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By

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ABSTRACT

GENDER ROLE BIAS IN FAMILY ASSESSMENT

By

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A literature review of feminists' contributions to the reevaluation of the traditional model of the nuclear family unit is presented, followed by a review of the assessment phase in the practice of family therapy. In discussing available literature on biases in clinical judgment, empirical investigations of sex role stereotyping in the assessment of individual clients are questioned in terms of their generalizability to the assessment of family members and their corresponding intrafamilial relationships. The concept of gender role bias (as opposed to sex role stereotyping) is formulated through a focus on the gender-typed roles and gender-typed intrafamilial relationships posited in the traditional model of the nuclear family unit.

As a result of the literature review, a major concern focused on the possible distorted perception of the individual family member(s) and the corresponding family relationships if an adjustment notion of health in regard to family relationships reflected only an acceptance of societal gender role expectations as defined in the traditional model of the nuclear family unit. The primary focus of this study is to investigate the possible influence of gender role bias in the assessment of family members and their corresponding

intrafamilial relationships. It was determined that it was necessary to first examine whether the relational context of the family unit influenced the clinical judgment of family members and family relationships.

Two versions of the same family case analogue depicting a traditional three-member nuclear family unit (father, mother, child) and varying only with the sex of the child was developed. To generate the two counterpart versions of the same family case analogue, the sex of the two parent profiles were reversed (role-reversal). The resulting four case versions were randomly distributed to a sample of graduate social work students (N = 91) as a stimulus condition in the form of a structured task. For each family member, subjects completed items designed to elicit clinical impression and items designed to elicit technique choices. The clinical impression items were summed and a mean clinical impression score for each family member was computed. Subjects also completed items designed to elicit clinical impression of the parent-child relationships and the overall prognosis for family therapy. In addition, subjects ranked five problem areas for each family member and the marital relationship. Finally, subjects completed an "orientation toward women" scale, yielding a contemporary-traditional ratio score.

For each family member, the mean clinical impression scores, each technique item, and each of the family relationship items (parent-child and overall prognosis) were analyzed using a 2^3 between subjects analysis of co-variance. The main effects tested were

relational context and sex of respondent, and the covariate in these analyses was the subject's orientation toward women as reflected in the C-T ratio score. Chi-square (X^2) tests for independence of the distributions between the frequency a problem area is identified as being the most problematic and case version were conducted for each family member and the marital relationship. In addition, the ranking distributions of each problem area for each family member and the marital relationship were examined.

The results presented in this study strongly suggest that relational context influences clinical impressions and judgments of family members and their corresponding intrafamilial relationships. Significant differences between male and female respondents also suggest that relational context and sex of the clinician may influence the assessment of the parent, the child, and the corresponding mother-child relationship. Further, there is some indication that family members and family relationships which conform to the traditional model of the nuclear family unit elicit more favorable clinical impressions and judgment. This is particularly the case for the clinical impressions of the mother-child relationship, the assessment of which was found to be significantly related to the respondent's orientation toward women. These preliminary results indicate the utility of further exploring the influence of gender role bias in the assessment of family members and their corresponding intrafamilial relationships.

TO MY "FAMILY"

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Chapter 1

Introduction

Every society has its share of resocialization movements, and each movement seems to generate consequences having a permeating impact on various sub-systems within a particular society. This was the case for both the "hippie movement" and the civil rights movement of the sixties (Agel, 1971). One movement which seems to be evolving as the resocialization movement of the seventies is the "women's liberation" or feminist movement. Like previous movements, feminists have both conducted and generated critical reviews of the behavioral sciences contributing theoretical models and/or frameworks to the practice of clinical assessment and various modalities of therapy (Kohlberg, 1966; Brodsky, 1973; Eastman, 1973; Jakubowski-Spector, 1973; Whitely, 1973; Kirsh, 1974; Beck, 1974; Fodor, 1974; Franks and Burtle, 1974; Gingras-Baker, 1976; Carlock and Martin, 1977). Since the practice of family assessment and therapy relies on a number of disciplines (e.g. social work, psychology, sociology, psychiatry, anthropology, etc.), critical reviews by feminists of those discipline-bound contributions to family assessment and therapy remain scattered throughout the social science literature. The primary focus of these reviews frequently seems to be on sexism in the practice of therapy and on the "traditional" model of women contributing to a biased assessment of the female client.

While feminists differ in regard to specific alternatives to sexism in therapy (de Beauvoir, 1953; Frieden, 1963; Bernard, 1972; Mitchell,

1973; Gingras-Baker, 1976; Romero, 1977), most would agree on a few general underlying assumptions. These general assumptions comprise a feminist perspective utilized in evaluating the "traditional" model of the female life cycle. Central to the feminist perspective is the assumption that social structure, culture, and the individual are integrally related and that some of the sources of women's role conflict and dissatisfaction can be identified and understood in terms of the social structure (Brodsky, 1973; Eastman, 1973; Kirsh, 1974; Gingras-Baker, 1976).

Feminists assert that for a woman in particular, gender role determines to a large degree future roles in life, dictating limitations on the options for development, regardless of intellect, activity level, or physical and emotional capacity (Epstein, 1970; Amundsen, 1971). The role confinement of women according to the traditional model is viewed to be psychologically frustrating and increasingly alarming as epidemiological studies reveal that women complain more of nervousness, impending breakdown, attempts at suicide, and are more frequently the clients of therapy. For these reasons, feminists frequently refer to the "traditional" model of women which is believed to be the predominant model used in assessment and therapy (Haan and Livson, 1973; Miller, 1974; Schwartz, 1974; Task Force Report, 1975; Geek and Ryan, 1975; Alsbrook, 1976; Harris and Lucas, 1976; Romero, 1977).

Feminists' contributions not only have called attention to the misconceptions of the "second" sex, but also to the reevaluation of the "traditional" model of the nuclear family unit (Casler, 1961; Bernard, 1971; Christie, 1970; Tanner, 1970; Weisstein, 1970; Laws, 1971; Millman, 1971; Wortis, 1971; Brogan, 1972; Gove, 1972;

Hochschild, 1973; Franks and Burtle, 1974; Brown and Hellinger, 1975; Rice and Rice, 1977). Closer scrutiny of the traditional model of the nuclear family unit reveals that the female gender role is consistently defined in relation to the male gender role. Further, if one were to expand the traditional model of the nuclear family unit, the end result would be two traditional models of the individual life cycle - one for males and one for females. This can be revealed by reviewing first what feminists usually refer to as the "traditional" model of the nuclear family unit.

According to the traditional model of the family unit, the nuclear family is universally found and can be considered the building block of society (Parsons and Bales, 1953; Birdwhistell, 1970; Laws, 1971; Skolnick and Skolnick, 1971; Peal, 1975). This model of the nuclear family is based on a clear-cut, biologically structured division of labor between men and women (Skolnick and Skolnick, 1971), and implicit in the model is the notion that both sexes should become experts in their respective domains (Birdwhistell, 1970). A major function of the family is perceived to be the socialization of children; that is, to tame their impulses and instill values, skills, and desires necessary to run society (Laws, 1971; Skolnick and Skolnick, 1971). From this perspective, normal personality development is viewed to be highly contingent on the proper combination of influences operating in the family unit, and the traditional arrangement posited is assumed to be the most functional arrangement for the children, the parents, and society in general (Parsons and Bales, 1953).

Inherent in the traditional model of the nuclear family unit is a traditional model of the marital relationship (Laws, 1971; Gurman

and Rice, 1975; Millman and Kanter, 1975; Gingras-Baker, 1976; Rice and Rice, 1977). The traditional, institutional, or utilitarian model of marriage ascribes an instrumental (or outward-directed) role to the husband and an expressive (directed inward toward family relations) to the wife (Hicks and Platt, 1970; Blood and Wolfe, 1960; Rollins and Feldman, 1970; Sillman, 1966). Task specialization is presumed to be the most efficient strategy and a sexual division of labor is presented as the most efficient structure (Blood and Wolfe, 1960). The model describes a traditional form of marriage in that the wife's activities are confined to the home and the husband's primary responsibility is managing the family unit's relations with the larger social sub-systems (Hicks and Platt, 1970). These marital roles are presumed to be complimentary (Sillman, 1966; Levin, 1969), with marital satisfaction contingent upon job satisfaction for the husband and upon the mother role for the wife (Rollins and Feldman, 1970). Getting a job and financially supporting his family is assumed to be the husband's major concern while for the wife it is assumed to be housework and caring for the children (Blood and Wolfe, 1960; Hicks and Platt, 1970).

Traditional models of the parent-child relationships may be expanded from the traditional models of the nuclear family unit and the marital relationship (Casler, 1961; Weisstein, 1970; Laws, 1971; Stevens, 1971; Wortis, 1971; Chesler, 1972; Mead, 1972; Osmond, Franks, and Burtle, 1974; Rosaldo and Lamphere, 1974; Daniels, 1975; Romero, 1977). The mother is assigned the major responsibility for child-rearing tasks (Orlansky, 1949; Mead, 1962; Stannard, 1970). The joys of motherhood are expected to offset whatever costs are associated with the mother giving up other sources of satisfaction during this period

(Morgan, 1970; Chesler and Cole, 1973; Laws, 1975). Since the mother is assumed to be the primary caretaker during the child's pre-school years, primary importance is attributed to the mother-child relationship as a source of children's emotional disturbances (Bowlby, 1951, 1961, 1969; Glueck and Glueck, 1957; Harlow, 1958; Rheingold, 1964). If the mother does not behave according to the traditional model, it is assumed that this can impede a girl's identification with the mother and a boy's with his father (Slater, 1964). For the father, fatherhood is presumed to be less important than keeping a job and financially supporting the family unit (Jourard, 1964; Brenton, 1966; Goldberg, 1966; Kayton and Biller, 1972; Nichols, 1975; Sattel, 1976).

The importance placed on the parents providing appropriate gender role models for their children to identify with is crucial to consider in these traditional models of family relationships. In essence, these models assume that children should be socialized according to the traditional gender role stereotypes so that at appropriate times throughout the individual's life cycle, males and females can assume their roles in the family unit (Gurin, Veroff, and Feld, 1960; Erikson, 1963, 1964, 1968; Rhinegold, 1964; Steadler, 1964; Johnson and Mediamus, 1967, Lidz, 1968; Mussen, Conger, and Kagan, 1969). Thus, the traditional models extend across the full range of the individual life cycle, with two separate models according to sex (Freud, 1925, 1933, 1936; Jung, 1931; Fromm, 1943; Deutsch, 1944; Erikson, 1963, 1964, 1968; Bettelheim, 1965; Lidz, 1968; Marmor, 1973). The nature of the male is assumed to be to show what he can do and to prove that he never fails while for the female it is the need to attract and to prove to herself that she can attract a man (Fromm, 1943; Erikson, 1963; Lidz, 1968). Traditional notions of

masculinity and femininity ascribe instrumental traits to the male and expressive traits to the female (Freud, 1933; Deutsch, 1944; Cronbach, 1970; Hoffman, 1972; Block, VonDerLippe and Block, 1973), traits that correspond to the gender-typed roles defined in the traditional model of the nuclear family unit (Parsons and Bales, 1953; Birdwhistell, 1970; Skolnick and Skolnick, 1971; Laws, 1971; Peal, 1975).

It thus becomes clear that the traditional model of the nuclear family unit inherently types individual family members and their corresponding intrafamilial relationships according to traditional gender role stereotypes (Birdwhistell, 1970; Skolnick and Skolnick, 1971; Laws, 1975; Gingras-Baker, 1976). While attitudes are in the process of changing and alternative perspectives are being utilized more and more frequently, the traditional models of the individual life cycles and family relationships still continue to be used in the training of mental health professionals (Chesler, 1971; Livson, 1973; Schwartz, 1973; Diangson, 1975; Task Force Report, 1975; Gingras-Baker, 1976; Romero, 1977). Feminists claim that if a traditional model of the nuclear family unit is exclusively employed in the assessment stage of family therapy, then the mental health of family members and their corresponding family relationships will be judged in reference to traditional gender role stereotypes (Birdwhistell, 1970; Laws, 1971; Millman, 1971; Skolnick and Skolnick, 1971; Hirsch, 1974; Peal, 1975; Gingras-Baker, 1976). This bias is believed to be facilitated by the way theoretical models are used in family assessment and therapy (Birdwhistell, 1970; Skolnick and Skolnick, 1971; Gingras-Baker, 1976).

The assessment of family members and their corresponding intra-familial relationships is generally accepted as the first step in

the practice of family therapy (Haley and Hoffman, 1967; Francis, 1968; Erikson et al., 1972; Satir et al., 1977). Haley (1976) notes that the act of therapy begins with the way the problem is examined, with the unit of attention being the intrafamilial relationships of the family unit. While family theorists differ as to which aspects of the family relationships are of primary importance (communication patterns, value orientations, family life history, etc.), most would agree that an assessment begins with some sort of fact-gathering process around the presenting problem (Haley and Hoffman, 1967; Committee, 1970; Erikson et al., 1972). Impressions, information, and observations of the family members interacting with one another are collected in the process and are organized according to some theoretical framework(s) or model(s). This is presumed to facilitate clinical appreciation of the family relationships and of the family as a social system (Satir, 1967; Haley, 1976; Satir, Stachowiak, and Taschman, 1977).

Family therapy textbooks encourage the use of theoretical frameworks in family assessment for two major reasons: 1) it is presumed to enhance the clinician's competence to deal with complex phenomena in family therapy sessions and 2) it can assist the clinician in devising future intervention strategies throughout the therapeautic process (Devis, 1967; Haley, 1976). By synthesizing clinical impressions and information according to some framework or model, the clinician then formulates a clinical judgment of the family members and their relationships. The clinical judgment formulated presumably influences both the systematic identification of causal-pertinent factors and implications in relation to the presenting problem and the development of a plan of action. Lehrman (1954) additionally notes that the

clinical judgment also provides an effective way of relating processes to outcomes, thereby enhancing predictive ability for designated interventions in the treatment plan.

The importance of family assessment to on-going therapy is sufficiently crucial for a number of professionals to be concerned about possible distorting biases (Boszormenyinagy and Framo, 1965; Ackerman, 1966; Erikson and Hogan, 1972; Zuk, 1972; Bell, 1974). While various possible sources of bias are briefly reviewed (race, ethnic background, age, etc.), most write at great length about a clinician's family of origin influencing how the family unit is perceived. This possible influence is conceptualized in the following manner. If a family being assessed functions differently from the clinician's family of origin (e.g. different cultural value orientations found in minority families), Ackerman (1966) suggests that a distorted perception of the family unit may result if the clinician is not cognizant of the "reality factors" manifested in <u>different</u> styles of family functioning. With the focus on similarities between the family being assessed and the clinician's family of origin, Devis (1967) discussess how these <u>similarities</u> may reactivate "unfinished business" the clinician may have with his/her family of origin. He notes that reactivated family conflicts may influence clinical impressions and judgments (and, therefore, interventions in the treatment plan of action) of the family being assessed if the clinician is not aware of possible countertransference reactions. Haley (1976), Skolnick and Skolnick (1971), and Birdwhistell (1970) also suggest that the traditional model of the nuclear family has come to define what is normal and natural both for research and therapy, and subtly influences our thinking to regard deviations from it

as sick, or perverse, or immoral.

