which suggests that sex role stereotypes continue to exist among non-psychotherapists. Several studies have been presented which demonstrate that men and women continue to be perceived by both males and females as fundamentally different from each other on many behavioral attributes. Although activism, advocacy, and legislation have

encouraged, and in some cases required, that men and women be viewed and treated equally, there remains a very strong and pervasive stereotype for both a man and a woman. Males and females continue to be viewed as very different from each other.

Psychotherapists

Since psychotherapists are products of their culture, it might be expected that they too share the stereotypes that are apparently so prevalent among non-psychotherapists. Indeed, several studies have shown that psychotherapists do have strong beliefs about not only what men and women are like, but also about what attributes describe a healthy man and a healthy woman.

The most widely cited study on this question was conducted by Broverman et al. (1970). Their subjects consisted of 79 practicing psychotherapists, including psychiatrists, psychologists, and social workers. More than half held doctorate degrees and their ages ranged from 23 to 55 years. All subjects were given the SRSQ developed by Rosenkrantz et al. (1968). The subjects were asked to use the 122 bipolar items to describe either a healthy female, a healthy male, or a healthy adult (sex-unspecified). Healthy women were found to differ significantly from healthy men by being, for example, more submissive, less independent, less adventurous, and more emotional. Furthermore, it was found that the concept of health for the sex-unspecified adult did

not differ significantly from the concept of the healthy man but was significantly different from the concept of the healthy woman. This finding has come to be known as the "double standard of mental health": healthy women were viewed as less healthy than healthy men. In addition, masculine traits were found to be more socially desirable than feminine traits on a significant number of items. Broverman and her colleagues concluded that clinicians viewed a client as healthy if he or she was fulfilling the expectations of one's sex role. Since men and women apparently have different sex roles, there would logically be different standards of health for the two sexes.

The Broverman et al. (1970) research precipitated Phyllis Chesler's classic Women and Madness (1972) in which she charged that psychotherapists reinforce the double standard of mental health by believing that normality for the female amounts to embracing the female sex role. Since accepting the female sex role requires a woman to believe that women are inferior to men, psychotherapy which subtly urges women to adopt the traditional sex role confines women to an oppressed position. Thus, women who are normal are less healthy than and inferior to men.

This negative view of women in relationship to men was further illustrated in more research. Fabrikant (1974) asked psychotherapists to describe male and female sex roles. Although the view of women differed somewhat from

previous research, the traditional view of women was retained. Women were seen as significantly more exploiting and fragile than men by both male and female psychotherapists. In addition, female psychotherapists viewed women as more subordinate than males. Eighty-three percent of male characteristics were viewed as positive by male psychotherapists, 86% by female psychotherapists. However, only 31% of all female traits were viewed as positive by male psychotherapists and 33% by female psychotherapists.

Swenson and Ragucci (1984) investigated the sex role stereotypes of psychotherapists using a slightly different method. Using the concept of androgyny proposed by Bem (1977), Swenson and Ragucci defined the androgynous individual as one who scored above the median on both stereotypic masculine and feminine characteristics. The undifferentiated person was defined as one who scored below the median on both stereotypic masculine and feminine characteristics. The purpose of the study was to determine the mental health standards of practicing psychotherapists when given an androgynous alternative. Twenty-one male and 21 female psychotherapists were given the Bem Sex Role Inventory. Each participant was asked to rate a mentally healthy person (sex-unspecified), a healthy man, and a healthy woman along a seven-point continuum for each characteristic. The Bem Sex Inventory is composed of 60

items, 20 items each which describe attributes traditionally masculine or feminine, and 20 items which describe neutral attributes (Bem, 1974). The order of presentation was counterbalanced. It was found that the mentally healthy person, man, and woman were categorized in significantly different ways. Almost 43% of the participants described the mentally healthy person (sex-unspecified) as masculine while nearly 62% of the subjects described the healthy man as androgynous. The mentally healthy female was classified as undifferentiated by 52% of the subjects. Swenson and Ragucci noted that this may be evidence for a new and more destructive double standard of mental health: that is, a combination of masculine and feminine traits is acceptable for both sexes but they should be strong for males and weak for females. Furthermore, male and female "ratees" were viewed as significantly different in the expected direction with regard to traditionally masculine and feminine characteristics.

O'Malley and Richardson (1985) also found evidence that males and females were still described in stereotypic ways by psychotherapists. They presented 249 psychotherapists (psychologists, counselors and social workers) with the SRSQ. Like the Broverman et al. (1970) study, participants were told to imagine they were about to meet an adult male (or female, or person, sex-unspecified). Only the 38 stereotypic items which had been shown in previous research

(Rosenkrantz et al. 1968) to differentiate men and women were analyzed. It was found that although the sex-unspecified person was perceived as having both masculine and feminine characteristics, the male and female were still perceived differently and in the traditionally stereotypic manner. Psychotherapists who were given healthy female instructions scored female-valued items significantly higher than male-valued items. Similarly, psychotherapists given healthy male instruction scored male-valued items significantly higher than female-valued items. O'Malley and Richardson concluded that psychotherapists continued to hold different concepts of men and women and that their standards paralleled societal sex role stereotypes.

At least two other studies revealed similar sex role stereotyping, but only on the part of male subjects. Both employed counselors-in-training as subjects. Maslin and Davis (1975) presented 22 doctoral and 68 masters degree candidates at Temple University with the SRSQ. Again, only the 38 items defined as stereotypic were scored and analyzed. It was found that there was a significant difference between the scores of males rating the healthy female and the scores of females rating the same. The male subjects rated the healthy female in more of the traditionally and stereotypically feminine direction whereas female subjects did not.

Harris and Lucas (1976) used the same methodology with social work students at the University of Minnesota. Male subjects viewed the healthy male and healthy female as significantly different with the healthy female being placed in the traditional feminine direction. In addition, male subjects rated the healthy woman in a significantly different manner than did female subjects. Male subjects again viewed the healthy female as possessing more of the traditional feminine traits than did female subjects.

In summary, several studies have been presented which support the belief that psychotherapists do possess sex role stereotypes of males and females. There is overwhelming evidence that psychotherapists continue to view men and women in traditionally stereotypic ways. Indeed, Whitely (1979) reviewed 12 studies investigating the existence of such stereotyping among mental health professionals and found some evidence for sex role stereotyping in 11 of the studies. Similarly, Sherman's (1980) extensive review shows evidence for sex role stereotyping by psychotherapists in 14 of 15 studies done in North America. It appears that a person is judged to be healthy when and if he or she possesses attributes and characteristics which conform to the traditional sex role stereotypes so pervasive in this society.

Findings such as these have led to the accusation that psychotherapists, in defining normality as conformity to traditional sex roles, subtly encourage women to be normal by being inferior to men and by being, for example, less active, less independent, and less dominant (Chesler, 1972). A further belief was that deviations from traditional sex role stereotypes play an important role in therapists' assessments of the relative normality of clients seeking psychotherapy. This question is addressed in the next sections.

Stereotype Deviations and Mental Health Judgements

If there exist different sex role standards of health for men and women, it follows that attributes and behavior which violate traditional sex role stereotypes will be viewed as evidence of maladjustment. Indeed, there is evidence that both non-psychotherapists and psychotherapists view a person as maladjusted if his or her attributes or behavior deviate from the stereotypic norm.

Non-psychotherapists

Zeldow (1976) asked 50 male and 50 female undergraduate students to read and evaluate statements that were attributed to psychiatric patients but were not symptomatic of emotional disturbance. The statements were drawn from the Masculinity-Femininity and Lie scales of the Minnesota

Multiphasic Personality Inventory. On half of the questionnaires the statements were attributed to male patients and on the other half to female patients. Subjects were asked to assess each statement for the degree of emotional maladjustment, using a seven-point scale that ranged from "none" to "severe". Results indicated that when a female patient expressed an attitude conventionally thought to be masculine, whe was evaluated as significantly more disturbed by a male judge than if she had described herself in terms of the traditional feminine stereotype. No similar bias against women was found when the judge was female.

Costrich, Feinsteen, Kidder, Maracek and Pascale (1975) presented 128 undergraduates with an audio recording of a discussion between a student and a counselor concerning a low term paper grade. In one tape the student was angry and critical of the professor who gave the grade (the aggressive treatment condition). In the other, the student was disappointed and apologetic, emphasizing his or her own feelings of inadequacy (the passive treatment condition). Each subject listened to only one version of the tape and rated the person on a number of items. It was found that the aggressive woman and the passive man were both seen as in need of therapy more than their stereotyped counterparts. Thus, behavior which deviated from the stereotype appeared to have resulted in a more harsh judgement by the subjects in this sample.

Coie, Pennington and Buckley (1974) were interested not only in the particular behavior which was judged to violate sex role stereotypes, but also the situational context in which it occurred. They presented 288 male and 288 female undergraduate students with a written vignette which described either a male or female student. Three different kinds of situational stressors that were used in the vignettes included rejection from a potential career choice (medical school rejection), interpersonal rejection (rejection by a fiance), and competency pressure (an oral examination). Four behavioral reactions to these situations were described: aggression, social withdrawal, somatic complaints, and cognitive dissociation. Subjects were asked to respond to nine questions along a seven-point continuum. In the oral examination condition, less psychological disorder was attributed to males than to females for the identical behavior, indicating that subjects of both sexes were perhaps more willing to be sympathetic with males who were reacting to career-related stress. In the interpersonal rejection condition, hospitalization was seen as significantly more appropriate for the male than the female. These results supported the hypothesis that psychotherapists would assess the female experiencing career-related stress and the male experiencing interpersonal stress as more maladjusted than the male experiencing career-related stress and the female experiencing interpersonal stress. Subjects

were presumably responding to the expectation that males, by virtue of being male, were accustomed to dealing with career stress and that females, by virtue of being female, were accustomed to dealing with interpersonal stress. Furthermore, it was also found that females were evaluated as more disordered than males when demonstrating aggressive behavior. Similarly, greater disorder was attributed to males than to females when exhibiting somatic complaints. The authors concluded that some stressful situations may have greater salience for members of one sex than those of the opposite sex because of the role-relatedness of the situation. Sex roles may not only alter the meaning of the behavior exhibited, but they also may interact with the context in which the behavior occurs to alter its meaning.

Since the traditional stereotypes of the sexes hold that males self-disclose less than females, it would be expected that they would be judged differently depending on whether their self-disclosing conformed to or deviated from the expected stereotype. Derlega and Chaikin (1976) presented 64 male and 64 female undergraduate students with a written vignette in which the sex of the person and the amount of self-disclosure was varied. It was found that subjects of both sexes rated a male stimulus person as being better adjusted psychologically when he failed to disclose than when he did disclose information about a personal problem. The female stimulus person, on the other hand, was viewed as

better adjusted when she disclosed than when she did not. These results are consistent with the expected stereotypes of men and women on the dimension of self-disclosure.