The above concerns dealing with possible biases in family assessment generate speculations in regard to what would be considered healthy and appropriate gender role behavior in the family unit. If a clinician's family of origin functioned according to a traditional model of the nuclear family unit, would these experiences influence his/her clinical impressions and judgments of a family unit manifesting alternative styles of functioning with respect to gender role behavior in the family unit? If a clinician utilized a traditional model of the nuclear family unit as a framework with which to organize clinical impressions of family members and their corresponding intrafamilial relationships, do families which adhere to traditional gender roles elicit a more favorable clinical impression? Do cultural stereotypes of male and female gender roles influence a clinician's acceptance of the traditional model of the nuclear family unit? These questions would lead one to wonder how these issues play a part (if at all) in a clinician's assessment of mental health.

Other researchers have continued along this line of questioning, specifically focusing on sex role stereotyping of individual clients. As a result of a study on sex role stereotypes and self concepts in college students (Rosenkrantz et al., 1968), Broverman et al. (1970) employed a similar methodology in order to investigate sex role stereotypes and clinical judgments of mental health. By asking clinicians to ascribe a cluster of different personality traits to the healthy mature adult, the healthy mature male, and the healthy mature female, they found that clinicians tended to ascribe the "male-valued, competency cluster traits" more often to healthy men than to healthy women. In

effect, clinicians were suggesting that healthy women differ from healthy men by being

> " . . . more submissive, less independent, less aggressive, less competitive, more excitable in minor crises, more emotional, more conceited about their appearance, and having their feelings more easily hurt" (p. 71)

The investigators interpreted their results to indicate a double-standard of mental health for men and women. Since the clinicians were more likely to attribute traits that were presumed to be characteristics of a healthy adult to men than to women, an "anti-female" bias was proposed (Broverman et al., 1972).

Brogan (1972), on the other hand, presented findings that were opposite to those of Broverman et al. (1970). Employing a different methodology, Brogan administered a questionnaire to a sample group of therapists. Her attitudinal questionnaire considered sociological, psychological, sexual, legal, economic, and political factors as well as those presumed to be related to the women's liberation movement. Her results revealed that the sample group of therapists assumed a significantly liberal orientation in their attitudes regarding women, suggesting a "pro-female" bias.

In their attempt to explore the apparent inconsistency between the above two studies, Brown and Hellinger (1975) administered an "orientation toward women" scale to a sample of mental health professionals. Of present concern are their data indicating that female therapists tend to have more "contemporary" attitudes toward women than do male therapists. This was particularly the case on items concerned with mothering and the maternal instinct. Brown and Hellinger propose that their data suggests a possible "anti-female" bias if a

clinician were not acutely aware of his/her biases toward women.

The influence of a therapist's attitudes toward women (both single women and married women) has been documented around cases involving individual clients (Abramowitz, Abramowitz, and Gomes, 1973; Fabrikant, 1974). While these attitudes are in the process of changing, others continue to assert that a clinician's negative valuation of women reflects the pervasive cultural view of women (Shainess, 1969; Bem and Bem, 1970; Miller and Mothner, 1971; Chesler, 1973; Hirsch, 1974; Levine, Kamin, and Levine, 1974; Laws, 1975; Gingras-Baker, 1976). Similar concerns prompted investigators to study the possible influence of sex role stereotyping in clinical judgment.

While the above studies certainly contributed valuable inferences regarding sex role stereotyping of individual clients, there are actually few studies which attempt to assess sex role stereotyping in clinical judgment. Gross et al. (1969) investigated the effect of race and sex on the variation of diagnosis and disposition in a psychiatric emergency room. While their data would allow inferences regarding the influence of the sex factor alone on clinical judgment, the reported data combines the race and sex factor. Inferences about the influence of sex role stereotyping in clinical judgment can also be made from the results of an investigation of therapeautic styles by Dell and Ryan (1975). However, they focus on therapeautic styles of the clinician and not on clinical judgment. Consequently, only Miller (1974) and Fischer, Dulaney, Fazio, Hudak, and Zivotofsky (1976) have attempted to assess the influence of sex role stereotyping in clinical judgment.

Following a model designed by Blake (1971), Miller (1974) devised

two forms of a case analogue in which every variable except sex was held constant. The case material that was created depicted a relatively healthy, twenty-six year-old single, white, Protestant client who was referred for evaluation because of psychosomatic complaints and mild depression. The most marked clinical feature that the individual client manifested was "passivity". A version depicting a male client and the same version depicting a female client wer devised, and alternate forms of the case analogue were randomly distributed to a sample of mental health professionals. Clinical impressions of the respondents were collected via a questionnaire designed to invite judgments about specific dimensions of the particular individual client. Results showed a fairly consistent tendency for the female case version to elicit clinical judgments slightly more favorable than the male case version. Further, when ranking general problem areas, "passivity" was the overwhelming choice of treatment focus for the male form while only half of the respondents chose that particular treatment focus for the female form. Miller interpreted her results to indicate an "anti-female" bias in clinical judgment.

Fischer et al. (1976) expanded Miller's methodology and developed their case analogues in the following manner. A one-page clinical history was devised depicting an individual client described as a 35-year-old college graduate who had been married for ten years and had two children. Two versions were then developed: one depicting an individual client with an "aggressive" personality and a second depicting an individual client with a "passive" personality. These two versions were then the basis for their four versions of the case histories: aggressive male, aggressive female, passive male, passive

female. An inventory designed to elicit judgments that were representative of those made in actual practice with individual clients accompanied each of the four versions randomly distributed to a sample of social workers. Significant results showed that female clients (both agressive and passive personality) were judged as more intelligent, more mature emotionally, needing more encouragement to be emotionally expressive, and elicited more positive personal feelings than the two male client versions. Fischer et al. concluded that a strong "pro-female" bias appears to characterize social worker's clinical judgments.

In reviewing the above studies investigating the influence of sex role stereotyping on clinical judgment, there is serious question concerning the generalizability of these results to family assessment. All of the above studies investigating clinical judgment focus on sex role stereotyping, i.e. the ascription of certain traits and/or characteristics based on the individual's sex. This is appropriate since in individual therapy the major focus is on the individual and since frequently the only interactional behavior perceived during treatment is that between the individual client and the therapist.

However, in family therapy, the major focus of assessment shifts to the relationships of the family unit in question. Further, the therapist has the opportunity during treatment to observe interactional behavior between family members, and these observations are frequently incorporated as part of the "clinical material" used in the assessment process. While the assessment of a family guides the treatment process, observations of interactions between family members continue to be utilized during treatment. Hence, behavior between individual family members and their corresponding intrafamilial relationships tend to

receive more clinical attention than the traits of an individual family member.

These same studies on clinical judgment of an individual client also vary on what at first may appear to be an insignificant factor. One of the studies employs a case analogue depicting a client who is married and has children. Other studies use case analogues in which the individual client is single or the marital status of the client is simply omitted. Studies utilizing paper-and-pencil scales of healthy adult, healthy male, and healthy female simply ignore this factor. Consequently, it is not clear whether the individual client was judged as an individual client or as an individual client in a particular relational context. In family assessment, the clinician may focus on the marital relationship (between a father and a mother) and/or any of the possible parent-child relationships (father-son, father-daughter, mother-son, mother-daughter) an individual family member may experience as being problematic. However, the individual family member is always assessed within the relational context of his/her family unit.

It seems inappropriate to generalize results of studies on sex role stereotyping in clinical judgments of individual clients to family assessment - the assessment of relationships in the family unit. This is particularly the case due to the variation of the marital and family status of the hypothetical individual client being judged and to the lack of clarity over whether the individual client was being assessed as an individual client or as an individual client in a particular relational context. Further, one's expectations of appropriate behavior for the gender-typed roles in the family unit (father, mother, son, daughter) and expectations around the possible

gender-typed intrafamilial relationships (e.g. father-son, father-daughter, mother-son, mother-daughter) would seem to be important to consider.

The results of these studies warrant further discussion. All of the above studies on clinical judgment offer interpretations falling under one of two categories: "pro-female" or "anti-female" bias. This is primarily due to the authors' attempts to evaluate the efficacy of applying presumably male standards of mental health to female clients. With this point as the designated focus (as well as sexism usually referring to female clients), it was not necessary to question the efficacy of male standards of mental health for male clients. However, when shifting from assessment of an individual client to assessment of family relationships, similar concerns for male clients are unavoidable.

The literature review on the traditional model of the nuclear family unit provides a cogent rationale for this issue. Recall that throughout the discussion of the traditional model of the female life cycle, the female gender role was consistently defined in relation to the male gender role. In other words, there also exists a "traditional" model of the individual life cycle for the male. One could propose that some males who wish to grow as full human beings (as opposed to the instrumental specialist depicted in the traditional model) may also find this model of the nuclear family unit limiting. Thus, in regard to family assessment (when family members are assessed in relation to one another), feminists' concerns may be viewed as cogent for both sexes.

Such a viewpoint would shift the focus of feminists' concerns from the female gender role to both the male and female gender roles in relation

to each other, an appropriate concern when conducting a family assessment. From this perspective, the central issue then becomes gender role bias (rather than sex role stereotyping) in clinical judgment, with different questions and concerns being generated. Does gender role bias influence the assessment of family members and their corresponding intrafamilial relationships? With the emphasis on relationships in family assessment, do relationships in the family unit which conform to the "traditional" model elicit more favorable clinical judgments? Should this be the case, then this bias could be perceived as reinforcement of gender-typed adult behavior, reinforcement of parental expectations of their children's appropriate gender role behavior, and the appropriate gender role behavior of the children - all according to the traditional model of the nuclear family unit. One would then be concerned with the possible distorted perception of the individual family member(s) and the corresponding family relationships if an adjustment notion of health in regard to family relationships reflected only an acceptance of societal gender role expectations as defined in the traditional model of the nuclear family unit. With the serious questions surrounding the generalizability of studies investigating sex role stereotyping of individual clients to family assessment remaining unresolved, we cannot make inferences from these studies of assessment of individual clients to assessment of family relationships.

Since gender role bias has never been investigated in regard to family assessment, it seemed appropriate to begin investigating the possible influences of this type of bias in the clinical impressions of family members and their corresponding intrafamilial relationships.

This line of inquiry would prove useful for several reasons. The reevaluation of both male and female gender roles can be accomodated. Methodological constraints around the generalizability of results from studies of individual assessments can be addressed while simultaneously determining if the relational context influences the assessment of an individual family member. In addition, further exploration around the stereotyping of family relationships as opposed to the stereotyping of individuals may lead to the formulation of gender role bias as a particular countertransference concept of family therapy.

Statement of Problem

The primary focus of this study is to investigate the possible influence of gender role bias in the assessment of family members and their corresponding intrafamilial relationships. Since this topic has never been previously investigated, it becomes necessary to first examine whether the relational context of the family unit influences the clinical judgment of family members and family relationships. These judgments would then contribute to an overall impression of the family unit providing the relational context in which family members and their corresponding intrafamilial relationships are assessed. It seems appropriate to begin with the relational context as defined in the traditional model of the nuclear family unit.

In essence, this model conceptually posits four gender-typed roles in the family unit: father, mother, son, daughter. These roles are gender-typed because the sex of the individual family member differentiates what is considered appropriate behavior for a parent and a child, and therefore what is considered appropriate behavior in the marital and parent-child relationships. The sex of the father is

male while the sex of the mother is female. However, the sex of the child may be either male or female. Consequently, the relational context of a three-member nuclear family unit presumably would vary depending upon the sex of the child. By focusing first on a three-member nuclear family unit, one can begin to assess the relational contexts of a traditional nuclear family unit comprised of a father, a mother, and a male child, and a traditional nuclear family unit comprised of a father, a mother, and a female child.

However, it would also seem useful to determine whether relationships in the family unit which conform to the "traditional" model of the nuclear family unit elicit more favorable clinical judgments in family assessment. Since this topic has never been previously investigated and since a family unit may be conceived on a traditional versus contemporary continuum, it seemed logical to compare the traditional relational contexts defined above with the opposite counterparts. This can be achieved simply by conceptually reversing the gender-typed roles of the parents (role-reversal) or, in other words, ascribing the traits and behaviors considered appropriate for the tradtional father to the mother and vice versa. When also considering both alternatives for the sex of the child, the end result would be the following four relational contexts: (a) two traditional relational contexts depending on the sex of the child and (b) their two reversed counterparts, also varying according to the sex of the child.

Shifting the focus of the present discussion from the family to the clinician conducting the assessment, the studies on sex role stereotyping in clinical judgment suggest that the sex of the clinician (Miller, 1974; Fischer et al., 1976) and the clinician's attitudes

toward women (Brown and Hellinger, 1975) have an influence on clinical impressions and judgments depending on the sex of the client. Since measurement of attitudes toward women yields a continuous variable (Brown and Hellinger, 1975), it would be possible statistically to control for an individual clinician's orientation toward women when soliciting clinical impressions and judgments of family members and relationships in the form of a structured task. This would allow one to attribute differential clinical impressions and judgments to the four relational contexts previously defined and not to an individual's orientation toward women. This is particularly important given the influence the women's movement has had over the past few years.

If gender role bias influenced the assessment of a family unit, such an influence would be expected to affect the assessment of individual family members, their corresponding intrafamilial relationships (marital relationship and parent-child relationships), and the family unit's prognosis for treatment, all generally considered a part of a clinician's clinical impressions and judgment of family relationships. The studies reviewed on clinical judgment also provide several appropriate scales with which to measure clinical impressions and judgments. Fischer and Miller (1973) and Fischer et al. (1976) developed eleven items designed to secure 1) clinical impressions and judgments of the client and 2) possible intervention techniques frequently used in actual practive of therapy. With minimal modification in the wording of these items (e.g. referring to "father" instead of the "client), these items would also serve the purposes of a family assessment. The only major modification necessary would be that <u>each</u> family member would need to be assessed on these items.

Miller (1974) developed five general problem areas in her study of assessment of individual clients, and the inclusion of these general problem areas would be useful in a family assessment. The same modifications would be needed: the items should refer to the family member instead of the individual client, and the problem areas would need to be ranked for each family member. Laws (1975) also proposes five general problem areas which are frequently problematic in the marital relationship between parents of school-age children. A ranking of these problem areas would provide information as to how the marital relationship is clinically perceived.

By adding three items designed to elicit judgments about the father-child relationship, the mother-child relationship, and the overall prognosis for family treatment, clinical impressions and judgments of those areas presumed to be influenced by gender role bias could then be assessed. Finally, Brown and Hellinger's (1975) "orientation toward women" scale would yield the continuous variable needed to control statistically for the possible influence a clinician's orientation toward women may have on clinical impressions and judgments of family members and their corresponding intrafamilial relationships.

The most appropriate way to examine the effects of one set of variables on a set of dependent variables is to develop a research design that allows for the manipulation of the identified independent variables. In other words, the design should insure objectivity by allowing the different variations, uncontaminated by one another, to have an effect on the dependent variables. Since this would prove difficult and time consuming with actual therapy sessions, and since investigation of gender role bias is only at the initial stage,

a three-member (father, mother, school-age child) family case analogue was developed.

The case analogue was comprised first around a father, a mother, and a male child, with the father conceptually being designated as the active parent and the mother conceptually being designated as the passive parent. The clinical profile of the father (and, therefore, the active parent) and the clinical profile of the male child were both designed around stereotypically male traits and behaviors: domineering, aggressive, pushy, and oriented towards instrumental tasks. This was done for both clinical profiles in order to reflect the appropriate role identification in the father-son relationship inherent in the tradtional model of the nuclear family unit. On the other hand, the clinical profile of the mother (and, therefore, the passive parent) was comprised around stereotypically female traits and behaviors: shy, passive, submissive, and with an orientation towards expressive tasks.

The end result was a family case analogue providing a traditional relational context in the form of a family unit comprised of a father, a mother, and a male child. The case analogue was then duplicated, changing only the name and sex of the child, providing a traditional relational context in the form of a family unit comprised of a father, a mother, and a female child. The two counterpart versions subsequently follow by duplicating each of the two traditional versions while reversing the sex of the two parent profiles. In this manner, the original family case analogue was expanded into four case versions, changing only the sex of the child and the sex of the parent profile(s). It should be noted that while the sex of the child and the sex of the parent profile(s) change, the clinical profiles of the family members

(active parent, passive parent, child) remain the same across all four case versions.

By manipulating the independent variables comprising the relational context in this fashion, the research design will insure objectivity by allowing the different variations to have an effect on clinical impressions and judgment of family members and their corresponding intrafamilial relationships. If the four family case versions were presented as a stimulus condition in the form of a structured task and data about the clinical impressions and judgments of each family member and their corresponding intrafamilial relationships were generated, the expected hypotheses would be:

H1) The relational context (sex of the child and sex of the parent profile(s)) and sex of the clinician is expected to influence clinical impressions and treatment expectations of <u>each</u> family member.

H2) There is a significant relationship between perceived severity of individual problem areas and the relational context (sex of the child and sex of the parent profile(s)). This is expected to be the case for <u>each</u> family member.

H3) There is a significant relationship between perceived severity of problem areas in the marital relationship and the relational context (sex of the child and sex of the parent profile(s)).

H4) The relational context (sex of the child and

sex of the parent profile(s)) and sex of the clinician is expected to influence clinical judgment of the parent-child relationships and impression of the family's overall prognosis for family treatment.

H5) A clinician's orientation toward women is expected to influence clinical impressions and judgments of family members and their corresponding intrafamilial relationships.

Chapter II

Method

Subjects

Arrangements were made to obtain subjects (S's) through the required graduate methods courses in the School of Social Work. A variety of reasons substantiated this choice of subject pool: 1) available data on practicing family therapists reveals that the largest proportion (40%) are social workers (Committee, 1970); 2) the discipline of social work has traditionally been associated with family assessment and therapy; and 3) since investigation of gender role bias in family assessment is in the initial stages, it seemed appropriate to begin with a group of easily accessible S's. Therefore, S's were drawn from all first- and second-year methods courses required for all graduate social work students. All S's participation was completely voluntary.

Procedure

Instructors of first- and second-year methods courses required for all graduate social work students were approached and class time to present a research project was solicited. To those instructors who inquired, the purpose of the research project was explained as an investigation of how social work students put together a clinical assessment of a family. All of the instructors granted class time and specific class sessions were then scheduled. At the beginning of the scheduled class session, students were told that their instructors had given permission

for class time to be used for a research project but that participation was strictly on a voluntary basis. No student present at the scheduled class sessions refused to participate in the present study.

Table 1 illustrates the distribution of S's (N = 91) who participated in the present study according to case version by sex of S. Overall, 74% of the sample of graduate social work students were female and 26% were male. The table also reveals that only four male subjects received case version three as compared to 19 female subjects. Table 2 provides the distribution of S's according to age, revealing that the largest number of S's (31%) were between the ages of 24 and 26. None of the S's were under 21. Table 3 reveals the distribution of S's according to marital status, with 42% single and 36% of the sample being married. Approximately 17% of the sample of S's were divorced. More than half of the sample of S's (54%) were second-year graduate social work students while 46% identified themselves as first-year graduate social work students. All of the S's indicated their major was social work, with 66% of the sample of S's (n = 60) indicating they had had coursework and/or training in family assessment.

All S's were randomly assigned to one of four groups corresponding to the four versions of the family case analogue. After explaining to the S's that the present study was attempting to investigate how social workers conduct a family assessment, S's were asked to read the family case analogue and to respond to the questions in order that followed. Subjects were reminded to focus on the family rather than on the worker conducting the assessment interview and they were instructed not to refer to the case analogue while responding to the questions but to rely totally on their clinical impressions of the family members and

Table 1

Distribution of Subjects According to Case Version by Sex

Sex	Case Version 1	2	3	4	
Males	6	7	4	7	
Females	18	16	19	14	
Totals	24	23	23	21	N = 91

Note:
THE RELATIONAL CONTEXTS PRESENTED IN EACH CASE VERSION ARE:

1: Active Father - Passive Mother - Son
2: Active Father - Passive Mother - Daughter
3: Passive Father - Active Mother - Son
4: Passive Father - Active Mother - Daughter

Table 2

Distribution of Subjects According to Age

Age					
18-20	21-23	24-26	27-29	over 29	
8	13	28	10	32	N = 91

Table 3

Distribution of Subjects According to Marital Status

Marital Status					
single	married	divorced	widowed	other	
39	33	15	1	3	N = 91

their family relationships.

Further, S's were reminded that the information in the family case analogue must be treated as confidential information, partly because the case analogue was developed from actual case material and partly to add a realistic tone to the requested task. Every attempt was made to structure the administration of the instruments to the S's in such a manner that both male and female administrators were equally used. Consequently, half of the graduate classes were administered the instruments by a male and the other half by a female administrator.

Instruments

Family case analogue: The family case analogue was developed from actual case material used in graduate social work methods courses. The general format of the training case materials was duplicated, as were the vocabulary and writing style. Portions of the family case analogue were literally taken from some of the training materials, with all possible identifying information disguised. As explained in the preceeding chapter, the only changes made to produce the four versions of the case analogue were sex of the child and sex of the parent profile(s). Table 4 identifies the four versions of the family case analogue. While the sex of the child and the sex of the parent profile(s) are the identified independent variables, it should be noted that the clinical profiles of the child, the active parent, and the passive parent are identical in all four versions of the family case analogue. The four versions of the family case analogue are included in Appendix A.

Clinical Impression Items: After reading the family case analogue, S's completed seven items (six-point, Likert-type scale) designed to elicit clinical impressions and used by Fischer and Miller (1973) and

Table 4

Four Versions Of The Family Case Analogue

		Active Parent	Passive Parent	Sex of Child
Case Version	1	Father	Mother	Son
	2	Father	Mother	Daughter
	3	Mother	Father	Son
	4	Mother	Father	Daughter

Fischer et al. (1976). Two modifications were needed: "the client" was replaced by the family members (father, mother, child) and the items were completed for each family member in the case analogue. These items elicited clinical impressions of each family member with regard to emotional maturity, overall degree of stability, general level of intelligence, degree self-reliance was perceived as a major problem, individual family member's prognosis for treatment, personal reaction to family member, and extent of the S's eagerness to have the family member as an actual client. The order of the family members being rated varied from S to S (e.g. father - mother - child; mother - child - father; child - father - mother, etc.).

The clinical impression items were analyzed in such a way that the "positive" and "healthy" aspect of the clinical impression was consistently associated closer to the numerical value of one while the "negative" and "unhealthy" aspect of the clinical impression was consistently associated closer to the numerical value of six. Consequently, if the clinical items are summed and an average computed, a mean clinical impression score could be generated. A mean clinical impression score was computed for each family member (father, mother, child). See Appendix B for examples of the clinical impression items used.

Technique Items: Additionally, S's were asked to respond to six items (six-point, Likert-type scale) used by Fischer et al. (1976) regarding the following intervention techniques: extent to which the family member is perceived to need encouragement to be more self-reliant, the amount of warmth and support the family member would need in treatment, the extent to which the family member would need a directive worker during treatment, the extent the family member should be

encouraged to be more family-oriented, the extent the family member needs to be encouraged to be more emotionally expressive, and the extent to which the S would be directive or non-directive with family member during treatment. Subjects responded to these items for each family member and the set of responses were solicited in the same random order as was used for the clinical impression items. See Appendix B for examples of the technique items used.

Ranking of Individual Problem Areas: For each family member, S's were asked to rank the following general problem areas from most problematic (first ranking position) to least problematic (fifth ranking position): immature sexual identity, limited object relations, environmental and social problems, passivity, and underdeveloped ego skills. While including these items in the same manner as used by Miller (1974), the only difference was that a ranking of these problem areas was solicited for each family member. See Appendix B for examples of the individual problem area items.

Ranking of Marital Problem Areas: After they had completed all of the above items for each family member, S's were then asked to rank the following general marital problem areas from most problematic (first ranking position) to least problematic (fifth ranking position) according to their impression of the marital relationship: companionship, handling of finances, household tasks, sex, and parent-child relationships. The literature suggests these general problem areas as being most problematic between couples who have school-age children (Laws, 1975). See Appendix B for an example of the marital problem area item.

Miscellaneous Items: Subjects next responded to three items

(six-point, Likert-type scale) regarding the following aspects of a family assessment: impression of the father-child relationship (healthy versus problematic), impression of the mother-child relationship (healthy versus problematic), and overall prognosis of the family for family treatment (extremely good versus extremely bad). See Appendix B for examples of these three items.

Biographical Data Sheet: Subjects then completed a biographical data sheet requesting the following general demographic information: sex, educational status, graduate level, age, marital status, an item to verify that the S's major is social work, and an item to check if the S had ever taken any coursework and/or training in family assessment. These data were used to describe the sample of S's who participated in the present study. For an example of the data sheet used, see Appendix B.

Orientation Toward Women Scale: Finally, S's were then asked to respond to 29 items (seven-point, Likert-type scale) designed and used by Brown and Hellinger (1975) in their assessment of attitudes toward women. Eighteen of the items are typed "traditional" and 11 of the items are typed "contemporary". The mean scores of each set for each S were computed, and a C-T ratio score was calculated by dividing the mean contemporary score by the mean traditional score. Thus, ratio scores less than one indicate a contemporary orientation toward women and ratio scores greater than one indicate a traditional orientation toward women. Note that S's responded to these items after their clinical impressions of family members and the corresponding family relationships were recorded. See Appendix B for an example of the orientation toward women scale used.

Analysis of Results

The same coding procedure was followed for all of the data generated. After the S's completed the instrument scales, two trained coders transferred the data onto coding sheets. Professional keypunchers then punched and verified the data on IBM computer cards. The biographical information on each S and the chi-square (X^2) analyses were analyzed using the Statistical Package for the Social Sciences (SPSS, 1975). The SPSS package was also used to compute all transformation scores and variables involved (mean clinical impression scores, frequency tabulations used, and the C-T ratio scores).

The mean clinical impression scores for each family member, the six technique items for each family member, and the three items on the parent-child relationships and overall family prognosis are dependent variables collected from the same subject. Consequently, multivariate statistical procedures would be most appropriate to use in analyzing the generated data. However, this statistical procedure considers the dependent variables as one set, thereby presenting the possibility that specific significant differences on specific items would be obscured in the overall analyses. It seemed more appropriate given the initial stage of investigation to be able to identify the direction of specific significant differences on specific items. For these reasons, alternative statistical procedures were examined.

In his discussion of the least-squares estimation for analysis-of-variance models, Finn (1974) argues that an alternative solution for the model of deficient rank is to select and estimate linear combinations of the parameters that are of scientific interest. These combinations are expressed as contrasts among subpopulation means and can be explicitly

chosen in accordance with the experimental design and procedures. This solution has the advantage of providing direct results concerning the experimental outcomes since it is usually differences amongst group means that are of concern. If one does not restrict the sum of the parameters, the connotation is avoided that experimental effects somehow nullify one another.

When there is no particular order to the groups in the experimental design and when it is useful to estimate the simple terms in the model, Finn (1974) argues that deviation contrasts may be employed (see pp. 215 - 232). Finn's model is appropriately suited for analyzing differences between the four case versions as differences in deviation contrasts. The mean of each item for each contrast (case version) is compared to the mean of each item for each of the other three contrasts (case versions). Thus, a significant contrast would indicate that the mean score of an item for that contrast (case version) is significantly different when compared to the mean scores of the same item for the other three contrasts (case versions).

With this statistical procedure, one would be able to identify the direction of specific significant differences on specific items with respect to case version and sex of the respondent. In addition, a computer software package developed by Finn (1974) and maintained by the Computer Institute for Social Science Research (CISSR) analyzes data using the above statistical rationale in the identification of significant contrasts. Therefore, the mean clinical impression scores for each family member, the six technique items for each family member, and the three items on the parent-child relationships and overall family prognosis were <u>each</u> analyzed by a 2^3 between subjects analysis of

co-variance. The three main factors were identified as the following: sex of the child and sex of the parent(s) profiled (case version), and sex of the respondent (S). The covariate in these analyses was the S's orientation toward women as reflected in the C-T ratio score. This procedure allows for the evaluation of crucial interaction effects while allowing one to account for more of the within-cell variance by controlling for the S's orientation toward women (i.e. by using the C-T ratio score as the covariate). The null hypotheses are that there are no significant differences in each of the dependent variables with respect to any of the effects tested and H_0 will be rejected at the $\alpha = .05$ level.

In regard to the two sets of ranking data (perceived problem areas of each individual family member and perceived problem areas of the marital relationship), the problem area designated as the most problematic problem area could also be interpreted as the designated central focus of treatment. One way of relating problem areas to sex of the child and sex of the parent(s) profiled would be a 5 x 4 frequency distribution table of the frequencies each problem area was identified as the individual family member's most problematic area according to case version (i.e. problem area by case version). The problem areas perceived by the S to be the most problematic can then be considered as the S's designated central focus of treatment. A chi-square (X^2) test for independence of the distribution between the frequency a problem area is identified as being the most problematic area and case version was conducted for the father, the mother, the child, and the marital relationship.