Psychotherapists

There is evidence that psychotherapists also are prone to assess a person as maladjusted if his or her behavior deviates from the expected sex role stereotype. Thomas and Stewart (1971) hypothesized that counselors would perceive female clients having traditionally feminine career goals differently in comparison to female clients having traditionally masculine career goals. Sixty-two volunteer high school counselors in St. Paul, Minnesota served as subjects for the study. All subjects were exposed to an audiotape in which a high school female gave personal information about herself, her family, her school and her career goals. The occupations of engineer and home economist were selected both because they hold extreme positions on the masculine-feminine continuum and because all of the girls on the audiotape had math and science interests and abilities. It was found that both male and female counselors rated conforming career goals as more appropriate than deviant career goals. Furthermore, both male and female counselors rated female clients with deviant career goals to be more in need of counseling than those with conforming career goals.

Abramowitz, Abramowitz, Jackson and Gomes (1973) exposed 71 counselors to a written vignette in which a person was described. The vignette presented the person as an intelligent individual but having a history of problems with parents and underachievement. The vignette varied the sex of the person as well as the political orientation, liberal or conservative. The subjects then rated the person on psychological adjustment. It was found that the liberal female client was rated as significantly more maladjusted than her liberal male counterpart. This was true for subjects with conservative political orientations only. This is similar to the findings of another study (Abramowitz et al., 1975) in which a female aspiring to go to medical school was rated as more maladjusted by traditional counselors than by untraditional counselors. Traditional counselors were more harsh in their judgements of the medical school-aspiring female presumably because her career decision deviated from the expected stereotype.

In clinical analogue studies, researchers attempt to tap the sex role stereotypes of subjects with vignettes usually in written form. Subjects are usually presented with case material in which the investigator is free to manipulate variables of interest such as the sex of the stimulus person, his or her behavior, or other pertinent variables. Although the analogue has been criticized by some for its lack of external validity (Stricker & Safrahan, 1983), it

remains an important and viable research tool. It is necessary in sex bias research in order to determine whether a given evaluation is either valid, representing the actual traits of the client, or prejudicial, representing the irrelevant trait of the sex of the client (Smith, 1980). In naturalistic studies, it is impossible to determine if a psychotherapist's judgement of a client is due to the relevant or irrelevant characteristics of a client. Analogue studies allow for an easier determination of the effect of irrelevant client attributes on the judgements of psychotherapists.

In his review of the literature, Whitely (1979) suggested that analogue material which clearly described sex role-deviant behavior seems to elicit more adverse judgements than material which merely describes traits. With non-psychotherapist subjects, for example, Derlega and Chaikin (1976) found a much stronger effect using a specific behavior (self-disclosure) than did other investigators (e.g. Chasen, 1975; Gomes and Abramowitz, 1976) who used traits. In such cases as these, behavioral descriptions seem to add authenticity and realism to the experimental situation. Several studies which describe both conforming and deviant sex role behaviors have produced significant results when using psychotherapists or psychotherapist-trainees as subjects.

Miller (1974) presented 67 psychotherapists with a written vignette in which a person was behaving in a passive manner. It was found that the stimulus person in the vignette was rated as better adjusted when the vignette was labelled as female than when it was labelled as male. Furthermore, more therapists chose passivity as the focus of therapy when the vignette was described as male than when it was described as female.

Feinblatt and Gold (1976) gave clinical and school psychology graduate students written vignettes in which the behavior of children was described. The sex of the child was varied as was the behavior of the child which was described as either passive and emotional, or defiant and aggressive. It was found that the child exhibiting behavior traditionally deemed inappropriate to his or her sex was viewed as more disturbed and significantly less likely to have a successful future than the child exhibiting stereotype-congruent behavior.

Tribich (1977) presented 80 psychotherapists and 80 lay people with three written vignettes, one in which the stimulus person was behaving in a way more stereotypic of males, one in which the stimulus person was behaving in a way more stereotypic of females, and one in which the behavior was sex-independent. Of significance was the finding that the male stimulus person who responded to a crisis with crying and other traditionally "feminine"

reactions was rated as more disturbed than a female stimulus person who reacted in the same manner. In addition, the male stimulus person who reacted with crying was rated as more disturbed than either a man or woman who reacted with anger or other stereotypically "masculine" behaviors.

In summary, there exists a large body of research which suggests that non-psychotherapists and psychotherapists alike are apt to judge a person as more maladjusted if his or her behavior deviates from behavior traditionally associated with the stereotypic notions of male and female. The effect of the sex of the stimulus person may be a complex one since it has been shown to interact with subject characteristics such as the sex of the subject (Zeldow, 1976) and the political orientation of the subject (Abramowitz et al., 1973). It may also interact with the situational context in which the behavior occurred (Coie et al., 1974). This is consistent with the observations of others who believe that the effect of a person's sex on clinical judgement is most likely a complex one (Murray, 1983; Zeldow, 1978). Despite the apparent complexity, it appears that violations of sex role norms lead to adverse mental health judgements. The clinical analogue is a viable and necessary tool for investigating sex bias. It may be that written analogues which present people exhibiting specific behavior are more likely to tap the sex role stereotypes of the subjects than are analogues which merely describe traits.

Dependence and Independence

Traditional sex role stereotypes clearly place males and females at distinctly different places along the continuum of dependence/independence. Males have been viewed as more independent than females, females as more dependent than males. In order to gain a perspective on why this is the case, it makes sense to briefly describe the traditional role of women. Also discussed will be the views of theorists who have discussed the differences between male and female identity formation. Finally, the empirical literature will be examined to see if research has indeed demonstrated whether healthy women and healthy men are viewed differently on this dimension.

Role of Women

An examination of how males and females are perceived to differ with regards to dependence and independence might appropriately begin with a brief discussion of the traditional role of women. In essence, the woman's role traditionally has been complementary to the roles of other people (Kirsch, 1974). That is, the role of women is to assist others in the expression of their roles.

Keller (1974) states that the role of women has been viewed as having three central themes: maternal, wifely, and erotic functions with primary emphasis on the maternal and wifely functions. Keller nicely summarizes the primary

aspects of the female role:

1. A concentration on marriage, home and children as the primary focus of feminine concern.
2. A reliance on a male provider for sustenance and status. This important component of the wife role is symbolized by the woman taking her husband's name and sharing her husband's income.
3. An expectation that women will emphasize nurturance and life-preserving activities, both literally as in the creation of life, and symbolically in taking care of, healing, and ministering to the helpless, the unfortunate, the ill. Preeminent qualities of character stressed for women include sympathy, care, love, and compassion, seemingly best realized in the roles of mother, teacher, and nurse.
4. An injunction that women live through and for others rather than for the self. Ideally, a woman is enjoined to lead a vicarious existence - feeling pride or dismay about her husband's achievements and failures or about her childrens' competitive standing.
5. A stress on beauty, personal adornment, and eroticism, which, though a general feature of the female role, is most marked for the glamour girl.
6. A ban on the expression of direct assertion, aggression, and power strivings except in areas clearly marked as a woman's domain - as in the defense of hearth and home (Keller, 1974, pp.417-418).

It appears then that the traditional role of women requires that a woman be others-oriented as well as dependent on her husband rather than herself for her own support and sense of well-being.

Masculine and Feminine Identity Formation

This orientation toward others is also emphasized in Chodorow's (1978) discussion of male and female development as it relates to identity formation. She contends that all children are initially dependent on, in most cases, a female mother or caretaker. This results in all children, both

girls and boys, forming a strong attachment to her. During separation and individuation (ages one through three), young girls experience themselves as like their mothers and fuse the experience of attachment with the process of identity formation. In contrast, young boys view themselves as different from their mother or caretaker and separate their mother from themselves as individuation develops. Consequently, Chodorow believes that the feminine personality is defined in relation to and in connection with others. The masculine personality, on the other hand, is defined by separation and independence from others. Chodorow concludes that female gender identity is threatened by separation and independence whereas male gender identity is threatened by intimacy and dependence.

After extensive interviews with many males and females, Gilligan (1982) made similar conclusions. She found that for women their identity was based on intimacy and was defined in the context of a relationship to or with someone. For men, their identity was based on being independent. In studying the self-descriptions of males and females, Gilligan found that males were likely to describe themselves as "intelligent", "logical", and even "cocky". These descriptions suggest a sense of one's separateness and independence from others. In contrast, women were prone to describe themselves as "giving to" or "helping out" which suggests a sense of one's attachment to others.

In summary, the traditional role of women has been presented as promoting functions in the service of others, most notably a husband or children. The traditional role also requires that a woman depend on her husband and not herself for her own sense of suppport, strength, and sense of well-being. Furthermore, it has been suggested that the feminine personality is defined in relationship to and in connection with other people whereas the masculine personality is defined by independence from others (Chodorow, 1978). This is confirmed vividly in the self-descriptions of both males and females (Gilligan, 1982). Since dependence implies an attachment to others and independence a separation from others, it follows that healthy males and females may be viewed differently on the dimension of independence and dependence. Available empirical studies which have addressed this are presented next.

Empirical Studies

It has been shown in several studies that males and females are perceived differently on the dependence/independence continuum. Rosenkrantz et al. (1968) found that subjects valued independence in men more so than in women. In addition, subjects considered having a strong need for security to be more valued in women than in men. In the Broverman et al. study (1970), healthy males were viewed as significantly more independent than healthy

females by the sample of practicing psychotherapists. Similarly, Harris and Lucas (1976) found that psychotherapist-trainees viewed the healthy male as significantly more independent than the healthy female.

More recent research employing non-psychotherapists as subjects reveals similar findings. Ruble (1983) found that undergraduate students viewed the attribute of independence as significantly more typical of men than women. It was also found that the need for security was seen as significantly more typical for women than for men. In a replication of Sherriff and McKee's (1957) study, Werner and LaRussa (1985) found that subjects of both sexes were more likely to describe a hypothetical male as independent than a female. In addition, a female was more likely to be described as submissive than was a male.

Given these findings, it might be expected that females viewed as independent would be judged as more maladjusted than males viewed as independent. Similarly, it would be expected that males viewed as dependent would be judged as more maladjusted than females seen as dependent. A review of the available literature reveals only one study (Pringle, 1973) in which this was investigated. In this study, subjects were not more likely to judge the dependent male and the independent female as more maladjusted than their stereotyped opposite-sex counterparts. It should be noted, however, that the subjects of this study were high school

counselors, not psychotherapists, who volunteered and who were judging the behavior of high school students.