Further, in order to extrapolate more meaning from the generated

ranking data, each problem area was analyzed in and of itself. The ranking distribution of one problem area may not be the same as the ranking distribution of the other identified problem areas, and this could easily be checked through a 5 x 4 frequency distribution table (ranking distribution of the problem area by case version) of the frequencies the problem area was ranked first, second, third, etc. (five ranking positions) for each case version. These tables would then reveal when a problem area was significantly not considered a problem for each family member. This would augment the information generated from the above frequency distribution tables. Therefore, for each identified problem area, an additional chi-square (X^2) test for independence between the ranking distribution of the problem area and case version was conducted for the father, the mother, the child, and the marital relationship. The null hypotheses for all chi-square (X^2) computations is that the distribution between the two identified factors is not significant and H_0 will be rejected at the $\alpha = .05$ level.

The hypotheses mentioned previously are restated in operational terms as follows:

H1A) Controlling for the respondent's orientation toward women (C-T ratio score), differences in each of the mean clinical impression scores for each family member are expected with respect to case version (sex of the child and sex of the parent(s) profiled) and sex of the respondent.

H1B) Controlling for the respondent's orientation toward women, differences in each of the technique items for each family member are expected with respect to case version

and sex of the respondent.

H2A) For each family member, there is a significant relationship between the frequency a problem area is identified as the most problematic area and case version (sex of the child and sex of the parent(s) profiled).

H2B) For each problem area, there is a significant relationship between the ranking distribution of the problem area and case version.

H3A) There is a significant relationship between the frequency a marital problem area is identified as the most problematic area and case version (sex of the child and sex of the parent(s) profiled).

H3B) There is a significant relationship between the ranking distribution of each marital problem area and case version.

H4) Controlling for the respondent's orientation toward women (C-T ratio score), differences in each of the three items on the father-child relationship, the mother-child relationship, and the family's overall prognosis for family therapy are expected with respect to case version (sex of the child and sex of the parent(s) profiled) and sex of the respondent.

Chapter III

Results

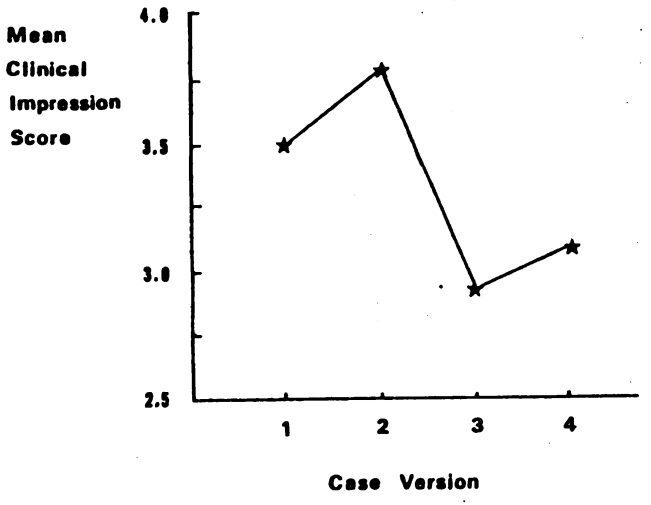
While significant results are included in this section in the form of figure graphs and summary tables, summary tables of all other non-significant results are included in Appendix C. A summary table presenting the means and standard deviations for each cell (2 x 4), the respective marginal means, and the error term can be found in Appendix C for each item analyzed using a 2^3 between subjects analysis of co-variance (see Tables 1 - 24). In addition, summary tables for all nonsignificant chi-square (X^2) analyses are also included in Appendix C (see Tables 25 - 39).

To test Hypothesis 1A, a 2^3 between subjects analysis of co-variance was conducted on the mean clinical impression scores for the father, the mother, and the child. Figure 1 shows that the fathers' mean clinical impression scores are significantly different with respect to case version ($F(1,82) = 10.08$, $p < .001$; $F(1,82) = 13.82$, $p < .0004$; $F(1,82) = 18.64$, $p < .0001$). A Scheffé post-hoc analysis of all possible comparisons between means reveals that the differences between case versions one and two and between case versions three and four are both nonsignificant (range = 4.03, $p < .05$). These results illustrate that active fathers elicited a more negative, unhealthy clinical impression than did passive fathers.

Figure 2 illustrates that significant differences in mothers' mean clinical impression scores were found only for case versions one and three ($F(1,82) = 13.56$, $p < .0005$; $F(1,82) = 7.94$, $p < .006$). A Scheffé

Figure 1

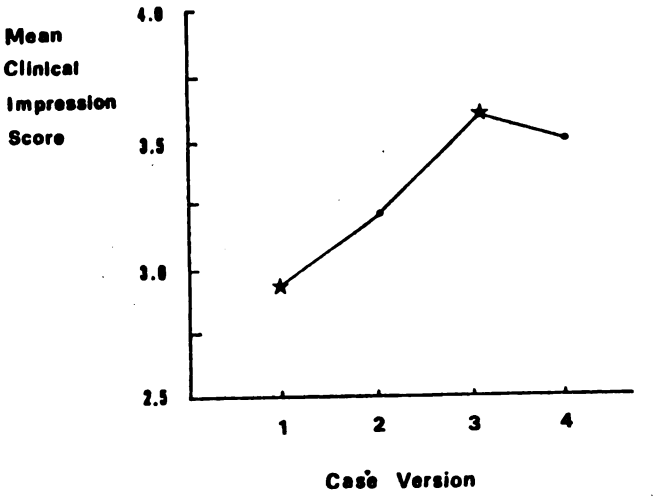
Father's Mean Clinical Impression Score by Case Version



★ = significant contrast

Figure 2

Mother's Mean Clinical Impression Score by Case Version



★ = significant contrast

Note:
THE RELATIONAL CONTEXTS PRESENTED IN EACH CASE VERSION ARE:

1: Active Father - Passive Mother - Son
2: Active Father - Passive Mother - Daughter
3: Passive Father - Active Mother - Son
4: Passive Father - Active Mother - Daughter

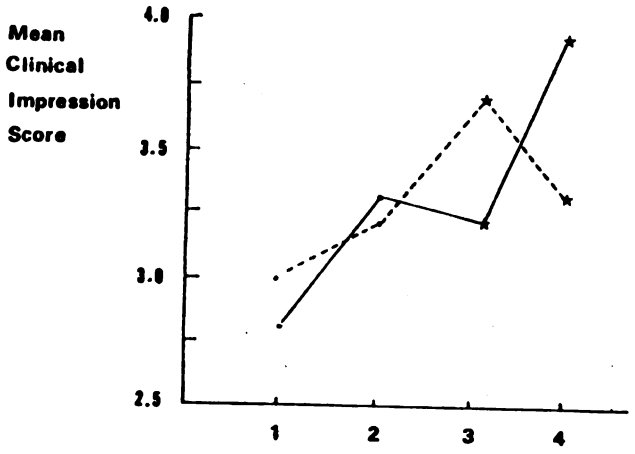
post-hoc analysis indicates there is a significant difference between the mean clinical impression scores for case versions one and three (range = 4.03, $p < .05$). The data show that the mother in case version three elicited a more negative, unhealthy clinical impression than did the mother in case version one. In addition, Figure 3 illustrates significant interactions of case version and sex of respondent for case versions three and four ($F(1,82) = 4.02$, $p < .04$) on mothers' mean clinical impression scores. For case version three, male respondents perceived the mother to be more healthy than did female respondents while for case version four, female respondents perceived the mother to be more healthy than did male respondents.

No significant differences in mean clinical impression scores with respect to case version and sex of respondent were found for the child (see Appendix C, Table 3). Thus, in testing Hypothesis 1A, significant differences in mean clinical impression scores were found only for the father and the mother. Active fathers elicited a more negative, unhealthy clinical impression than did passive fathers. The mother in case version three elicited a more negative, unhealthy clinical impression than did the mother in case version one. In addition, male respondents perceived the mother in case version three to be more healthy than did female respondents while female respondents perceived the mother in case version four to be more healthy than did male respondents.

In order to test Hypothesis 1B, the same analysis of co-variance was used to analyze each of the technique items asked about the father, the mother, and the child. Five technique items were significant when asked about the father. Figure 4 shows the significant differences of Father Item #8 (self-reliant) with respect to all four case versions ($F(1,82) = 30.14$, $p < .0001$; $F(1,82) = 12.63$, $p < .007$; $F(1,82) = 20.53$, $p < .001$).

Figure 3

Interaction of Case Version and Sex of Subject On Mother's Mean Clinical Impression Score



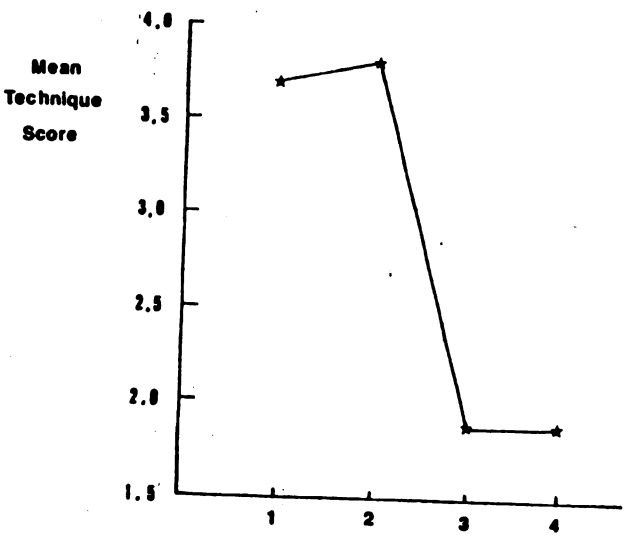
★ = differences are significant

—— = male subjects

- - - = female subjects

Figure 4

Mean Technique Score (8) for Father by Case Version (Self-Reliant)



★ = significant contrast

Note:
THE RELATIONAL CONTEXTS PRESENTED IN EACH CASE VERSION ARE :

1: Active Father - Passive Mother - Son
2: Active Father - Passive Mother - Daughter
3: Passive Father - Active Mother - Son
4: Passive Father - Active Mother - Daughter

A Scheffé post-hoc analysis indicates there are no significant differences between case versions one and two and between case versions three and four (range = 4.03, $p < .05$). These results show that respondents indicated that passive fathers should be encouraged to be more self-reliant while active fathers should not receive this type of encouragement.

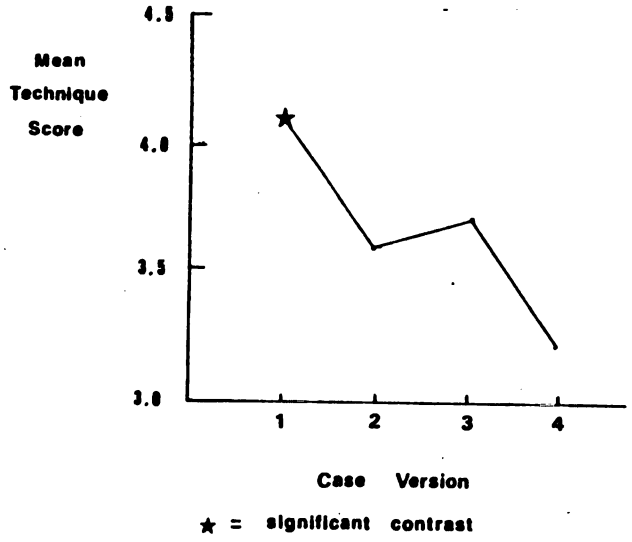
Figure 5 reveals that Father Item #9 (directive worker) is only significant for case version one ($F(1,82) = 4.10$, $p < .05$). Respondents indicated that the father in case version one should not have a directive worker. In addition, Figure 6 illustrates a significant interaction between case version three and sex of respondent on this particular technique item ($F(1,82) = 5.37$, $p < .02$). Male respondents indicated that the father in case version three should have a directive worker while female respondents indicated he should have a non-directive worker.

Figure 7 shows that Father Item #10 (warmth and support) elicited significant interactions between sex of respondent and case versions two and four ($F(1,82) = 6.19$, $p < .01$). For case version two, male respondents tended to perceive the father as needing warmth and support more than did female respondents. In contrast, female respondents tended to perceive the father in case version four as needing warmth and support more than did male respondents.

Figure 8 presents a significant contrast for case version three only in regard to Father Item #11 (family-oriented) ($F(1,82) = 3.96$, $p < .05$). These results show that respondents felt the father in case version three should be encouraged to be family-oriented less so than the father in the other three case versions. Figure 9 presents a significant interaction between case version three and sex of respondent on Father Item #13

Figure 5

Mean Technique Score (9) for Father by Case Version
(Directive Worker)



Note:
THE RELATIONAL CONTEXTS PRESENTED IN EACH CASE VERSION ARE:

1: Active Father - Passive Mother - Son
2: Active Father - Passive Mother - Daughter
3: Passive Father - Active Mother - Son
4: Passive Father - Active Mother - Daughter

Figure 6

Interaction of Case Version and Sex of Subject On Mean Technique Score (9) for Father
(Directive Worker)

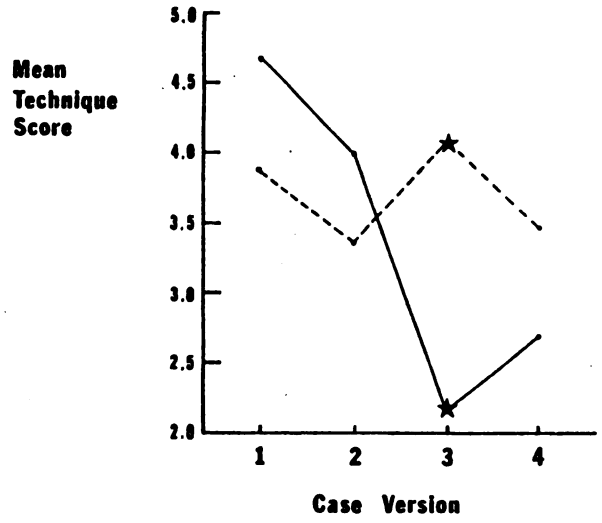
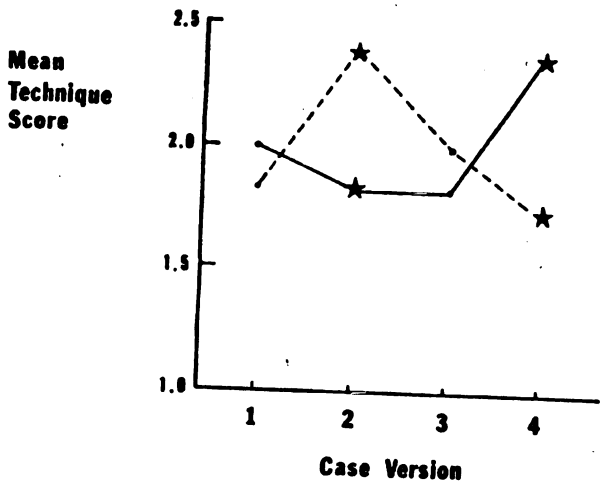


Figure 7

Interaction of Case Version and Sex of Subject On Mean Technique Score (10) For Father (Warmth and Support)



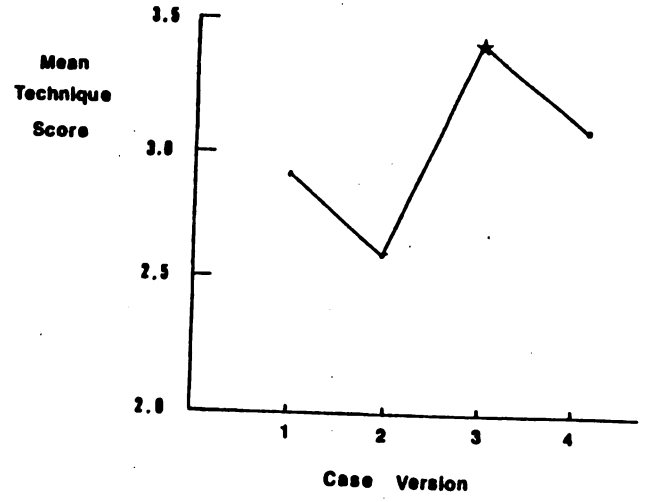
★ = differences are significant
—— = males
---- = females

Note:
THE RELATIONAL CONTEXTS PRESENTED IN EACH CASE VERSION ARE:

1: Active Father - Passive Mother - Son
2: Active Father - Passive Mother - Daughter
3: Passive Father - Active Mother - Son
4: Passive Father - Active Mother - Daughter

Figure 8

Mean Technique Score (11) for Father by Case Version (Family Oriented)



★ = significant contrast

(non-directive versus directive) ($F(1,82) = 4.34$, $p < .04$). For case version three, male respondents indicated they would be directive with the father while female respondents indicated they would be non-directive during therapy with the father.