This decline in research is unfortunate. Whitely (1979) suggested that vignettes which merely describe client traits may not be as potent or salient in eliciting adverse mental health judgements than are vignettes which describe a client's behavior. Such a description adds authenticity to the vignette. If this is true, there is more that can be learned about the effect of client sex and behavior on the assessments of psychotherapists. Furthermore, the decline in research is particularly unfortunate because very few investigators have examined the effects of a client's behavior and sex on psychotherapists' judgements within the therapist-client relationship. Most researchers who have studied the effects of sex role-deviant behavior on the clinical judgements of psychotherapists have used analogues which have described a client's behavior which is irrelevant to the therapist-client relationship. Since there are many client behaviors within psychotherapy which may still invoke the stereotypes of psychotherapists, the research possibilities remain abundant.

In summary, it has been suggested by several researchers that healthy or typical males are perceived as more independent than healthy or typical females who are viewed as more submissive and as having a stronger need for security. A review of the literature reveals only one study

which examined whether a dependent male or an independent female were judged to be more maladjusted than their stereotypic opposite-sex counterparts. No study has had as its focus psychotherapists' evaluations of clients on the basis of client behavior (dependent versus independent) within the context of the therapy relationship. Research involving sex role stereotyping has declined and possible reasons for that decline were presented. Finally, it was suggested that since there are many client behaviors within psychotherapy that may invoke the stereotypes of psychotherapists, many research possibilities still exist.

Psychotherapy and Dependence/Independence

The process of psychotherapy involves both attachment and separation, dependence and independence. In distress, a client is dependent on a therapist for help and forms an alliance with the therapist. Termination of therapy is an experience of independence and separation for the client and for the therapist. James Mann, in his classic Time-Limited Psychotherapy (1974), advocates limiting certain clients' treatment to 12 sessions so as to keep clients focused on the inevitability of ending treatment and separating from the therapist. He contends that the human condition is characterized by a denial of separation and advocates the time-limiting of therapy in order to raise the client's

awareness that separation is inevitable.

Traditional sex role stereotypes hold that males are expected to have little problem with separations from significant people in their lives while women are expected to have difficulty with such separations. Since psychotherapy termination is a separation experience, it follows that males and females might be expected to have more problem with separating and being independent from the therapist than would males. Furthermore, if sex role stereotypes affect the mental health judgements of therapists and if sex role-deviant behavior leads to adverse mental health judgements, it might be predicted that therapists may judge a male demonstrating "dependent" or "clinging" behavior in the therapy situation as more maladjusted than his female counterpart. Similarly, a female demonstrating "independent" or "separating" behavior may be viewed as more maladjusted than her male countepart. Since no study has had this as its focus, the current research is designed to investigate this.

Since the emergence of the Diagnostic and Statistics Manual of Mental Disorders (DSM-III) published by the American Psychiatric Association in 1980, psychotherapists have become increasingly active in assessing in a client those pervasive features which characterize the client's relatively stable and enduring personality pattern. This is commonly done on Axis II of the DSM-III's multi-axial

format. Axis I is reserved for the client's current symptom picture. Millon (1981) defines personality as "a complex pattern of deeply embedded psychological characteristics that are largely unconscious, cannot be eradicated easily, and express themselves in almost every facet of functioning" (p. 8). Axis II gives the psychotherapist an opportunity to assess the degree to which a client's personality is integrated. It assesses the personality style or disorder of a client and reflects the therapist's assessment of the client's overall vulnerability to maladjustment. Hence, most psychotherapists now view a client's current symptom pattern (as reflected on Axis I) within the context of whatever assessment can be made of the client's overall personality style (as reflected on Axis II).

If the feminine personality is defined by attachments to and dependence on other people and the masculine personality is defined by independence and separation from others, dependency will be viewed as incongruent with the masculine personality and independence with the feminine personality. It might be expected, then, that psychotherapists will view a male demonstrating dependent behavior as more vulnerable to maladjustment than a similar female. Similarly, a female behaving in an independent manner may be viewed as more vulnerable to maladjustment than her male counterpart.

In general, research exploring sex role stereotyping and the mental health judgements of psychotherapists has been explored. Males and females appear to be viewed differently with respect to many attributes, including dependence and independence. Despite the need to investigate the effect of client sex and client behavior within the therapist-client relationship, research on the sex role stereotyping of psychotherapists has declined in recent years. The process of psychotherapy requires a client to attach to and be dependent on a psychotherapist at the beginning of therapy and be independent from the therapist at the end of therapy. If the healthy masculine personality is congruent with independence and separation from others and the healthy feminine personality is congruent with dependence and attachments to others, and if psychotherapists view men and women differently on the dimension of dependence/ independence, it might be expected that clients whose behavior deviates from the expected stereotype will be judged as more vulnerable to maladjustment than clients of the opposite sex for whom the same behavior is stereotype-conforming. The current study examines these relationships.

CHAPTER III

METHOD

Subjects

Psychotherapists asked to participate in the study were selected from membership lists of the Michigan Psychological Association and the National Association of Social Workers. Only those persons who listed clinical practice as main activity were selected. Every eighth social worker and every fourth psychologist on their respective lists were selected. This yielded a total of 392 psychotherapists, 196 social workers and 196 psychologists. Of the 196 social workers, 78 were males and 118 were females. Of the 196 psychologists, 110 were males and 86 were females.

Procedure

Each psychotherapist was mailed a packet of materials including a cover letter, a client and treatment vignette, an instruction sheet, a questionnaire, and a stamped and addressed envelope for easy return of the questionnaire. Identical materials were sent to all subjects, with the exception that the sex and degree of dependency of the hypothetical client was varied. Subjects were randomly

assigned to one of four treatment conditions: dependent male, dependent female, independent male, independent female. All client information was created by the experimenter and did not represent any actual client. A follow-up post card was mailed one week after the intital mailing and again two weeks after the initial mailing in order to increase compliance. The post cards were composed of a few sentences which conveyed appreciation for filling out the questionnaire if it had already been done. The post cards also emphasized the importance of the research and gently encouraged compliance.

Cover Letter

The cover letter was constructed on Michigan State University stationery using the letterhead of the School of Health Education, Counseling Psychology and Human Performance. Its primary purpose was to engage the psychotherapists in completing the task. Since the primary purpose of the research was to determine whether psychotherapists invoke sex role stereotypes in their clinical judgements, the true purpose of the research could not be revealed in order to avoid social desirability of responding. The cover letter informed subjects that the true nature of the study was not able to be revealed at the time when they received the materials, but promised them a full and complete explanation of both the nature and results of the study as soon as the results were available. The

cover letter also described the procedure for carrying out the exercise and gave a reliable estimate of completion time. It mentioned the voluntary nature of the exercise and assured confidentiality of responding. The cover letter appears as Appendix A.

Client Vignettes

The client vignettes were designed by the experimenter to be credible and realistic. The vignettes described the client as either male or female and as either dependent or independent. The dependent vignette described a client who was demonstrating behavior which is commonly thought of as dependent. After improvement, the client was described as clinging to and resisting separation from the therapist. The independent vignette described a client who valued relying on his or her own resources and, after improving, initiated separation from the therapist. In order to ensure that the vignettes validly and accurately portrayed dependence and independence, five experienced psychotherapists were given the independent vignette and five other psychotherapists were given the dependent vignette. They were asked to read the description and then answer along a seven-point continuum the degree to which they viewed the client in question as dependent or independent. A score of one represented "very independent" while a score of seven represented "very dependent". The mean of psychotherapists' scores on the dependent vignette

was 6.6 with a standard deviation of .55. The mean of the scores of psychotherapists who received the independent vignette was 2.8 with a standard deviation of .84. The difference between the means for the dependent and independent vignette on degree of dependence was 3.8, a difference of at least 4.5 standard deviations. Therefore, there is evidence which suggests that for these psychotherapists, the vignettes did indeed differentiate the dependent from the independent client on degree of dependence. The dependent and independent vignettes appear as Appendix B1 and B2, respectively.

Instruction Sheet

The instruction sheet encouraged the psychotherapist to use his or her expertise and clinical intuition in assessing the extent to which he or she believed the client in question was vulnerable to maladjustment. In short, it encouraged an assessment of the client's general vulnerability to maladjustment, not an assessment of the client's current level of maladjustment. The instruction sheet appears as Appendix C.

Maladjustment Assessment Questionnaire

The development of the questionnaire was an arduous and time-consuming task. The goal of this development was to produce a reliable and valid questionnaire, one which contained items related to psychological maladjustment which were sufficiently correlated with each other so as to derive

a total score for all of the items combined. Construct validity was demonstrated by agreement of five experienced psychotherapists that all items were indicators of or correlated with psychological maladjustment. In addition, most items contained symptoms taken directly from the DSM-III.

There were a total of four pilot studies done. The experimenter relied on verbal feedback from psychotherapists who participated in the pilot studies. This feedback helped to make improvements and refinements in the questionnaire. Items which used terminology such as "severe" or "very low" were eliminated since therapists were likely to respond to the item on the basis of the descriptive terms "severe" or "very low". Other items were eliminated for other reasons. For example, an item which stated "This client is vulnerable to having problems at his or her place of employment" was eliminated because pilot scores revealed a large variability, suggesting that psychotherapists varied greatly in their willingness to project this type of maladjustment onto the client. Furthermore, the number of items was sharply reduced on the recommendation of several respondents, some of whom had done research using a similar format. The first three pilot studies used 30 to 35 items with each item requiring a response along a five-point Likert scale. It was felt that such a large number of items, some of which were worded in the negative direction, produced fatigue in

respondents who found their attention to the task waning significantly as they neared the end of the questionnaire. The fourth pilot study used 20 items with each item requiring a response along a seven-point Likert scale. No less than twenty different psychotherapists were employed in each pilot study. The intercorrelation of items, as measured by coefficient alpha (Anastasi, 1976) calculated on each pilot study ranged from .75 to .96 with the final questionnaire generating the latter reliability. Hence, there is very strong support for using this dependent measure and combining scores from items into a final score.

The final questionnaire contained 20 items all of which asked the subject to, along a seven-point Likert scale, either agree or disagree with a statement concerning their perception of the client's vulnerability to maladjustment. Items were worded in both the affirmative and negative so as to eliminate any response set in a subject. From each item a maladjustment score was able to be found, ranging from one to seven. The sum of all items represented the final score.

The second part of the questionnaire asked the subjects to give information about themselves which included their sex, age, profession, theoretical orientation, years of experience, whether they were currently conducting therapy, hours of therapy per week, and their primary client population, adults or children or both. Also included in the second part of the questionnaire was the question which

asked the subjects to rate the client on the degree of dependency. This was embedded in the second part of the questionnaire so as not to alert the subjects to the true nature of the study. The questionnaire appears as Appendix D.

Post Cards

All subjects were mailed a post card both one week and two weeks after the initial mailing. All subjects were mailed both cards since there was no way of determining the identity of respondents from non-respondents. The post cards thanked respondents for their compliance and urged non-respondents to consider the importance of the task. The wording of the post cards is presented as Appendix E.

Hypotheses

Two main hypotheses were tested. Hypotheses I stated that psychotherapists would view the dependent male as more vulnerable to maladjustment that the dependent female. Similarly, hypotheses II stated that psychotherapists would view the independent female as more vulnerable to maladjustment that the independent male. Since dependency is commonly considered to be more pathological than independence, it was anticipated that psychotherapists would view the dependent client as more vulnerable to maladjustment than the independent client. To that end, hypothesis III stated that the dependent male would be

viewed as more vulnerable to maladjustment that the independent male. In like manner, hypothesis IV stated that the dependent female would be viewed as more vulnerable to maladjustment than the independent female. The null hypotheses of no relationship between each demographic variable and psychotherapists' ratings of maladjustment vulnerability were also tested. All hypotheses were tested against a .05 level of significance.

Statistical Analyses

The interitem consistency of the questionnaire was analyzed by calculating coefficient alpha (Anastasi, 1976) based on the responses of all subjects.

The balance of the data analysis was conducted using nonparametric statistical techniques. There were several reasons for this choice. First, the level of measurement achieved in this research was, strictly speaking, ordinal. Parametric statistics require at least an interval scale of measurement whereas nonparametric statistics can be applied to data based on nominal and ordinal scales. Second, the assumptions underlying parametric statistics are by no means guaranteed in this research. Of particular significance is the assumption that the variances of comparison groups are equal. Inspection of raw data revealed a wide range of variability among comparison groups. For example, there was much variability in the distribution scores from the subjects given the independent vignette but comparatively

little variability in the distribution of scores from the subjects given the dependent vignette. Since assuming equal variances and applying parametric statistics under these conditions would jeopardize the validity of the findings, nonparametric statistics seemed a logical choice. Furthermore, when cell sizes are unequal (as in the current study), the researcher runs an even greater risk of jeopardizing the validity of the final inference (Hays, 1981). Third, the nonparametric statistical tests used in this study are the most powerful nonparametric tests and compare very favorably to the most powerful parametric tests (Siegel, 1956). Since the samples in the current study were large, the nonparametric tests represented an attractive alternative to parametric tests. Power was maximized and the researcher was free from the restrictive assumptions and requirements of parametric statistics.

Three nonparametric statistical tests were employed in this study. The Mann-Whitney U test is used to test whether two independent groups have been drawn from the same population. Thus, the main hypotheses were tested using the Mann-Whitney U test. It was also used to test the significance of demographic variables which had two levels (such as therapist sex, for example). When using the Mann-Whitney U test, the researcher first assigns all scores a rank from the lowest to the highest. That is, the lowest score receives a rank of one, the next lowest a rank of two

and so on. The value of $\underline{U}$ is equal to the number of times in the ranking a score in one comparison group precedes a score in the other comparison group. With large numbers of scores, $\underline{U}$ is computed using the following formula:

$$\underline{U} = n_1 n_2 + \frac{n_1(n_1+1)}{2} - R_1$$

Here, n_1 and n_2 refer to the number of scores in the respective comparison groups. R_1 is the sum of the ranks assigned to the group whose sample size is n_1. The sampling distribution of $\underline{U}$ approaches normality as n_1 and n_2 increase in size. The mean of this distribution is given as follows:

$$\mu_{\underline{U}} = \frac{n_1 \, n_2}{2}$$

The standard deviation of the sampling distribution of $\underline{U}$ is given as follows:

$$\sigma_{\underline{U}} = \frac{n_1 \, n_2 \, (n_1+n_2+1)}{12}$$

Thus, one determines the significance of an observed value of $\underline{U}$ by using the following formula:

$$\underline{z} = \frac{\underline{U} - \mu_{\underline{U}}}{\sigma_{\underline{U}}}$$

The second nonparametric statistic used in this study was the Kruskal-Wallis One-Way Analysis of Variance by Ranks test. It is used to test whether more than two independent samples were drawn from different populations. Thus, one way in which it was used in this study was to test whether therapists from different theoretical orientations differed in their assessment of maladjustment vulnerability. In the Kruskal-Wallis test, scores are ranked and the sum of the ranks in each group is found. The Kruskal-Wallis test determines whether these sums of ranks are so disparate that they are not likely to come from samples which were all drawn from the same population. The formula employed is as follows:

$$\underline{H} = \frac{12}{N + (N+1)} \sum_{j=1}^{k} \frac{R_j^2}{n_j} - 3(N+1)$$

where $\underline{H}$ is the statistic used in this test,

k is the number of samples,

n_j is the number of scores in the jth group,

N is the total number of scores in all groups combined, R_j is the sum of the ranks in the jth group. When all groups are drawn from the same population, H is distributed approximately as chi square with k-1 degrees of freedom.

The final nonparametric test used in the current study was the Spearman Rank Correlation Coefficient ($\underline{r}_s$). It measures the association between two variables and requires that both variables are measured in at least an ordinal scale so that scores may be ranked in two ordered series. Thus, this statistical test was used to determine the degree of association between maladjustment vulnerability scores and variables such as therapist age, years of experience and hours of therapy per week. The significance of an obtained $\underline{r}_s$ can be then tested using the following formula:

$$\underline{t} = \underline{r}_s \sqrt{\frac{N - 2}{1 - \underline{r}_s^2}}$$

where N is the total number of subjects. The value defined in the above formula is distributed as Student's $\underline{t}$ with N-2 degrees of freedom.

CHAPTER IV

RESULTS

Description of Subjects

A total of 392 questionnaires were mailed to prospective subjects. Six questionnaires did not reach their intended destination and were returned. A total of 242 (62.7%) responses to the task were received. From these, 231 (58.9%) usable questionnaires were produced. Eleven responses were not usable for a variety of reasons. One person elected not to participate because of taking another vocation. One person stated she had no time. One person felt she had insufficient information to risk making a judgement about the client in question. Three people expressed disagreement with the underlying assumption that inferences about a client's personality could be drawn on the basis of the given information. Five potential subjects either incompletely or incorrectly filled out the questionnaire. Their responses were not used in the data analysis.

Of all 231 subjects whose responses were used, 125 were social workers and 106 were psychologists (see Table 1). There were 123 male psychotherapists and 108 female

Table 1

Psychotherapists' Profession

Profession	Number	Percent
Psychology	125	54.1
Social Work	106	45.9
Total	231	100.0

Table 2

Psychotherapists' Sex

Sex	Number	Percent
Male	123	53.2
Female	108	46.8
Total	231	100.0

Table 3

Psychotherapists' Theoretical Orientation

Theoretical Orientation	Number	Percent
Analytic	40	17.3
Neoanalytic	19	8.2
Transactional Analysis	3	1.3
Gestalt	1	.4
Rogerian	1	.4
Cognitive-Behavioral	19	8.2
Behavioral	7	3.1
Eclectic	123	53.3
Other	18	7.8
Total	231	100.0

psychotherapists (see Table 2). A majority of the subjects (53.3%) described themselves as eclectic in their theoretical orientation (see Table 3). Adults were the primary clients of 170 subjects (see Table 4). Most subjects (83.6%) were active in the practice of psychotherapy (see Table 5). The average age of subjects was 46.4 years (see Table 6). Subjects had an average of 13.5 years of psychotherapy experience (see Table 7). The average number of hours per week spent conducting psychotherapy was 17.5 hours (see Table 8). Of the 231 subjects whose questionnaires were used, 57 each responded to the dependent male and the dependent female, 54 responded to the independent male and 63 responded to the independent female.

Questionnaire inter-item consistency

Analysis of the inter-item consistency of the questionnaire based on the subjects' responses produced an *r* of .932. This is indicative of an instrument which is highly reliable and which is composed of items which are sufficiently correlated with each other to derive a composite score from the sum of all items.

Ratings of Client Dependency

Subjects' ratings of both the independent and dependent client on degree of dependency were analyzed using the Mann-Whitney *U* test. As expected, it was found that subjects did view the client in the dependent vignette as

Table 4

Psychotherapists' Primary Clients

Primary Client	Number	Percent
Adults	170	73.6
Children	46	19.9
Both	15	6.5
Total	231	100.0

Table 5

Psychotherapists' Activity in Psychotherapy

Activity	Number	Percent
Active	193	83.6
Inactive	38	16.4
Total	231	100.0

Table 6

Psychotherapists' Age

	Males		Females		All	
Age	Number	Percent	Number	Percent	Number	Percent
21-30	5	4.1	7	6.5	12	5.2
31-40	61	49.5	40	37.0	101	43.7
41-50	33	26.9	29	26.9	62	26.8
51-60	21	17.1	20	18.5	41	17.8
61-70	2	1.6	10	9.2	12	5.2
71+	1	.8	2	1.9	3	1.3
Total	123	100.0	108	100.0	231	100.0

Table 7

Psychotherapists' Years of Experience

Years of psycho-therapy experience	Males		Females		All	
	Number	Percent	Number	Percent	Number	Percent
1-5	11	8.9	21	19.4	23	9.9
6-10	45	36.6	37	34.3	82	35.5
11-15	33	26.8	17	15.7	50	21.7
16-20	14	11.4	20	18.6	34	14.7
21-25	8	6.5	4	3.7	12	5.2
26-30	5	4.1	4	3.7	9	3.8
31+	7	5.7	5	4.6	12	5.2
Total	123	100.0	108	100.0	231	100.0

Table 8

Psychotherapists' Average Hours of Therapy Per Week

Average hours per week	Males		Females		All	
	Number	Percent	Number	Percent	Number	Percent
0-5	21	17.1	23	21.3	44	19.0
6-10	14	11.4	16	14.8	30	13.0
11-15	13	10.6	11	10.2	24	10.4
16-20	26	21.1	24	22.2	50	21.7
21-25	15	12.2	16	14.8	31	13.4
26-30	15	12.2	7	6.5	22	9.5
31+	19	15.4	11	10.2	30	13.0
Total	123	100.0	108	100.0	231	100.0

significantly more dependent than the client in the independent vignette, z = 10.45, p = .0001 (see Table 9). There was no difference in the ratings of the dependent male and the dependent female on degree of dependency, z = .192, p = .848. Similarly, there was no difference in the ratings of the independent male and the independent female on degree of dependency, z = -.461, p = .645.