No significant differences with respect to case version and sex of respondent were found for Father Item #12 (emotionally expressive). An examination of Table 8 in Appendix C reveals that irrespective of case version and sex of respondent, respondents perceived the father as needing to be encouraged to be more emotionally expressive. Consequently, only five of the six technique items were significant when asked about the father. Respondents indicated that passive fathers should be encouraged to be more self-reliant while active fathers should not. The father in case version one is perceived as not needing a directive worker while respondents felt the father in case version three should be encouraged to be family-oriented less so than the father in the other three case versions.

Male respondents indicated that the father in case version three should have a directive worker while female respondents indicated he should have a non-directive worker. For case version two, male respondents tended to perceive the father as needing warmth and support more than did female respondents. However, female respondents tended to perceive the father in case version four as needing warmth and support more than did male respondents. Further, male respondents indicated they would be directive with the father in case version three while for the same father, female respondents indicated they would be non-directive during treatment.

Five technique items were significant when asked about the mother. Figure 10 presents all four case versions significant for the Mother Item #8 (self-reliant) ($F(1,82) = 54.31$, $p < .0001$; $F(1,82) = 10.76$,

$p < .001$; $F(1,82) = 37.75$, $p < .0001$). A Scheffé post-hoc analysis shows that the differences between case versions one and two and between case versions three and four are both nonsignificant (range = 4.03, $p < .05$). These data show that respondents indicated that passive mothers should be encouraged to be more self-reliant while active mothers should not.

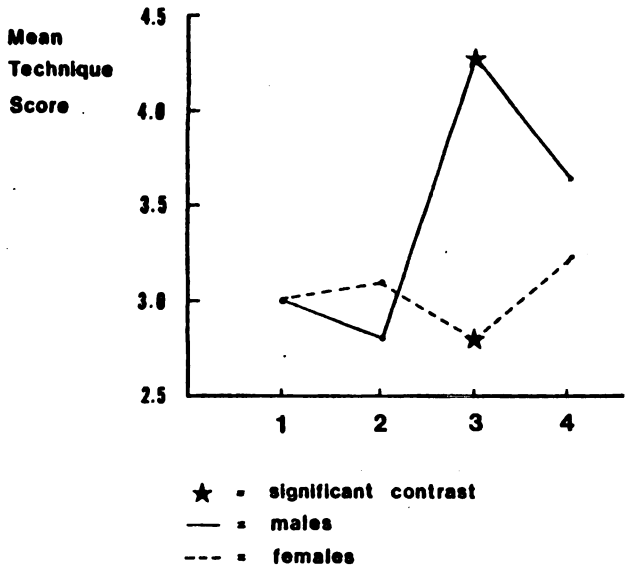
Figure 11 reveals significant interactions between sex of respondent and case versions one, three, and four in regard to Mother Item #8 (self-reliant) ($F(1,82) = 6.78$, $p < .01$; $F(1,82) = 5.30$, $p < .02$). Female respondents tended to perceive the mother in case versions one and three as needing to be encouraged to be more self-reliant more than did male respondents. However, for case version four, male respondents perceived the mother as needing to be encouraged to be self-reliant more than did female respondents. These results (Figure 10 and Figure 11) show that Mother Item #8 (self-reliant) elicited both a main effect with respect to case version and significant interaction effects with respect to sex of respondent and case versions one, three, and four.

Figure 12 shows that Mother Item #9 (directive worker) elicited significant mean scores with respect to case versions two and four ($F(1,82) = 12.34$, $p < .0008$). A Scheffé post-hoc analysis reveals that the difference in mean scores between case versions two and four is significant (range = 4.03, $p < .05$). These results show that respondents indicated the mother in case version two should have a non-directive worker while the mother in case version four should have a directive worker.

Figure 13 illustrates that Mother Item #11 (family-oriented) was significant with respect to case version ($F(1,82) = 6.84$, $p < .01$, $F(1,82) = 23.80$, $p < .0001$, $F(1,82) = 12.21$, $p < .0008$). A Scheffé

Figure 9

Interaction of Case Version and Sex of Subject On Mean Technique Score (13) For Father (Non-Directive vs. Directive)



Note:
THE RELATIONAL CONTEXTS PRESENTED IN EACH CASE VERSION ARE :

1: Active Father - Passive Mother - Son
2: Active Father - Passive Mother - Daughter
3: Passive Father - Active Mother - Son
4: Passive Father - Active Mother - Daughter

Figure 10

Mean Technique Score (8) for Mother by Case Version (Self-Reliant)

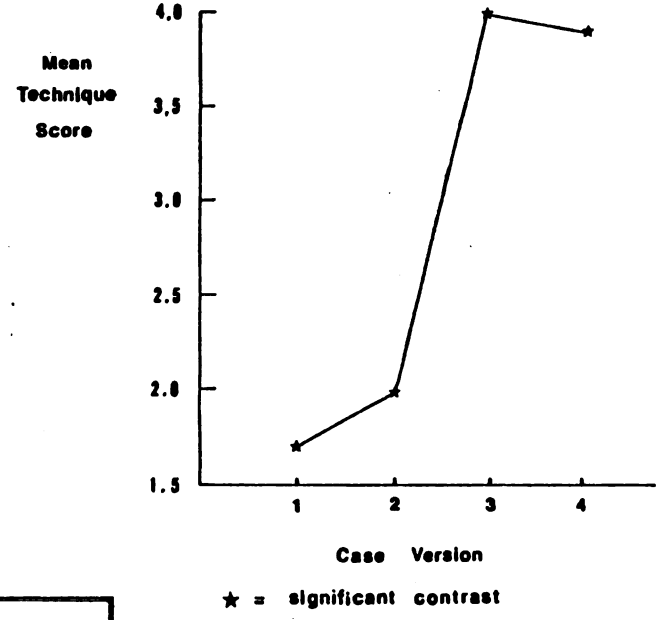
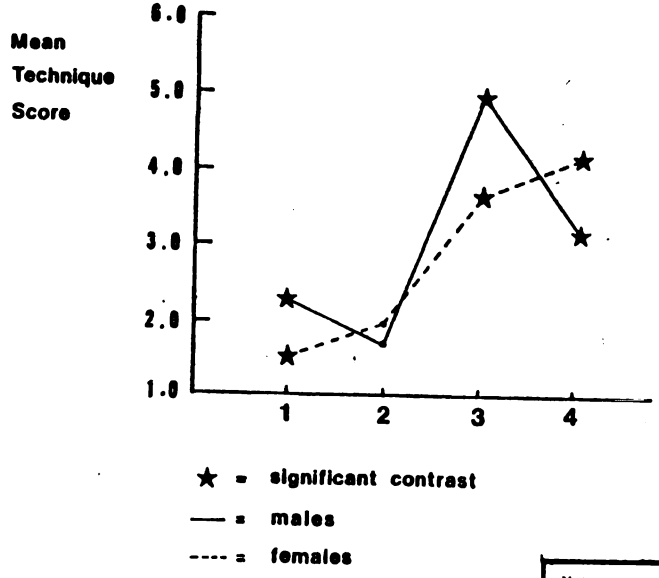


Figure 11

Interaction Of Case Version And Sex Of Subject On Mean Technique Score (8) For Mother (Self - Reliant)

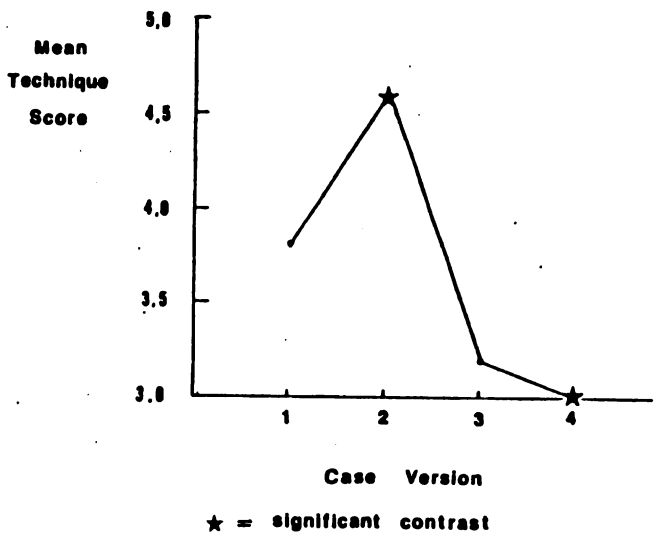


Note:
THE RELATIONAL CONTEXTS PRESENTED IN EACH CASE VERSION ARE :

1: Active Father - Passive Mother - Son
2: Active Father - Passive Mother - Daughter
3: Passive Father - Active Mother - Son
4: Passive Father - Active Mother - Daughter

Figure 12

Mean Technique Score (8) for Mother by Case Version (Directive Worker)



post-hoc analysis reveals that 1) the difference in mean scores between case versions three and four is nonsignificant, 2) there is a significant difference in mean scores between case versions one and three, and that 3) the mean score for case version two is a homogeneous subset in and of itself. These data show that respondents indicated the mother in case versions three and four should be encouraged to be more family-oriented, and that while the mother in both case versions one and two should not be encouraged to be family-oriented, the mother in case version two should be encouraged less so than the mother in case version one.

Figure 14 reveals that for Mother Item #12 (emotionally expressive), case versions one and four elicited significant mean scores ($F(1,82) = 5.01$, $p < .03$). However, while an overall main effect with respect to case version is indicated for case versions one and four, a Scheffé post-hoc analysis shows that the difference in mean scores between case versions one and four is nonsignificant (range = 4.03, $p < .05$).

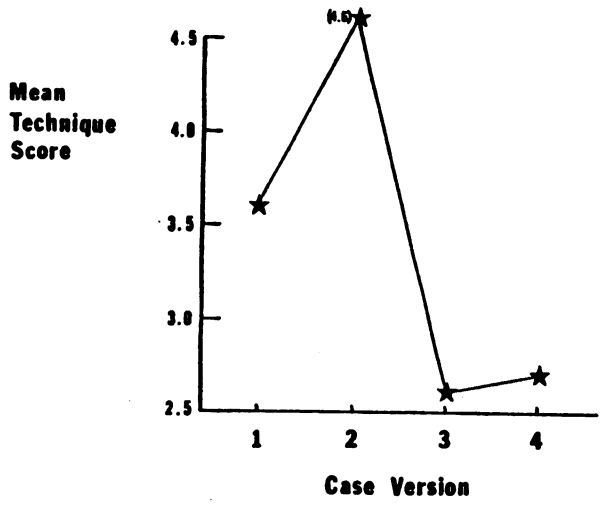
Figure 15 illustrates that Mother Item #13 (non-directive versus directive) elicited significant mean scores with respect to case versions two and four ($F(1,82) = 7.47$, $p < .007$). Further, a Scheffé post-hoc analysis indicates that there is a significant difference in mean scores between case versions two and four. These results indicate that respondents would be non-directive during therapy with the mother in case version two while they would be directive during therapy with the mother in case version four.

No significant differences with respect to case version and sex of respondent were found for Mother Item #10 (warmth and support). Table 12 in Appendix C shows that respondents perceived the mother as needing a considerable amount of warmth and support during treatment irrespective

Figure 13

Mean Technique Score (11) for Mother by Case Version

(Family - Oriented)

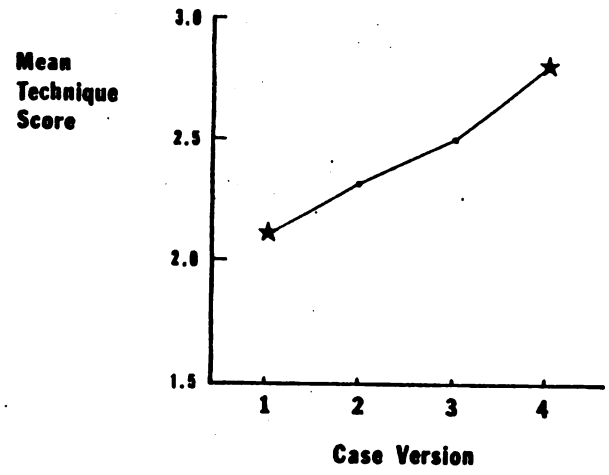


★ = significant contrast

Figure 14

Mean Technique Score (12) for Mother by Case Version

(Emotionally Expressive)



★ = significant contrast

Note:
THE RELATIONAL CONTEXTS PRESENTED IN EACH CASE VERSION ARE:

1: Active Father - Passive Mother - Son
2: Active Father - Passive Mother - Daughter
3: Passive Father - Active Mother - Son
4: Passive Father - Active Mother - Daughter

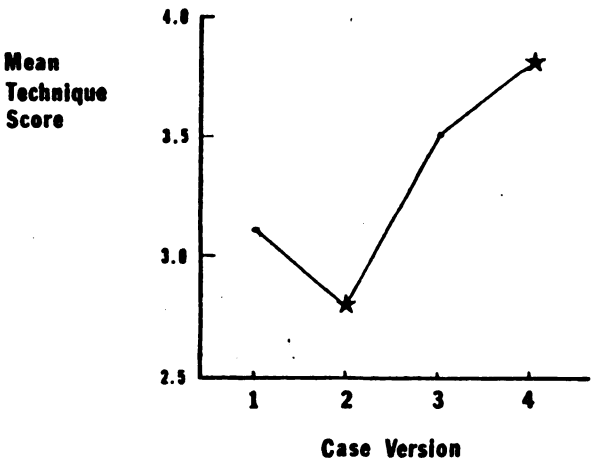
of case version and sex of respondent. This leaves only five technique items significant when asked about the mother. Respondents indicated that passive mothers should be encouraged to be more self-reliant while active mothers should not. The mother in case version two is perceived to need a non-directive worker while the mother in case version four is perceived to need a directive worker. The mother in case versions three and four should be encouraged to be more family-oriented. While the mother in both case versions one and two is viewed as not needing to be encouraged to be more family-oriented, this is the case more so for the mother in case version two. Respondents also indicated they would be non-directive during therapy with the mother in case version two while they would be directive during therapy with the mother in case version four. Female respondents tended to perceive the mother in case versions one and three as needing to be encouraged to be self-reliant more than did male respondents. However, male respondents perceived the mother in case version four as needing to be encouraged to be self-reliant more than did female respondents.