Main Hypotheses

Since ranking is essential to the application of the nonparametric statistical techniques used in this study, it is beneficial to present the mean rank of each of the four comparison groups. A perspective is gained by examining these mean ranks in relationship to each other. The mean ranks for the dependent male, independent male, dependent female and independent female on the measure of vulnerability to maladjustment are 150.13, 87.18, 122.88, and 103.60, respectively (see Figure 1).

Hypothesis I stated that psychotherapists would view the dependent male as more vulnerable to maladjustment than the dependent female. A one-tailed Mann-Whitney U test on the data supported this hypothesis, z = 2.34, p = .009 (see Table 10). Subjects did view the dependent male as significantly more vulnerable to maladjustment than the dependent female.

Hypothesis II stated that psychotherapists would view the independent female as more vulnerable to maladjustment

Table 9

Mann-Whitney U Test for Degree of Dependence in Dependent and Independent Vignette Situations

Vignette	Number	Mean Rank	z	p
Dependent	114	161.33		
Independent	117	71.83		
Dependent vs. Independent	231		10.45	.0001*

* one-tailed

Table 10

Mann-Whitney U Test for Maladjustment Vulnerability Scores in Dependent Male and Dependent Female Vignette Situations

Vignette	Number	Mean Rank	z	p
Dependent Male	57	64.73		
Dependent Female	57	50.27		
Dependent Male vs. Dependent Female	114		2.34	.009*

* one-tailed

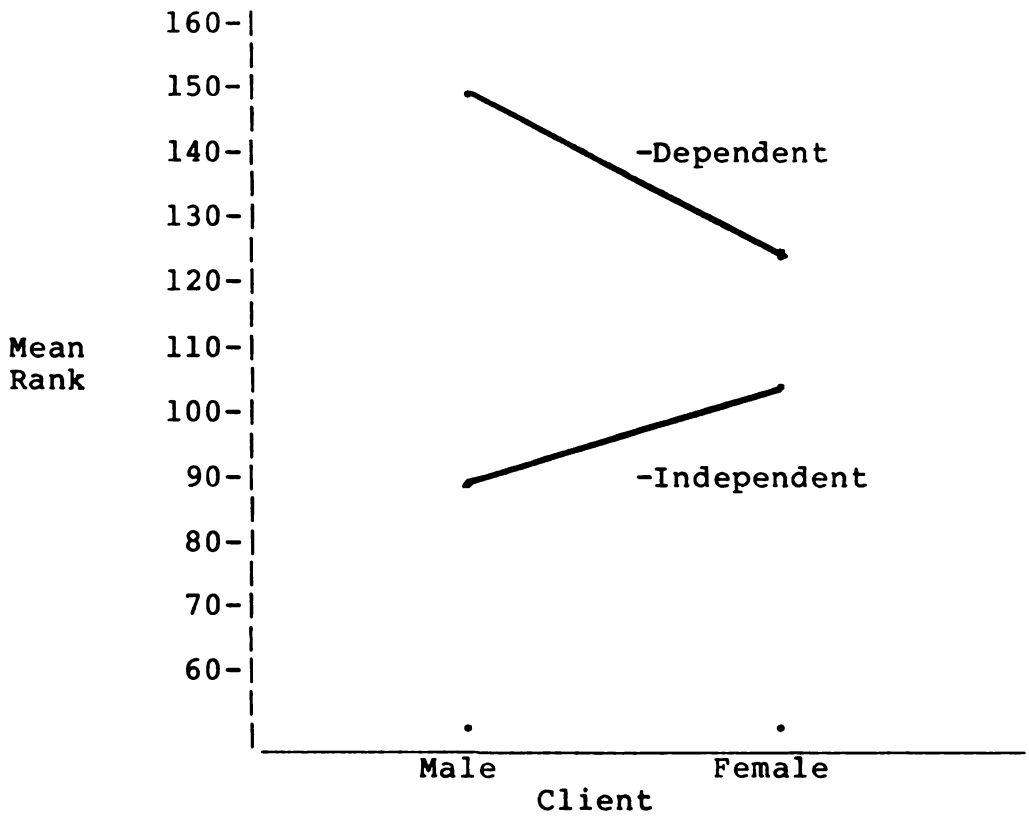

Figure 1

Mean Ranks of Maladjustment Vulnerability Scores for Dependent Male, Dependent Female, Independent Male and Independent Female

than the independent male. This hypothesis was not supported using the same test, $z = -1.26$, $p = .103$ (see Table 11). Responses of subjects revealed no significant difference in maladjustment vulnerability ascribed to the independent male and the independent female.

Other Hypotheses

Hypothesis III stated that psychotherapists would view the dependent male as more vulnerable to maladjustment than the independent male. The data supports this hypothesis, $z = 4.90$, $p = .0001$ (see Table 12). Subjects viewed the dependent male as significantly more vulnerable to maladjustment than the independent male.

Hypothesis IV stated that psychotherapists would view the dependent female as more vulnerable to maladjustment than the independent female. This hypothesis was not supported by the data, $z = 1.62$, $p = .052$ (see Table 13). Responses of subjects revealed no significant difference in maladjustment vulnerability ascribed to the dependent female and independent female.

The null hypothesis of no difference between the levels of each demographic variable was tested using two-tailed non-parametric tests. No differences were found in psychotherapists' maladjustment vulnerability ratings due to therapists' sex, $z = .424$, $p = .671$ (see Table 14). Similarly, no differences were found due to therapists' profession, $z = -.185$, $p = .853$ (see Table 15). There were

Table 11

Mann-Whitney U Test for Maladjustment Vulnerability Scores in Independent Male and Independent Female Vignette Situations

Vignette	Number	Mean Rank	z	p
Independent Male	54	54.72		
Independent Female	63	62.67		
Independent Male vs. Independent Female	117		-1.26	.103*

* one-tailed

Table 12

Mann-Whitney U Test for Maladjustment Vulnerability Scores in Dependent Male and Independent Male Vignette Situations

Vignette	Number	Mean Rank	z	p
Dependent Male	57	70.57		
Independent Male	54	40.62		
Dependent Male vs. Independent Male	111		4.90	.0001*

* one-tailed

Table 13

Mann-Whitney U Test for Maladjustment Vulnerability Scores in Dependent Female and Independent Female Vignette Situations

Vignette	Number	Mean Rank	z	p
Dependent Female	57	65.93		
Independent Female	63	55.60		
Dependent Female vs. Independent Female	120		1.62	.052*

* one-tailed

Table 14

Mann-Whitney U Test for Maladjustment Vulnerability Scores of Male and Female Psychotherapists

Psychotherapist Sex	Number	Mean Rank	z	p
Male	123	117.75		
Female	108	114.01		
Male vs. Female	231		.421	.671*

* two-tailed

Table 15

Mann-Whitney U Test for Maladjustment Vulnerability Scores of Social Workers and Psychologists

Profession	Number	Mean Rank	z	p
Social Work	106	116.88		
Psychology	125	115.25		
Social Work vs. Psychology	231		-.182	.853*

* two-tailed

Table 16

Mann-Whitney U Test for Maladjustment Vulnerability Scores by Psychotherapist Activity in Conducting Psychotherapy

Psychotherapist Activity	Number	Mean Rank	z	p
Active	193	116.41		
Inactive	38	110.89		
Active vs. Inactive	231		.467	.640*

* two-tailed

no differences in vulnerability to maladjustment scores between psychotherapists who were active in conducting psychotherapy and those who were not, z = .467, p = .640 (see Table 16). These null hypotheses were tested using the Mann-Whitney U test.

The Kruskal-Wallis One-Way Analysis of Variance by Ranks test was used to test the null hypothesis of no relationship between psychotherapists' vulnerability to maladjustment ratings and psychotherapists' theoretical orientation. No effect was found between theoretical orientation and maladjustment vulnerability ratings, χ^2 (7, N = 231) = 9.40, p = .310 (see Table 17). Similarly, the same test was used to test the null hypothesis of no relationship between maladjustment vulnerability scores and psychotherapists who differed in their primary clients. No difference was found in psychotherapists' ratings between psychotherapists who worked with predominantly adults, children or both, χ^2 (2, N = 231) = 1.03, p = .598 (see Table 18).

The Spearman Rank Correlation Coefficient was calculated to determine the degree of association between psychotherapists' maladjustment vulnerability scores and the variables of psychotherapist age, years of experience and hours conducting therapy per week. The calculated coefficient, r_s, was then tested for significance against the null hypothesis of no relationship between maladjustment vulnerability scores and each variable. A summary of the

Table 17

Kruskal-Wallis One Way Analysis of Variance by Ranks Test for Maladjustment Vulnerability Scores by Psychotherapist Theoretical Orientation

Theoretical Orientation	Number	Mean Rank	χ^2	p
Analytic	40	131.32		
Neoanalytic	19	124.89		
Transactional Analysis	3	124.67		
Gestalt	1	115.0		
Rogerian	1	5.0		
Cognitive-Behavioral	19	93.79		
Behavioral	7	88.61		
Eclectic	123	114.94		
Other	18	122.11		
Total	231		9.40	.310

Table 18

Kruskal-Wallis One Way Analysis of Variance by Ranks Test for Maladjustment Vulnerability Scores by Psychotherapist Primary Clients

Primary Clients	Number	Mean Rank	χ^2	p
Adults	170	113.46		
Children	46	121.53		
Both Adults and Children	15	127.80		
Total	231		1.03	.598

Table 19

Spearman Rank Correlation Coefficient (r_s) for Maladjustment Vulnerability Scores by Psychotherapist Age, Years of Experience and Hours per Week of Psychotherapy

Variable	Number	r_s	p
Age	231	.181	.003
Years Experience	231	.246	.001
Hours per Week of Psychotherapy	231	.102	.061

tests is presented in Table 19. The null hypothesis was rejected for psychotherapist age and years of experience. Psychotherapists' ratings of maladjustment vulnerability were positively and significantly associated with psychotherapist age (r_s = .181, p = .003) and psychotherapist years of experience (r_s = .246, p = .001). The null hypothesis was retained with respect to the average number of hours of therapy per week. No association was found between psychotherapists' ratings of maladjustment vulnerability and the average number of hours per week spent conducting psychotherapy (r_s = .102, p = .061).

Summary of Findings

Consistent with the expectation that psychotherapists would invoke sex role stereotypes when assessing vulnerability to maladjustment in a client, psychotherapists did view the dependent male as more vulnerable to maladjustment than the dependent female. Contrary to expectations, they did not view the independent female as more vulnerable to maladjustment than the independent male. While the dependent male was viewed as more vulnerable to maladjustment than the independent male, the dependent female was not viewed as more vulnerable to maladjustment than the independent female (although results in the direction of the hypothesis nearly reached significance, p = .052). Psychotherapist sex, profession, theoretical orientation, activity, primary clients and hours of therapy

per week were not related to maladjustment vulnerability scores while psychotherapist age and years of experience were related. Specifically, older therapists and therapists with more years of experience gave higher scores.

CHAPTER V

DISCUSSION

During the 1970's there was a tremendous research emphasis on the sex role stereotyping of clients by psychotherapists. The Womens Movement and the landmark research by Broverman et al. (1970) precipitated a controversial but healthy movement toward the examination of the feelings, attitudes and preconceived beliefs of the psychotherapist. This was long overdue. It raised the awareness of psychotherapists to their own belief systems and sensitized the mental health community to paying more attention to the therapist in the therapist-client dyad.

Such an awareness went beyond the traditional psychoanalytical concept of countertransference. The classic viewpoint of countertransference proposed by Freud (1910/1959) restricts countertransference to the unconscious reactions of the psychotherapist to the transference manifestations of the client. That is, the psychotherapist's feelings and attitudes toward a client were thought to be precipitated by the client's behavior and conduct within the psychotherapy relationship. It was then the psychotherapist's job to identify and dispel such reactions to the client.

Such a conceptualization of countertransference seems unacceptably restrictive. It implies that the feelings, attitudes, and beliefs of a psychotherapist toward a client are due to the client's unique pathology and presentation in the therapy relationship. To some extent it relieves the psychotherapist of the responsibility for owning his or her feelings toward a client since these feelings are considered to be more revealing of the client than the psychotherapist. Fortunately, the concept of countertransference has evolved significantly in recent years. Epstein and Feiner (1979), for example, described countertransference as "all of the feelings and attitudes of the therapist toward the patient" (p. 12).

This totalistic notion of countertransference is more appealing because it embraces a more permissive attitude toward the feelings and attitudes of the psychotherapist. Such feelings and attitudes are not considered to be precipitated solely by the client. They also emanate from the psychotherapist who is viewed as a unique individual, a person whose thoughts, feelings, and beliefs were shaped through many life experiences. This definition of countertransference accepts the psychotherapist for what he or she is: a human being.

Since psychotherapists are human, they are products of their culture. Existing research on sex role stereotyping strongly suggests that our culture has had and still has

clear ideas of what attributes and behavior constitute normality for a man and a woman. Long before psychotherapists decide on their career, their culture leaves lasting impressions of what constitutes normality and what does not. During their formative years, children and adolescents are exposed to and adopt many of their cultures's beliefs about males and females. This comes about in both overt and subtle ways through many different influences - religious institutions, the words and conduct of parents, the mass media, teachers, textbooks. Beliefs about what males and females ought to be like and how they are thought to be fundamentally different from each other are internalized quickly by children. Such beliefs are rigid and not easily modifiable.

To say that psychotherapists are always objective and neutral in their clinical judgements is to deny their humanity. It would indeed be surprising to find that psychotherapists are immune to the influences of their culture. Since our culture has adopted the belief that men and women are fundamentally different from each other on many different attributes, it would be expected that psychotherapists would share in such a belief. Much research in the 1970's has provided support for this claim.

Unfortunately, research involving the sex role stereotyping of psychotherapists has declined dramatically in the 1980's. This decline was premature since there have

been few studies which have addressed the sex role stereotypes of psychotherapists faced with a client's actual behavior in therapy. Every psychotherapy committment involves both a dependence on and later an independence from a psychotherapist. Since dependence and attachments toward people are viewed as being congruent with the stereotypic feminine personality while independence and separations from people are viewed as being congruent with the stereotypic masculine personality, it could be expected that the clinical judgements of psychotherapists would be influenced by client behavior, depending on whether or not such behavior conformed to or deviated from the behavior expected given the client's sex. The current study was designed to address this. It is hoped that this research will encourage further examination of the most neglected individual in the therapeutic dyad - the psychotherapist.

In the balance of this chapter, the findings of the current research are reviewed and examined in more detail. Limitations of the study are briefly presented and implications of the findings for further research and for clinical training and practice are discussed.

Review of Findings

Hypothesis I stated that psychotherapists would view the dependent male client as more vulnerable to maladjustment than the dependent female. The findings support this hypothesis. Psychotherapists in the current study did view the dependent male as more vulnerable to maladjustment than the dependent female. This finding is in agreement with the findings of other research (Thomas & Stewart, 1971; Miller, 1974; Tribich, 1977) which supported the general hypothesis that psychotherapists are more likely to assess a person as maladjusted if his or her behavior or attributes deviate from the expected sex role stereotype. The positive support for hypothesis I suggests that psychotherapists were more harsh in their judgement of the male client that the female client, presumably because the dependent behavior attributed to the client was viewed as more incongruent with the male stereotype than the female stereotype. If this explanation accounts for the finding, it can be said that stereotyping by psychotherapists continues. That is, psychotherapists may indeed continue to view the healthy or typical female as being more dependent than the healthy or typical male simply because she is female. It also suggests that the strong prohibition against males behaving in a dependent manner continues to exist for this sample of psychotherapists.

Hypothesis II was analogous to hypothesis I. If it was

expected that psychotherapists would view the dependent male as more vulnerable to maladjustment than the dependent female because of the incongruence of dependence with "maleness", it could also be expected that psychotherapists would view the independent female as being more vulnerable to maladjustment than the independent male because of the incongruence of independence with "femaleness". This was hypothesis II. Contrary to expectation, the findings did not support this hypotheses. There are several possible explanations for this. Perhaps psychotherapists no longer view independence as incompatible with the female stereotype. Indeed, during the past 15 years much has occurred to erode the traditional prohibition against independence for women. The Womens Movement raised the public's awareness to the unequal way in which males and females were viewed. It actively encouraged women to demonstrate their independence and strength. The institution of affirmative action policies opened the door wider for women to be placed in occupations and training programs where their self-sufficiency and ability to rely on their own resources were demonstrated. In addition, the independence of women is modeled everywhere today in the person of the working woman. Although an inequity still exists in the way men and women are viewed and treated at the workplace, women are rising to top levels at their places of employment, assuming more and more responsibility.

It is conceivable that psychotherapists, influenced by these dramatic changes, now view independence as more permissible for the female than it once was. Considering hypotheses I and II together, the findings suggest that it may be more permissible for a female to be independent than it is for a male to be dependent. This makes sense when one considers that there was no corresponding social movement which encouraged dependent behavior in males to be viewed as acceptable. Instead, the focus was entirely on encouraging independence in females to be viewed as acceptable.

This changing role of women may be one reason why psychotherapists did not view the independent female as more vulnerable to maladjustment than the independent male. Stated differently, independence, separating from others and using one's own resources may be more congruent with the feminine personality than it once was. If this is so, a female's independent behavior may not represent as much of a deviation from the behavior expected as it once did. Therefore, less vulnerability to maladjustment would be attributed to her. Inspection of the data reveals another possible reason why psychotherapists failed to attribute more maladjustment vulnerability to the independent female than to the independent male. This reason will be discussed after the findings of hypotheses III and IV are briefly presented.

It was anticipated that psychotherapists would assess

the dependent client as more vulnerable to maladjustment than the independent client and that this would hold true for both male and female clients. Hypothesis III was supported by the findings. That is, the dependent male was viewed as more vulnerable to maladjustment than the independent male. Hypothesis IV was not supported by the findings. The dependent female was not viewed as more vulnerable to maladjustment than the independent female. It should be noted, however, that the statisical test employed to test hypotheses IV resulted in $p = .051$, very close to the .05 level of significance necessary to give support to the hypothesis. Taken together, these findings suggest that when psychotherapists make a determination of client maladjustment on the basis of degree of dependency, client dependence or independence may be more salient in that determination if the client is male than if the client is female. It could be that for psychotherapists the stereotype for females is less polarized on the dimension of dependence/independence than it once was while for males the stereotype remains sharply polarized. When making a judgement on the vulnerability of a client to maladjustment, psychotherapists may attend more to the male whose behavior violates the traditional stereotype than to the female whose behavior violates the traditional stereotype.

Let us now return to hypothesis II which unexpectedly showed that psychotherapists did not view the independent

female as more vulnerable to maladjustment than the independent male. It was mentioned that another possible reason exists for this finding. Inspection of raw data revealed much variability in both the maladjustment scores and the degree of dependence scores of psychotherapists who received the independent vignette. In contrast, comparatively little variability was noted in the maladjustment vulnerability scores and degree of dependence scores of psychotherapists who received the dependent vignette. Even though psychotherapists in general viewed the independent client as significantly different from the dependent client on the dependence/independence dimension (see Table 9), it seems that many psychotherapists viewed the independent client as dependent. This was not anticipated. Possible reasons for this are now discussed.

It was anticipated that psychotherapists would attend to the client's dependent or independent behavior with the therapist as described in the vignette and use that information in order to make a judgement of the client's vulnerability to maladjustment. It was expected that this would be the most salient stimulus in the vignette. However, it could be that some psychotherapists made their judgements on the basis of the nature of the client's presenting problem. Since the vignette described the client as having some trouble coping with the loss of an opposite-sex friend, this may have suggested "dependence",

even in the independent vignette situation. It is possible that some psychotherapists attended more to this than was expected.

There is another reason why psychotherapists may have viewed the client in the independent vignette as dependent. Psychotherapists may have simply read too much into the vignette, attemping to see what was not there. Although the independent vignette represented the experimenter's best attempt at presenting a client who valued independence and relying on his or her own resources, some psychotherapists may have tried to project dependence onto the independent client. It was interesting to note that four subjects, all of whom received the independent female vignette, made comments near the question which asked them to rate the client on the degree of dependency. All suggested, in essence, that although at first glance the client appeared independent, she was in reality dependent. Two of these four described her as "counterphobic", a term denoting the deliberate seeking out of anxiety producing situations (Cameron, 1963). For these psychotherapists, the female client in the independent vignette was actually dependent because she was running toward the very thing she feared, namely independence. It may not be coincidental that no such unsolicited comments were made by psychotherapists receiving the independent male vignette.

Since some psychotherapists apparently did view the

client in the independent vignette as dependent, it was possible that the maladjustment vulnerability scores for the independent males could have been increased relative to the malajustment vulnerability scores for the independent females since, as hypothesis I suggested, dependent males were more harshly judged than dependent females. Thus, the hypothesized differences between the independent male and the independent female may have been obscured due to the fact that the scores of psychotherapists who viewed the independent client as dependent may have been more inflated for the male than the female client. This inflation may have offset the expected effect of the stereotype.