All six technique items generated significant results when asked about the child. Figure 16 shows that the Child Item #8 (self-reliant) is significant with respect to sex of respondent ($F(1,82) = 9.70$, $p < .003$). Further, a Scheffé post-hoc analysis indicates that the difference in mean scores on this item between male and female respondents is significant (range = 2.81, $p < .05$). These results indicate that female respondents saw the child as needing to be encouraged to be self-reliant more than did male respondents.

Figure 17 presents case version three eliciting a significant mean score for Child Item #9 (directive worker) ($F(1,82) = 16.80$, $p < .0001$). The child (son) in case version three is perceived to need a non-directive

Figure 15

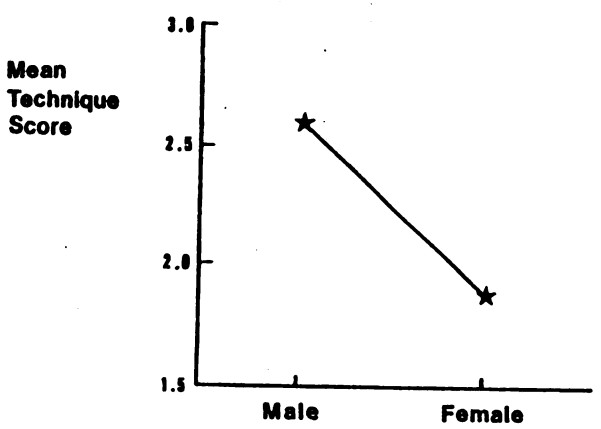
Mean Technique Score (13) for Mother by Case Version (Non-Directive x Directive)



★ = significant contrast

Figure 16

Mean Technique Score (8) for Child by Sex of Subject (Self - Reliant)



★ = significant contrast

Note:
THE RELATIONAL CONTEXTS PRESENTED IN EACH CASE VERSION ARE:

1: Active Father - Passive Mother - Son
2: Active Father - Passive Mother - Daughter
3: Passive Father - Active Mother - Son
4: Passive Father - Active Mother - Daughter

worker more than the child in the other three case versions. Figure 18 illustrates that for Child Item #10 (warmth and support), there are significant differences with respect to sex of respondent ($F(1,82) = 4.41$, $p < .04$). However, while an overall main effect with respect to sex of respondent is indicated, a Scheffé post-hoc analysis reveals that the difference in mean score between male and female respondents is nonsignificant (range = 2.81, $p < .05$).

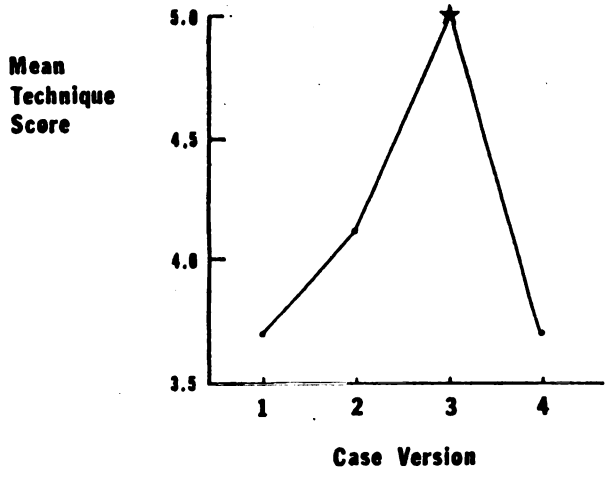
Figure 19 presents Child Item #11 (family-oriented) significant with respect to case version three ($F(1,82) = 4.43$, $p < .04$). These results indicate that the child (son) in case version three should not be encouraged to be family-oriented, significantly more so than the child in the other three case versions. Figure 20 shows that case versions one, two, and four are significant on the Child Item #12 (emotionally expressive) ($F(1,82) = 5.17$, $p < .03$). However, while an overall main effect is presented with respect to case versions one, two, and four, a Scheffé post-hoc analysis reveals that the mean scores for all four case versions are considered in the same homogeneous subset and that there are no significant differences in any pair of mean scores (range = 4.03, $p < .05$).

Figure 21 reveals that the Child Item #13 (non-directive versus directive) was significant only with respect to case version three ($F(1,82) = 5.27$, $p < .02$). These data show that respondents indicated they would be non-directive during treatment with the child (son) in case version three, more so than with the child in the other three case versions.

While overall main effects were found for Child Item #10 (warmth and support) and Child Item #12 (emotionally expressive), post-hoc analyses revealed that the differences in the mean scores in question

Figure 17

Mean Technique Score (9) for Child by Case Version (Directive Worker)



★ = significant contrast

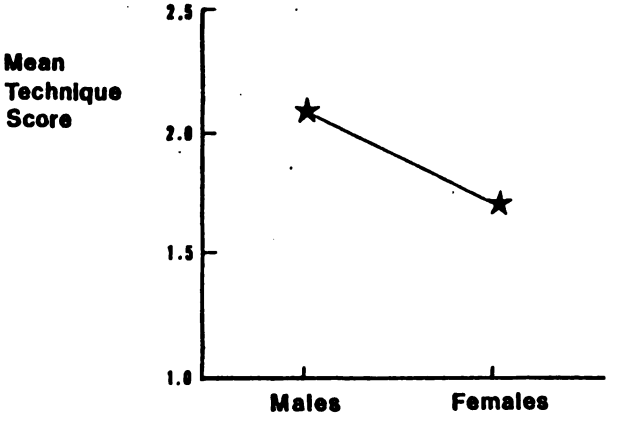
☆☆ = covariate significant

Note:
THE RELATIONAL CONTEXTS PRESENTED IN EACH CASE VERSION ARE:

1: Active Father - Passive Mother - Son
2: Active Father - Passive Mother - Daughter
3: Passive Father - Active Mother - Son
4: Passive Father - Active Mother - Daughter

Figure 18

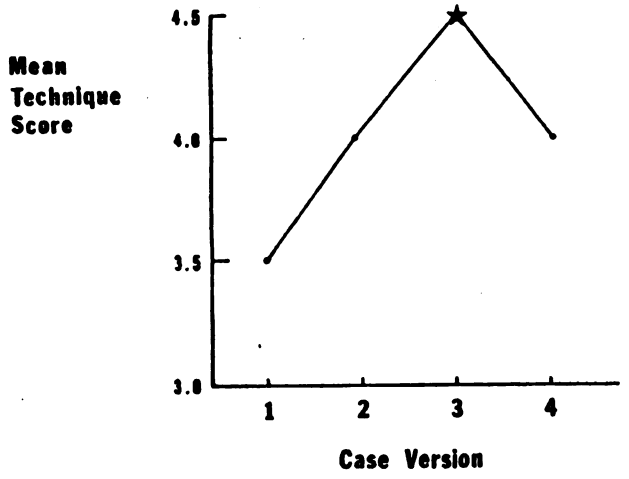
Mean Technique Score (10) for Child by Sex of Subject (Warmth and Support)



★ = significant contrast

Figure 19

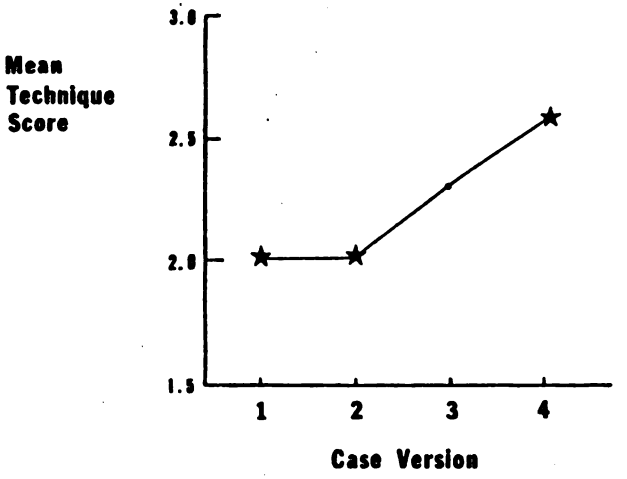
Mean Technique Score (11) for Child by Case Version (Family - Oriented)



★ = significant contrast

Figure 20

Mean Technique Score (12) for Child by Case Version (Emotionally Expressive)



★ = significant contrast

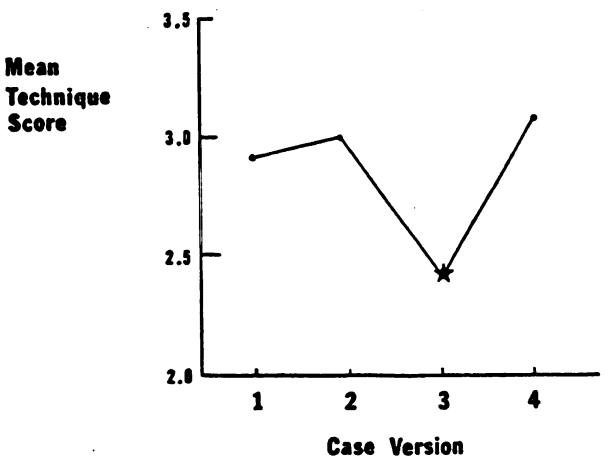
☆☆ = covariate significant

Note:
THE RELATIONAL CONTEXTS PRESENTED IN EACH CASE VERSION ARE:

1: Active Father - Passive Mother - Son
2: Active Father - Passive Mother - Daughter
3: Passive Father - Active Mother - Son
4: Passive Father - Active Mother - Daughter

Figure 21

Mean Technique Score (13) for Child by Case Version (Non-Directive x Directive)



★ = significant contrast

Note:
THE RELATIONAL CONTEXTS PRESENTED IN EACH CASE VERSION ARE:

1: Active Father - Passive Mother - Son
2: Active Father - Passive Mother - Daughter
3: Passive Father - Active Mother - Son
4: Passive Father - Active Mother - Daughter

were nonsignificant. Consequently, only four technique items will be considered as truely significant. Female respondents saw the child (irrespective of case version) as needing to be encouraged to be self-reliant more than did male respondents. The child (son) in case version three is perceived to need a non-directive worker more than the child in the other three case versions. The child (son) in case version three should also not be encouraged to be family-oriented, significantly more so than the child in the other three case versions. In addition, respondents indicated they would be non-directive during treatment with the child (son) in case version three, more so than with the child in the other three case versions. Significant results on child technique items seem to focus on the child (son) in case version three.

Hypothesis 2A proposes a relationship between frequency a problem area is identified as the central focus of treatment and case version. The chi-square (X^2) test for independence was used to identify the significant X^2 distributions according to frequencies a problem area is ranked as most problematic and case version. The distributions were computed for each family member. A significant distribution between perceived major problem area and case version was found for the father, as reported in Table 5 ($X^2 = 51.39$, $p < .00$). Table 5 suggests that for the father in case versions one and two, "limited object relations" and "immature sexual identity" were perceived as major problematic areas. In contrast, "passivity" was identified as a major problematic area for the father in case versions three and four.

Table 6 presents a significant distribution between perceived major problem area and case version for the mother ($X^2 = 53.15$, $p < .00$). The results suggest that for the mother in case versions one and two, it is

Table 5

Perceived Major Problem Area Of Father By Case Version

Case Version	Problem Area 1	2	3	4	5
1	7	13	2	0	2
2	6	9	2	0	6
3	1	1	2	11	4
4	2	2	4	6	6

N = 89

χ^2 = 51.39

df = 12

★ p < 0.00

★ = significant

Table 6

Perceived Major Problem Area of Mother by Case Version

Case Version	Problem Area 1	2	3	4	5
1	1	2	4	12	5
2	0	0	3	12	0
3	3	10	1	0	9
4	1	14	0	1	4

N = 90

χ^2 = 53.15

d.f. = 12

★p < .00

★ = significant

Note:
THE RELATIONAL CONTEXTS PRESENTED IN EACH CASE VERSION ARE:

1: Active Father - Passive Mother - Son
2: Active Father - Passive Mother - Daughter
3: Passive Father - Active Mother - Son
4: Passive Father - Active Mother - Daughter

"passivity" which is identified as the major problematic area. However, "limited object relations" is identified as the major problematic area for the mother in case versions three and four.

No significant distribution between perceived major problem area and case version was found for the child (see Table 25 in Appendix C). Therefore, significant results with respect to Hypothesis 2A were found only for the father and the mother. For active fathers, "limited object relations" and "immature sexual identity" were perceived as major foci of treatment while "passivity" was perceived as the major focus of treatment for passive fathers. "Limited object relations" was identified as the central focus of treatment for active mothers while for passive mothers, "passivity" was identified as the central focus of treatment.

To test Hypothesis 2B, chi-square (X^2) tests for independence were conducted between the ranking distribution of a problem area and case version. This was computed for the father, the mother, and the child on each of the five identified problem areas. For the father, three problem areas were found to have significant ranking distributions with respect to case version. Table 7 illustrates the significant ranking distribution of the problem "immature sexual identity" ($X^2 = 28.08$, $p < .005$). Table 8 shows the significant ranking distribution of the problem "limited object relations" ($X^2 = 34.07$, $p < .0007$) and Table 9 presents the significant ranking distribution of the problem area "passivity" ($X^2 = 74.91$, $p < .00$). No significant ranking distributions were found for the problem areas "environmental and social problems" and "underdeveloped ego skills" (see Tables 26 and 27 in Appendix C).