It was appropriate, then, to try to determine if only those psychotherapists who viewed the independent client as independent differed in the maladjustment vulnerability ascribed to the independent male and the independent female. Of the 54 psychotherapists responding to the independent male vignette, 37 rated the client as independent (a score of one to three on the scale assessing degree of dependency). Of the 63 psychotherapists responding to the independent female vignette, 40 rated the client as independent. A one-tailed Mann-Whitney U test was performed on these scores. Again, a .05 level of significance was required in order to support they hypothesis that the independent female would be viewed as more vulnerable to maladjustment than the independent male. Results did not

support the hypothesis (z = 1.40, p = .081). When only the scores of psychotherapists who viewed the independent client as independent were used, no difference was found in maladjustment vulnerability ascribed to the independent male and the independent female.

The purpose behind the independent vignette was to present client independence in a way that psychotherapists would respond to that independence as a stimulus. The validity of the findings are in jeopardy if psychotherapists responded to other factors. One such factor - the possibility that the independent client was instead viewed as dependent - was discussed. There is evidence that the scores of psychotherapists who viewed the independent client as dependent appear not to have biased the original findings. It is possible that psychotherapists responded to other vignette stimuli. One possible stimulus may have been the manner in which the client initiated psychotherapy termination. This seems unlikely, however, since the client was described as being able to be dependent, in a healthy manner, on the therapist (as all clients must), and, after improving, initiating separation. The manner in which the client requested termination of psychotherapy was not considered by the experimenter or his consultants to be evidence in any way for maladjustment. Indeed, clients often leave therapy in this manner and do so appropriately. Even if psychotherapists viewed the client's way of

separating from the therapist as aberant, it would be expected that they would view the female as more vulnerable to maladjustment than the male since separating is more congruent with the stereotypic masculine personality.

In summary, it is unlikely that psychotherapists attended to the manner in which the client initiated the termination of therapy. Furthermore, the scores of psychotherapists who viewed the independent client as dependent appear not to have biased the original finding. Taken together, this discussion is evidence for the validity of the original finding. It may be that psychotherapists are more willing to view independence as congruent with the feminine personality. Perhaps this aspect of the stereotype has changed.

These findings can be discussed in terms of Gilligan's (1982) developmental theory. She discusses developmental perspectives of each sex and suggests that as they merge into adulthood, members of each sex see the limitations of their developmental path and consider more seriously the developmental path of the opposite sex. The current findings suggest that psychotherapists may allow this "crossing-over" for women but not for men.

Regarding psychotherapists' demographic characteristics, the sample of psychotherapists who responded to the study was, in comparisons to other samples, very experienced. With an average age of 46.4 years of age and an average of

13.5 years of clinical experience, this was a fairly seasoned group. The findings suggest that the psychotherapists were very homogeneous in their manner of responding to the task. There were no differences in vulnerability to maladjustment scores due to psychotherapist sex, profession, or theoretical orientation. Similarly, psychotherapists who were currently active conducting psychotherapy did not differ from inactive psychotherapists in the way they assessed the clients. No difference was found in the response of psychotherapists on the basis of their primary client or the number of hours of therapy conducted per week. There was a significant effect for both age of the psychotherapist and years of experience. Specifically, older and more experienced psychotherapists rated the client as more vulnerable to maladjustment than younger and less experienced psychotherapists. This trend has been observed in other studies (Murray & Abramson, 1983). One possible explanation is that as therapists get older and acquire more experience, they are not as idealistic and become a bit more pessimistic in their assessments. It should be noted that since age and years of experience are highly correlated with each other, they may not represent two distinct factors. It is probable that years of experience was more salient than age in terms of psychotherapists' assessments. Psychotherapist age, then, was significantly related to psychotherapists assessments by

virtue of the fact that psychotherapists with more years of experience are likely to be older than psychotherapists with fewer years of experience.

Although there was a statistically significant relationship between psychotherapists' vulnerability to maladjustment scores and both age and years of experience of the psychotherapist, inspection of the actual correlation coefficients reveals very weak relationships (r_s = .181 and r_s = .246, respectively). It is likely, therefore, that the clinical judgements of psychotherapists had less to do with the age and years of experience of the psychotherapists than with other factors, presumably psychotherapists' sex role stereotypes as invoked by the stimuli in the vignette, the sex and behavior of the client.

Limitations of the Study

The findings of this study are to be considered in the light of the limitations of the study. There are several limitations which are noteworthy. First, the questionnaire used in the research was an unproved instrument. However, it is thought to possess good validity and reliability. Second, the validity of the findings is affected by the rate of psychotherapist compliance. Nearly 60% of psychotherapists responded with usable questionnaires. While this is considered a good response rate, it is

possible that respondents differed from non-respondents in some way. To the extent that this is true, the findings of the study are more tenuous. However, since psychotherapists who did respond were very homogeneous in their responses, it is anticipated that non-respondents did not differ from respondents in a way affecting the final findings. Third, to the extent that the findings are generalizable, such generalization can only apply to Michigan psychotherapists who are members of the clinical divisions of the National Association of Social Workers and the Michigan Psychological Association. Fourth, there is a possibility that the independent vignette may not have represented independence to a degree which was salient enough to elicit stereotypic responding.

Implications for Research

The findings of the present study imply that the apparent decrease of interest in investigating sex role stereotyping during the past several years was premature. There is evidence that stereotyping continues. It behooves researchers, therefore, to pay more attention to it. Although the current study suggested that psychotherapists assessed the dependent male more negatively than the dependent female, further research is needed in order to determine if psychotherapists' clinical decisions and

behavior are affected by these assessments.

There is much variability in the degree to which people are tolerant of attachments to and affiliations with other people (including psychotherapists). On one extreme end of the continuum is a certain clinginess, a desire for intense closeness and union. On the other end of the continuum is intentional avoidance, a desire to be as removed from and uninvolved with people as possible. While the two vignettes in this study did not represent these extremes, the independent vignette was further removed from its extreme than was the dependent vignette from its extreme. Perhaps further research could determine if a client's more overt desire to be detached from and uninvolved with a psychotherapist would be more powerful in invoking sex role stereotyping on the part of psychotherapists. The female may be judged as more vulnerable to maladjustment than the male when her behavior more blatantly violates the traditional stereotype.

The advantage of clinical analogue methodology lies in its ability to control extraneous client variables which also may affect the clinical judgements of psychotherapists. There are so many client variables in actual therapy settings that to say a particular clinical judgement was made on the basis of the client's sex would be difficult to defend. Although the clinical analogue study has been criticized for its lack of external validity, it is felt

that it remains a viable research tool and, as such, should not be abandoned.

The present study was conducted with the assumption that psychotherapists have been influenced by their culture. Because of that influence, it was assumed that they are prone to view males and females differently in regards to attributes and behavior such as dependence/independence which are traditionally sex role linked. While it is assumed that all psychotherapists are influenced by their culture in this global manner, it is also true that psychotherapists all have different life histories. Our experiences in childhood and adulthood are all different. Therefore, it seems vital to pay attention not only to the influences of our culture, but also to the unique life experiences of psychotherapists. The more general notion of countertransference mentioned earlier accepts the uniqueness of each psychotherapist. It would be well for researchers to consider the countertransference paradigm recommended by Davidson (1983). She states that the notion of sex bias is "incapable of moving beyond the surface structure of overt social attitudes to the less accessible level of covert deep structures inherent in the reciprocal exchange between patient and therapist" (p. 179). In contrast, Davidson feels that countertransference takes into account the therapist's own personal history and personal dynamics. Such an approach would attempt to relate sex role

stereotyping on the part of a psychotherapist to the therapist's own personal history and life experiences as well as to his or her culture.

Implications for Clinical Training and Practice

Since the present study suggests that psychotherapists are likely to be more harsh in their assessments of a male who is behaving in a dependent manner, psychotherapists will need to evaluate their own biases. This study concerned itself only with clinical assessment. However, it seems logical to assume that the assessments psychotherapists make about clients intimately affect their conduct and decision making with clients. Psychotherapists could respond clinically to a "dependent" male in many different ways depending on the uniqueness of each psychotherapist. Some of these responses could be untherapeutic and counterproductive. For example, a psychotherapist, alarmed by such a client, may feel the client is incapable of assuming responsibility for himself or herself and may make recommendations (such as hospitalization, for example) which may further undermine the client's self esteem. Another psychotherapist may simply abhor the client's behavior because it violates his or her own notion of "maleness" and consequently, may terminate therapy prematurely. The possible reactions are endless. The obvious implication is

that psychotherapists in clinical practice need to know themselves. They need to be open to examining how they are impacted on an affective and cognitive level by clients. A willingness to examine those feelings and thoughts in the light of their own biases is a necessary trait in effective psychotherapists.

Since sex role stereotyping is rooted in one's experience with society as well as one's unique past history, it is important for clinical supervisors and graduate programs to challenge psychotherapist-trainees to examine their beliefs about men and women. It seems that too many graduate psychology programs emphasize knowledge acquisition at the expense of healthy introspection and self-examination. Graduate programs designed to train future psychotherapists would do well to pay more attention to the unique beliefs that students have about men and women. Students should be challenged to examine both the origins of such beliefs and how these beliefs could be expected to affect their work with clients. This kind of emphasis during a student's training not only benefits clients but it also shapes psychotherapists who view self-examination as absolutely essential to the helping process.

APPENDICES

Appendix A

Cover Letter

MICHIGAN STATE UNIVERSITY

COLLEGE OF EDUCATION • SCHOOL OF HEALTH EDUCATION,
COUNSELING PSYCHOLOGY AND HUMAN PERFORMANCE •
513 ERICKSON HALL

EAST LANSING • MICHIGAN • 48824-1034

June 7, 1986

We would very much appreciate your help with a study we are conducting involving client assessment. The true nature of the study cannot be revealed at this time but deals generally with variables affecting client vulnerability to maladjustment. In order to do this, we are dependent on psychotherapists like yourself answering a very brief questionnaire.

Enclosed is a brief description of a client and the client's treatment. Please read the description and the instructions to the questionnaire. Using your clinical expertise and intuition, please answer all questions and return the questionnaire in the stamped envelope provided.

Please be assured that your responses will be confidential as there is no way of identifying you from your responses. A full explanation of the nature and results of this study will be mailed to each person receiving the questionnaire as soon as those results are available.

This is an important project for us and we anticipate that what we learn will help therapists and clients alike. Your participation is voluntary and you may withdraw your participation at any point. Of course, a very high rate of compliance is vital with studies of this nature. This exercise will take only 10 to 15 minutes of your time. We hope you can give your most serious attention to this brief exercise.

Thank you in advance for your cooperation with this very important research.