Four problem areas were found to have significant ranking distributions by case version for the mother. Table 10 reveals the ranking distribution

Table 7

Ranking Distribution Of Father

Problem (1) By Case Version

(Sexual Identity)

Case Version	Ranking Position				
	1	2	3	4	5
1	7	6	9	2	0
2	6	7	4	6	0
3	1	6	3	6	7
4	2	2	8	5	4

N = 91

χ^2 = 28.08

d.f. = 12

★ p < 0.005

★ = significant

Note:
THE RELATIONAL CONTEXTS PRESENTED IN EACH CASE VERSION ARE :

1: Active Father - Passive Mother - Son
2: Active Father - Passive Mother - Daughter
3: Passive Father - Active Mother - Son
4: Passive Father - Active Mother - Daughter

Table 8

Ranking Distribution Of Father

Problem (2) By Case Version

(Limited Object Relations)

Case Version	Ranking Position				
	1	2	3	4	5
1	13	5	2	3	1
2	9	8	4	2	0
3	1	4	6	8	4
4	2	2	7	5	5

N = 91

χ^2 = 34.07

d.f. = 12

★ p < 0.0007

★ = significant

Table 9

Ranking Distribution Of Father

Problem (4) By Case Version

(Passivity)

Case Version	Ranking Position 1	2	3	4	5
1	0	1	0	6	17
2	0	0	1	2	20
3	14	5	1	1	1
4	6	5	5	2	3

N = 91

χ^2 = 74.91

df = 12

★ p < 0.0000

★ = significant

Note:
THE RELATIONAL CONTEXTS PRESENTED IN EACH CASE VERSION ARE :

1: Active Father - Passive Mother - Son
2: Active Father - Passive Mother - Daughter
3: Passive Father - Active Mother - Son
4: Passive Father - Active Mother - Daughter

Table 10

Ranking Distribution Of Mother

Problem (1) By Case Version

(Sexual Identity)

Case Version	Ranking Position 1	2	3	4	5
1	1	3	5	9	6
2	0	1	6	6	10
3	3	5	9	6	0
4	1	6	7	6	1

N = 91

χ^2 = 26.06

d.f. = 12

★ p < 0.01

★ = significant

by case version of the problem area "immature sexual identity" ($X^2 = 26.06$, $p < .01$) and Table 11 presents the ranking distribution of the problem area "limited object relations" ($X^2 = 50.63$, $p < .00$). Table 12 shows the ranking distribution by case version of the problem area "environmental and social problems" ($X^2 = 21.16$, $p < .05$) while Table 13 reports the ranking distribution by case version of the problem area "passivity" ($X^2 = 90.57$, $p < .00$).

Accordingly, no significant ranking distributions were found for any of the five identified problem areas for the child (see Tables 29 - 33 in Appendix C). These ranking distributions were examined in order to identify problem areas which were significantly perceived as not being a problematic area so that results generated in Hypothesis 2A could be augmented. The only additional information found for the father is that "passivity" was significantly perceived as not being a problem for active fathers. While no significant ranking distribution was found for the problem area "underdeveloped ego skills" for the mother (see Table 28 in Appendix C), both "passivity" and "environmental and social problems" were significantly perceived as not being a problematic area for active mothers. In addition, "immature sexual identity" was significantly perceived as not being a problem for the mother in case version two (see Table 10).

Hypothesis 3A required a chi-square (X^2) test for independence in order to examine the distribution between perceived major marital problem area by case version and Hypothesis 3B required the same test for independence in examining the ranking distribution of each identified marital problem area. None of the tests for independence conducted on the perceived major marital problem areas by case version and on the

Table 11

Ranking Distribution Of Mother

Problem (2) By Case Version

(Object Relations)

Case Version	Ranking Position 1	2	3	4	5
1	2	1	6	6	9
2	0	4	6	8	5
3	10	6	6	0	1
4	14	4	1	1	1

N = 91

χ^2 = 50.63

d.f. = 12

★p < 0.0000

★ = significant

Note:
THE RELATIONAL CONTEXTS PRESENTED IN EACH CASE VERSION ARE :

1: Active Father - Passive Mother - Son
2: Active Father - Passive Mother - Daughter
3: Passive Father - Active Mother - Son
4: Passive Father - Active Mother - Daughter

Table 12

Ranking Distribution Of Mother

Problem (3) By Case Version

(Environmental - Social)

Case Version	Ranking Position 1	2	3	4	5
1	4	3	4	5	8
2	3	6	5	4	5
3	1	3	6	10	3
4	0	3	7	11	0

N = 91

χ^2 = 21.16

d.f. = 12

★p < 0.05

★ = significant

Table 13

Ranking Distribution Of Mother

Problem (4) By Case Version

[Passivity]

Case Version	Ranking Position 1	2	3	4	5
1	12	12	0	0	0
2	12	6	4	1	0
3	0	0	1	3	19
4	1	0	2	0	18

N = 91

χ^2 = 90.57

d.f. = 12

★ p < 0.0000

★ = significant

Note:
THE RELATIONAL CONTEXTS PRESENTED IN EACH CASE VERSION ARE :

1: Active Father - Passive Mother - Son
2: Active Father - Passive Mother - Daughter
3: Passive Father - Active Mother - Son
4: Passive Father - Active Mother - Daughter

ranking distribution of each identified marital problem area were significant (see Tables 34 - 39 in Appendix C).

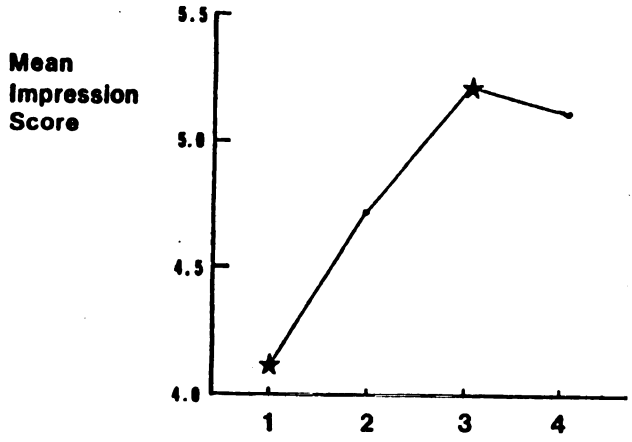
To test Hypothesis 4, the same analysis of co-variance used to test Hypotheses 1A and 1B was conducted for each of the three items on the father-child relationship, the mother-child relationship, and overall prognosis for family therapy. No significant differences in mean clinical impression scores with respect to case version and sex of respondent were found for the father-child relationship (see Table 22 in Appendix C).

Figure 22 illustrates significant differences in mean clinical impression scores of the mother-child relationship with respect to case versions one and three ($F(1,82) = 20.79$, $p < .0001$; $F(1,82) = 7.59$, $p < .007$). Further, a Scheffé post-hoc analysis reveals that the difference in mean clinical impression scores between case versions one and three is significant (range = 4.03, $p < .05$). These results indicate that the mother-child relationship in case version three elicited a more problematic clinical impression than did the mother-child relationship in case version one. In addition, Figure 23 illustrates a significant interaction between sex of respondent and case version one in regard to subjects' assessment of the mother-child relationship ($F(1,82) = 3.73$, $p < .05$). These results indicate that female respondents perceived the mother-child relationship in case version one as being problematic more than did male respondents.

Figure 24 shows that the family prognosis item was significant with respect to sex of respondent ($F(1,82) = 4.76$, $p < .03$). However, while an overall main effect with respect to sex of respondent is indicated, a Scheffé post-hoc analysis reveals the difference in the mean impression scores of male and female respondents to be nonsignificant (range = 2.81, $p < .05$). Consequently, only the results with respect to

Figure 22

Mean Impression Score Of The Mother - Child Relationship By Case Version



★ = significant contrast

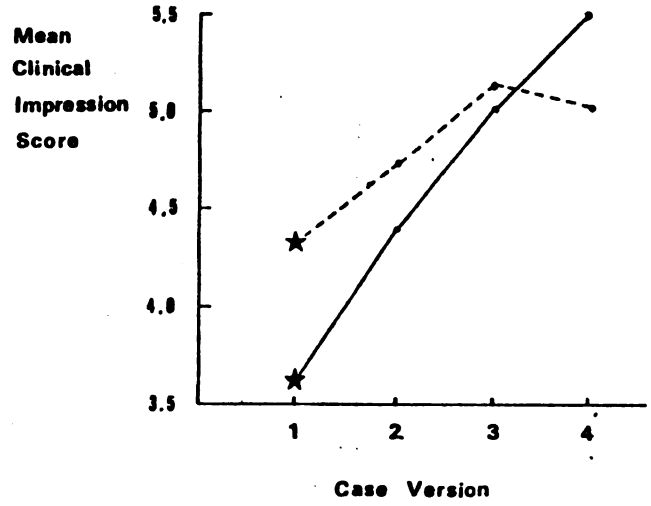
☆☆ = covariate significant

Note:
THE RELATIONAL CONTEXTS PRESENTED IN EACH CASE VERSION ARE :

1: Active Father - Passive Mother - Son
2: Active Father - Passive Mother - Daughter
3: Passive Father - Active Mother - Son
4: Passive Father - Active Mother - Daughter

Figure 23

Interaction of Case Version and Sex of Subject On Subject's Assessment of the Mother – Child Relationship



★ = differences are significant

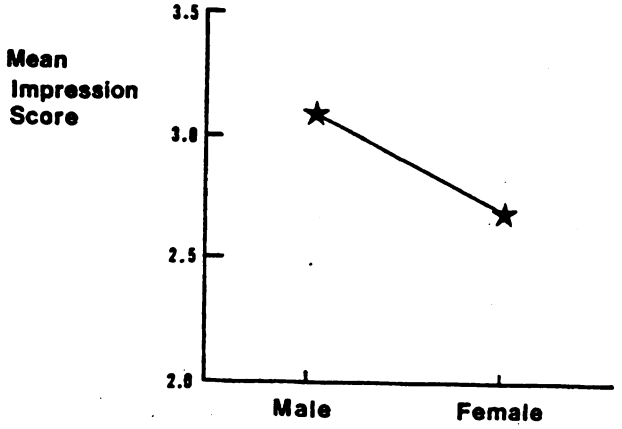
—— = male subjects

- - - = female subjects

☆☆ = covariate significant

Figure 24

Mean Impression Score for Family Prognosis by Sex of Subject



★ = significant contrast

Note:
THE RELATIONAL CONTEXTS PRESENTED IN EACH CASE VERSION ARE :

1: Active Father - Passive Mother - Son
2: Active Father - Passive Mother - Daughter
3: Passive Father - Active Mother - Son
4: Passive Father - Active Mother - Daughter

the mother-child relationship will be considered significant. That is, the mother-child relationship in case version three elicited a more problematic clinical impression than did the mother-child relationship in case version one. Further, female respondents perceived the mother-child relationship in case version one as being problematic more than did male respondents.

The covariate was found to be significant on three items: child technique item #9 (directive worker), child technique item #12 (emotionally expressive), and subjects' assessment of the mother-child relationship. Recall that the covariate used was a contemporary-traditional ratio score reflecting the respondent's orientation toward women. A ratio score less than one reflected a more contemporary orientation toward women while a ratio score greater than one reflected a more traditional orientation toward women. Hence, a significant covariate would indicate that a subject with a contemporary orientation tended towards one response pattern while a subject with a traditional orientation toward women tended towards the opposite response pattern.

A significant covariate on the child technique item #9 ($F(1,82) = 16.80$, $p < .0001$) indicates that respondents with a contemporary orientation toward women were more apt to chose a directive worker for the child while respondents with a traditional orientation toward women were more apt to choose a non-directive worker for the child. In regard to child technique item #12 ($F(1,82) = 5.17$, $p < .03$), a significant covariate is interpreted to mean that respondents with a contemporary orientation toward women tended to perceive the child as needing to be encouraged to be more emotionally expressive while respondents with a traditional orientation toward women tended to perceive the child as

not needing this type of encouragement. A significant covariate on the item eliciting an impression of the mother-child relationship ($F(1,82) = 4.61$, $p < .03$) indicates that respondents with a contemporary orientation toward women tended to perceive the mother-child relationship as being less problematic while those respondents with a traditional orientation toward women were more apt to perceive the mother-child relationship as being problematic. With the exception of the above three items, none of the other items were found to be significant with respect to the covariate.

Chapter IV

Discussion

Since one of the major issues investigated in the present study involves whether or not relational context influences the assessment of family members and their corresponding intrafamilial relationships, a recapitulation of the relational contexts used is in order. Each relational context presents an active parent profile, a passive parent profile, and an active child profile. The active parent profile and the active child profile were initially designed around stereotypically male traits in order to reflect the appropriate identification bond between a father and a son. The passive parent profile was initially designed around stereotypically female traits in order to reflect the traditional role of the mother.

These profiles comprised the traditional relational context of an active father, a passive mother, and a son. By duplicating the relational context, changing only the sex of the child, a second traditional relational context comprised of an active father, a passive mother, and a daughter ensued. The two counterpart relational contexts followed by duplicating these two versions, reversing only the sex of the parent profiles and yielding the following two additional relational contexts: one comprised of a passive father, an active mother, and a son, and one comprised of a passive father, an active mother, and a daughter. These then were the four relational contexts within which family members and their corresponding intrafamilial relationships were assessed.

As mentioned above, each relational context presented an active parent profile and a passive parent profile. The subjects were able to differentiate between the active and passive parent profiles regardless of the sex of the parent or the sex of the child. The active parent was viewed significantly as not needing to be encouraged to be more self-reliant and "limited object relations" was chosen as the central focus of treatment. Further, for an active parent, "passivity" was significantly viewed as not being a problem. In contrast, the passive parent was perceived as needing to be encouraged to be more self-reliant, with "passivity" designated as the central focus of treatment. On these dependent variables, the active-passive parent profiles were differentiated regardless of the sex of the parent and the sex of the child.

However, the active-passive parent profiles were further delineated depending only on the sex of the parent. When the parent was a father, active fathers elicited a more negative, unhealthy clinical impression than did passive fathers. In addition, "immature sexual identity" was identified as a major problem area for active fathers only. Since the active parent profile was initially designed to illustrate active parental involvement in the parent-child relationship, these results suggest that active fathers are perceived as being more unhealthy than are passive fathers, and that the sexual identity of the active father is seriously questioned.

The active-passive parent profiles were also further differentiated when the parent was a mother. Active mothers were perceived as needing to be encouraged to be more family-oriented while passive mothers were not. Further, "environmental and social problems" was significantly

viewed as not being a problem for active mothers (regardless of the sex of the child). These results are interesting given that the mother in all four relational contexts was presented as being employed outside of the family unit. When considering that "environmental and social problems" did not generate any significant differences for the father, these results seem to suggest that environmental and social problems are not considered germane to the emotional problems of the active mother (regardless of the sex of the child).

While the above specific differences in regard to relational context were found to be delineated with respect to the active-passive parent profiles, other specific results illustrating the influence of relational context on the assessment of family members and their corresponding intrafamilial relationships were found. For ease of presentation and discussion, the significant results with respect to relational context will be presented for each family member.

Relational context alone seemed to influence the assessment of the father on only two dependent variables and only when the child was a son. The active father with a son (-passive mother) was significantly perceived as needing a non-directive worker. Quite frequently an appropriate way to deal with an angry, pushy, concerned father is to gently reflect the underlying feelings he is expressing in order to allow him to ventilate and to feel he is being heard and listened to. However, this does not account for why the active father with a son would be considered as needing a non-directive worker and not an active father with a daughter.