Sincerely,

Richard Johnson, Ph.D.
Professor
School of Health Education, Counseling Psychology and Human Performance

Randall Wolthuis, Ph.D. cand.
School of Health Education, Counseling Psychology and Human Performance

Appendix B1

Dependent Vignette

Carol is a 20-year-old undergraduate student who was referred to counseling by a classmate. One month prior to Carol's seeking help, her boyfriend whom she had been seeing regularly for a few months told her he wanted to break up with her. At the intake interview, Carol complained of severe depression with a lack of energy and initiative. She appeared anxious and visibly distraught. She acknowledged difficulty getting to sleep and a recent inability to concentrate. She appeared depressed and tired. Carol stated that she had missed several classes recently.

A course of psychotherapy was recommended to Carol by her therapist and that therapy focused on Carol's adjustment to the loss of her boyfriend. Carol agreed with the plan of treatment but felt she needed to be seen in therapy more than once per week as her therapist had suggested. She felt that once a week sessions would not be enough and said to her therapist, "I think I need to talk to you alot right now."

Carol's approach to therapy can best be described as eager. She seemed to enjoy her time with her therapist. She talked about how good it felt to, in her words, "lean on someone who cares". Carol was able to talk about her feelings she had about losing her boyfriend as well as feelings about a rejecting and critical parent. After 12 weekly psychotherapy sessions Carol began to show improvement. Her energy level increased and her sleep patterns returned to normal. She was attending classes again. During the course of therapy, Carol often expressed her appreciation of her therapist, noting at times, "I don't know what I would have done if you were not here to lean on."

After approximately five months of therapy Carol and her therapist reviewed the treatment goals. Carol's therapist felt that Carol was ready to end treatment and although Carol agreed that the original treatment goals had been reached, she talked about her hesitance to stop therapy. She said she was afraid to, in her words, "go it alone". Carol and her therapist discussed this and her therapist asked Carol how she felt continued therapy would benefit her. Carol replied, "I'm not sure...I just don't think I'm ready to stop yet." Carol and her therapist were able to discuss further Carol's apprehension and together they

agreed on a therapy termination date. As that date approached, Carol made a few phone calls to her therapist, at times requesting special appointments. She acknowledged an increase in anxiety. One week before therapy was to end, Carol said, "I don't think I'm ready to stop coming here. I just don't think I can cope well enough right now. You have helped me so much. It seems like you are the only one who seems to know how to help me." She asked for therapy to continue.

Appendix B2

Independent Vignette

Carl is a 20-year-old undergraduate who was referred to counseling by a classmate. One month prior to Carl's seeking help, his girlfriend whom he had been seeing regularly for a few months told him she wanted to break up with him. At the intake interview, Carl complained of severe depression with a lack of energy and initiative. He appeared anxious and visibly distraught. He acknowledged difficulty getting to sleep and a recent inability to concentrate. He appeared depressed and tired. He also stated that he had missed several classes recently.

A course of psychotherapy was recommended to Carl by his therapist and that therapy focused on Carl's adjustment to the loss of his girlfriend. Carl agreed with the plan of treatment which included weekly therapy appointments. He acknowledged that seeking help was difficult for him and noted, "I've always solved my own problems." He wondered if weekly therapy sessions were therapy. He expressed regret about not being able to help himself but admitted, "I can't go on like this anymore."

At first, Carl was tentative in his therapy sessions. He acknowledged that he was accustomed to, in his words, "working out my own problems by myself". He was able, however, to form a working relationship with his therapist. He talked about the feelings he had about losing his girlfriend as well as feelings about a rejecting and critical parent. After 12 weekly psychotherapy sessions Carl began to feel better. His energy level increased and he was again sleeping normally. He was attending classes again. Almost as soon as he began to feel better, Carl began to talk about ending therapy. He said he felt he had benefitted greatly from the counseling and had weighed carefully the option of continuing therapy. However, Carl said he felt better and saw no need to continue in treatment. Carl's therapist noted that Carl had arrived a bit late for the last two appointments and had less to say in his therapy sessions.

Although Carl's therapist would ideally have liked Carl to continue in therapy a bit longer, extending therapy was not viewed as absolutely necessary. Carl's resolve to end therapy was strong and his therapist, sensing that resolve, agreed to end treatment. Carl expressed appreciation to his

therapist for the help he received. He also said he was glad to be ending therapy, stating that he was anxious to, in his words, "prove to myself that I can get along by myself."

Appendix C

Instruction Sheet

Most psychotherapists view a client's behavior as having its origin from two sources:

1. A client's maladjustment or impaired functioning may be a reaction to certain stressors or current events. An Adjustment Disorder diagnosis on Axis I or the DSM-III would be an example.

2. The client's maladjustment or impaired functioning may be indicative of and arising from the client's basic level of personality adjustment which, for our purposes here, shall refer to the client's basic character structure or personality style (analogous to Axis II of the DSM-III). This is the extent to which the personality is integrated, a measure of the client's general vulnerability to having problems coping at any time in life, not just in crisis. A client's basic level of adjustment is reflected in her or her ability to adapt to change, relate to others, control impulses and be relatively free from debilitating symptoms. This basic level of personality adjustments is not generally thought to vary within adult clients over time.

It is possible for some therapists to view a client's maladjustment as well as a client's behavior in therapy as purely a reaction to a clearly identifiable stressor or stressors. If this were true, a therapist would not necessarily view the client as particularly vulnerable to future problems, assuming the current problems are resolved. However, some therapists may view a client's maladjustment and behavior in therapy to arise not only from the client's recent stress but also from deficits in the client's basic character structure/personality style. If this were true, one would possibly view the client as much more likely to be vulnerable to future maladjustment.

We have found that therapists are able to make reliable and consistent judgements and inferences about a client's general vulnerability to maladjustment and impaired functioning. You have just read about this client and have formed impressions. We understand that only a limited amount of information is available to you in this client and therapy description. However, based on your perception of this client's general vulnerability to symptoms and impaired

functioning, please answer the following questions using all client information given to you as well as your own clinical intuition. The questions are not asking for your perception of the client's current clinical condition. Instead, we are asking you to determine the extent to which you think this client is vulnerable in general to maladjustment. For example, question #2 is not asking if you think this client is depressed now. It is asking if you think the client is in general vulnerable to depression.

Appendix D

Maladjustment Assessment Questionnaire

Please answer all questions by circling one of the following responses:

SA Strongly Agree
MA Moderately Agree
SLA Slightly Agree
N Neutral
SLD Slightly Disagree
MD Moderately Disagree
SD Strongly Disagree

1. This client is likely to experience psychological problems and impairment in functioning later in life.

   SA MA SLA N SLD MD SD

2. This client is likely to be vulnerable to depression.

   SA MA SLA N SLD MD SD

3. This client is not vulnerable to problems which would require treatment again later in life.

   SA MA SLA N SLD MD SD

4. This client is vulnerable to periods of low energy levels.

   SA MA SLA N SLD MD SD

5. This client is vulnerable to having suicidal thoughts.

   SA MA SLA N SLD MD SD

6. This client is not vulnerable to feelings of inadequacy.

   SA MA SLA N SLD MD SD

7. This client is likely to experience impaired relationships with others.

   SA MA SLA N SLD MD SD

8. This client is not likely to be vulnerable to feelings of hopelessness.

   SA MA SLA N SLD MD SD

SA Strongly Agree
MA Moderately Agree
SLA Slightly Agree
N Neutral
SLD Slightly Disagree
MD Moderately Disagree
SD Strongly Disagree

9. This client is vulnerable to experiencing feelings of alienation and loneliness.

SA MA SLA N SLD MD SD

10. This client will not likely be in need of some form of psychotherapy again later in life.

SA MA SLA N SLD MD SD

11. This client is likely to have a tendency toward being pessimistic about the future.

SA MA SLA N SLD MD SD

12. This client is not vulnerable to experiencing periods of nervousness and tensions.

SA MA SLA N SLD MD SD

13. This client is vulnerable to feelings of despair.

SA MA SLA N SLD MD SD

14. This client is vulnerable to experiencing anxiety.

SA MA SLA N SLD MD SD

15. This client is not likely to be vulnerable to feelings of helplessness.

SA MA SLA N SLD MD SD

16. This client is likely to cope with stress satisfactorily.

SA MA SLA N SLD MD SD

17. This client is likely to cope with change adequately.

SA MA SLA N SLD MD SD

18. This client is vulnerable to experiencing mood swings and affective lability.

SA MA SLA N SLD MD SD

SA Strongly Agree
MA Moderately Agree
SLA Slightly Agree
N Neutral
SLD Slightly Disagree
MD Moderately Disagree
SD Strongly Disagree

19. This client is likely to worry excessively

SA MA SLA N SLD MD SD

20. This client is likely to have experienced psychological problems and maladjustment in the past.

SA MA SLA N SLD MD SD

(please turn to next page)

The following information about yourself is needed in order to compare your responses to therapists similar to you. Please provide the following information and place the questionnaire in the envelope provided.

1. Your profession (check one):
   __Social Work
   __Psychiatry
   __Psychology
   __Other, please specify: _____

2. Number of years of counseling and/or psychotherapy experience (please round off to nearest year):_____

3. Your sex:
   __Male
   __Female

4. Your age:_____

5. Your theoretical orientation (please check only one):
   __Mainly Analytic
   __Mainly Neoanalytic
   __Mainly Transactional Analysis
   __Mainly Gestalt
   __Mainly Rogerian
   __Mainly Behavioral
   __Mainly Cognitive Behavioral
   __Eclectic
   __Other, please specify: _____

6. Are you currently conducting therapy?
   __Yes
   __No

7. Looking at only the personality trait of dependency, on the following continuum please rate the degree to which you view this particular client as dependent. We realize that more information about this client would make such a determination easier. However, please give your best inference:

   Very dependent 7 6 5 4 3 2 1 Very independent

8. Do you work primarily with adults or children?

   __Adults
   __Children

9. Please provide the average number of hours per week you spend conducting therapy: _____

Thank you very much for your help! Please place the questionnaire in the envelope and mail it at your earliest convenience.

Appendix E

Post Cards

Dear Colleague,

Just a reminder! If you have already mailed your completed Maladjustment Assessment Questionnaire which we sent to you recently, thank you very much. Be assured, your responses will be very useful.

If you have not found time yet, at your earliest convenience, please fill out the questionnaire and mail it to us. This is very important to us and your response will be very useful. Thank you in advance!

Sincerely,

Dear Colleague,

Just another friendly reminder. We have no way of knowing if you have filled out and mailed the Maladjustment Assessment Questionnaire we recently sent to you. If you have, great! We really appreciate your concern for what we are doing.

If you have not, we urge you to do so. We are very dependent on your responses which will be useful to both our clients and therapists. Please respond as soon as possible. Thanks again in advance.

Sincerely,

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