In a similar fashion, the passive father with a son (-active mother) was perceived significantly as not needing to be encouraged

to be more family-oriented while such was not the case for the passive father with a daughter. One explanation for this specific finding could involve the father providing an appropriate gender role model (i.e. outer-directed) for the son. Such a viewpoint would require the passive father with a son to be more outer-directed in order that the son may learn the appropriate role behavior when he himself becomes a father. This presumably would not be as important when the child was a daughter.

In contrast with the father, several dependent variables were found to be influenced by the relational context in the assessment of the mother. Further, in terms of clinical impressions of the mother, the son was rather influential while the daughter seemed to influence technique decisions when asked about the mother. The active mother with a son (-passive father) elicited a more negative, unhealthy clinical impression than did the passive mother with a son (-active father). In addition, the active mother-son relationship was perceived as being significantly more problematic than was the passive mother-son relationship. These results seem to suggest both the extent the son influences the assessment of the mother and the clinical attention awarded to the male child. Clinical attention to both the son and the daughter were suggested in the formulation of the clinical impressions of the father while for the mother, clinical impressions seem to be influenced by the son only.

On the other hand, the only technique items for the mother that were significant with respect to relational context involved the daughter. For the active mother with a daughter (-passive father), subjects indicated that the mother would need a directive worker and

that they themselves would be directive with this mother during treatment. In contrast, subjects indicated they would be non-directive with a passive mother with a daughter (-active father) and also indicated that this mother would need a non-directive worker. These results are somewhat puzzling given the significant influence the son seems to play in the formulation of clinical impressions of the mother. Even more striking is a comparison of these results with the non-directive worker chosen for the active father with a son (-passive mother). The pattern seems reversed, with the active mother with a daughter perceived as needing a directive, rather than a non-directive, worker and the passive mother with a daughter designated as needing a non-directive worker.

One additional finding seems to single out the passive mother with a daughter (-active father). For the mother in this relational context, "immature sexual identity" was significantly perceived as <u>not</u> being a problem. Since the child in this relational context was a daughter, this may suggest that the passive mother was perceived as providing an appropriate sexual identity model for the daughter. Since sexual identity is generally considered to develop from identification with the same-sex parent, this significant result may also comment indirectly on what is considered an appropriate sexual identity model for a daughter.

In regard to the child, the relational context seemed only to influence technique decisions about the son with an active mother and a passive father. The son in this relational context was significantly perceived as needing a non-directive worker, and subjects indicated they themselves would be non-directive with this son during treatment. In addition, the son was significantly perceived as <u>not</u> needing to be

encouraged to be more family-oriented. These data seem to reflect some concern over the active mother-son relationship and the clinical attention awarded to the son. This seems to follow suit with the active mother-son relationship perceived as being more problematic and the active mother (with a son) eliciting a more negative, unhealthy clinical impression.

The above significant results strongly suggest that relational context does influence the assessment of family members and their corresponding intrafamilial relationships. Further, the results also reveal the clinical attention frequently awarded to the son, both in terms of technique decisions in regard to individual family members and in the assessment of the mother and the mother-child relationship. These specific results were identified despite the subjects' ability to differentiate, on some dependent variables, between the active and passive parent profiles.

In addition to examining the influences of relational context on the assessment of family members and their family relationships, the other main effect tested was sex of respondent. Out of all of the data generated, only one item was significant with respect to sex of the respondent. Female subjects perceived the child as needing to be encouraged to be self-reliant more than did male subjects. This was the case irrespective of the relational context within which the child was assessed. This finding suggests that female clinicians perceive a school-age child as needing to be encouraged to be self-reliant while male clinicians perceive the child as needing this type of encouragement to a lesser degree. Perhaps this differential in degree lies in the issue over whether or not a child is ready to be self-reliant. Female

subjects seem to think so while male subjects may not view the child as being ready or needing to be self-reliant.

While the above result was the only significant item found with respect to sex of the respondent, a number of significant interactions between relational context and sex of respondent were found. These results seem to suggest that, within a particular relational context, male and female clinicians perceive the family member and the mother-child relationship in somewhat different ways. For the passive father with a son (-active mother), males perceived the father as needing a directive worker and indicated they themselves would be directive with this father during treatment. In contrast, female subjects perceived the father as needing a non-directive worker and they indicated they themselves would be non-directive with the father during treatment. It is not clear to what extent the son and/or the active mother is influencing these outcomes, or to what extent a passive father in this relational context elicits these differential responses in male and female subjects.

Additionally, male subjects perceived the active father with a daughter (-passive mother) as needing warmth and support more than did female subjects while the reverse was so for the passive father with a daughter (-active mother). Females felt the passive father with a daughter needed warmth and support more than did male subjects. These results suggest male clinicians would give the active father with a daughter considerably more warmth and support while female clinicians would give the passive father with a daughter considerably more warmth and support during treatment. Again, it is not clear which aspect of the relational context (or, for that matter, the relational context

itself) seems to be influencing these generated results. However, it is clear that subjects were considering the father with a daughter.

Other significant interactions between relational context and sex of the respondent were found to be influential in the assessment of the mother and the mother-child relationship. Males perceived the active mother with a son (-passive father) as being more healthy than did female subjects. However, female subjects perceived the active mother with a daughter as being more healthy than did males. These results seem to suggest that the sex of the child and sex of the clinician together influence the assessment of the active mother, with possible same-sex identification between the child and the clinician being a possible influencing factor.

The same-sex factor may also explain why males perceived the passive mother-son relationship as being less problematic than did female subjects. Male respondents could be identifying with both the son and the active father, thereby reducing possible perceived negative effects stemming from the passive mother-son relationship. The active father as an appropriate model for the son could also be perceived as being enough of a model to offset the passive mother-child relationship when the child is a son, a situation males could possibly identify with more so than females.

Interestingly enough, female respondents perceived the passive mother with a son (-active father) and the active mother with a son (-passive father) as needing to be encouraged to be self-reliant more than did males. This reflects the attention awarded by females to the mother (with a son) in terms of needing to be self-reliant. However, when it is an active mother with a daughter (-passive father), males

perceive the mother as needing to be self-reliant more than female respondents. This reversal could be due either to the fact that the child is a daughter or due to the passive father in the relational context. Since the same result was not found for the passive mother with a daughter (-active father), it may very well be the passive father in the relational context that is the influential factor.

Admittedly, the ratio of male to female subjects participating in the present study is rather low. However, the above results strongly suggest that in regard to particular relational contexts, male and female clinicians perceive the situation somewhat differently. These differences in perception seem to be elicited more so by the passive father-active mother-child relational contexts, with these elicited differences influencing the assessment of the father and of the mother. Sex differences in clinicians' assessment of parents and the mother-child relationship in particular relational contexts should be further explored with larger samples of male and female subjects.

While all of the above results comprise the significant results generated, a number of nonsignificant results were found. Since there are a number of specific dependent variables which were nonsignificant, they are presented for each family member and the corresponding intrafamilial relationship. There were no significant differences on the "emotionally expressive" technique item for the father with respect to relational context and sex of the respondent. The generated mean scores indicate that respondents perceived the father as needing to be encouraged to be more emotionally expressive, irrespective of the relational context and sex of the respondent. These results suggest that fathers, in general, are perceived to need help in expressing emotions. This would

be considered to be the case if the father were always the instrumental, outer-directed specialist depicted in the traditional model of the nuclear family. These results suggest that the fathers in the four relational contexts were perceived in this fashion in regard to needing to be more emotionally expressive.

With respect to the problem areas "environmental and social problems" and "underdeveloped ego skills", neither was significant when asked about the father. While "underdeveloped ego skills" was also not significant for the mother, it is interesting that "environmental and social problems" was not found to be a significant problem area for the father. One could argue that a very limited amount of information was presented in the case analogues with which subjects could assess this problem area. Such a rationale would suffice for the nonsignificant finding for the father, but would then highlight the significant finding of this problem area for the active mother.

No significant differences with respect to relational context and sex of respondent were found in the assessment of the father-child relationship. One could propose that the item eliciting an impression of the father-child relationship was itself deficient. However, were this the case, then no significant differences should have been found for impressions of the mother-child relationship since the same item was used. Rather, it would seem that these results suggest the tendency to ignore the father-child relationship in the assessment of a family. This would particularly be the case if the mother and the mother-child relationship were awarded clinical attention as a major source of internal family problems.

As mentioned previously, no significant results were found in regard

to the problem area "underdeveloped ego skills" when asked about the mother. A similar finding of nonsignificance of this problem area was found when asked about the father. Both nonsignificant results are interpreted to mean that other designated problem areas were significantly perceived as major problem areas for the mother and the father as opposed to identifying "underdeveloped ego skills". Consequently, no significant distributions between this problem area and relational context were found for either parent.

In contrast, the nonsignificant result on the warmth and support technique item for the mother suggests that mothers in general are perceived to need a considerable amount of warmth and support during treatment, irrespective of relational context and sex of respondent. This perception would hold true given the expressive specialist the mother is portrayed as in the traditional model of the nuclear family unit. In addition, these data also comment on how mothers should be handled during treatment. While most individuals would welcome warmth and support during treatment, it is particularly noteworthy that mothers, and not fathers, were perceived as needing a conciderable amount of warmth and support during treatment.

Neither the clinical impression scores nor the ranking of problem areas were significant when asked about the child. One could argue that these data reflect a tendency to ignore the child in family assessment. Such an argument is not tenable, particularly given the influences of the sex of the child in assessment of the parents and the mother-child relationship. A more tenable argument would focus on the methodological structure of the items eliciting a clinical impression and on the problem areas designated for ranking. Both sets of items were previously designed for the assessment of individual adults, and may very well be inappropriate

in identifying specific differences with respect to the relational context and sex of the respondent in regard to the child.

A similar argument may be posited for the nonsignificant results generated in the ranking of marital problem areas. It could very well be that analysis of a marital relationship is not amenable to the ranking of the specific marital problem areas identified. Further, a review of the case analogues used reveals that very little information about the marital relationship was included which subjects could use in assessing the marital problem areas identified. Perhaps a more funtional way of recording subjects' impressions of the marital relationship would have been to use a similar item as was used for the parent-child relationships, rather than a more detailed ranking of designated marital problem areas.

A lack of significant results was also found on the overall family prognosis item with respect to relational context. This finding is interpreted to mean that regardless of the relational context presented in the case analogue, all four versions generally elicited favorable prognoses for family therapy. These data suggest that the relational context does not influence a family's overall prognosis for family treatment. It is important to recognize that this finding is with respect to the overall prognosis for family treatment, and does not necessarily reflect a lack of specific significant results with respect to relational context, as previously reported significant results indicate.

While several dependent variables were initially significant with respect to an overall main effect, post-hoc analyses reveal the differences to be nonsignificant. These results can not legitimately be considered significant. However, neither can they legitimately be classified as

nonsignificant results. Rather, these results should be identified as areas in need of further exploration in order to more precisely determine the influential factors in operation. It would be best not to comment on the following items at this initial stage of investigation: emotionally expressive technique item for the mother (relational context), warmth and support technique for the child (sex of respondent), emotionally expressive technique item for the child (relational context), and overall prognosis for the family treatment (sex of respondent).

Finally, the covariate was found to be significant on two child technique items and on subjects' assessment of the mother-child relationship. These findings are in accord with the results presented by Brown and Hellinger (1975). In regard to the child technique items, the results suggest that those respondents with a contemporary orientation toward women were more apt to choose a directive worker for the child and tended to perceive the child as needing to be encouraged to be more emotionally expressive. On the other hand, those respondents with a traditional orientation toward women were more apt to choose a nondirective worker for the child and tended to perceive the child as not needing to be encouraged to be more emotionally expressive. These items seem to reflect a difference in child rearing modes depending on the individual's orientation toward women.

However, it is the significant covariate with respect to subjects' assessment of the mother-child relationship that is the most crucial finding of the three. The results strongly suggest that respondents with a contemporary orientation toward women tended to perceive the mother-child relationship as being problematic. This finding is crucial in that significant results were generated in subjects' assessment of

the mother-child relationship while the father-child relationship tended to be ignored. If clinical attention is awarded to the mother-child relationship (as seems to usually be the case), then a clinician's cultural orientation toward women would seem to be an influential factor in the assessment of the family relationships involved.

This finding is important in family assessment for implications other than just the assessment of the mother-child relationship. Since it was previously delineated in the literature review how gender-typed roles in the family unit are defined in relation to one another, a stereotyping of the mother-child relationship along traditional lines would suggest a possible stereotyping of all the gender-typed roles and gender-typed family relationships in the family unit. Such a perspective would not accomodate fathers being actively involved in the parent-child relationships, and would lead to clinically favor behavior and family relationships which adhere to the gender-typed roles and gender-typed family relationships as defined in the traditional model of the nuclear family unit.

Summary

Preliminary results in the investigation of gender role bias in family assessment strongly suggest that relational context does influence the assessment of family members and their corresponding intrafamilial relationships. While subjects were able to differentiate between an active and passive parent profile, the active-passive parent profiles were further delineated depending only on the sex of the parent. Specific results illustrating the influence of relational context on clinical impressions and technique choices were also found for family members and the mother-child relationship. While only one technique item for

the child was found to be significant with respect to sex of the respondent, numerous interaction effects between relational context and sex of respondent were found to be significant in subjects' assessment of the parents and the mother-child relationship. In addition, the covariate was found to be significant with respect to two child technique items and subjects' assessment of the mother-child relationship.

Significant results generated reflect the clinical attention awarded to the son in technique choices made for all three family members (father, mother, child), and in subjects' assessment of the mother and the mother-child relationship. In fact, the noticeable lack of clinical attention given to the daughter may indeed reflect the differential value placed on a male child as opposed to a female child. These results seem to suggest that a male child is paid more clinical attention than is given a female child, with clinical impressions of the mother and the mother-child relationship being influenced by the son. Further investigation of this differential degree in clinical attention awarded to sons as opposed to daughters is warranted.

There is also some indication that family members and family relationships which conform to the traditional model of the nuclear family unit elicit more favorable clinical judgments. This was particularly the case for the mother-child relationship, the assessment of which was found to be significantly related to the subject's orientation toward women. In addition, the results also suggest a tendency to ignore the father-child relationship, with active fathers eliciting a more negative, unhealthy clinical impression than did passive fathers.

Since available data on instruments used in the present study were generated in the assessment of individual clients, it would prove meaningless to compare the present results with previously generated results. On the other hand, the results of the present study would be more beneficial in delineating future areas of investigation. As previously noted, further investigation of the difference in clinical attention awarded to the male child as opposed to the female child seems desirable. Additionally, further investigation of the mother-daughter relationship would be justified given the identified influence of the son in the assessment of the mother and of the mother-child relationship.

Fathers who are active in their parent-child relationships would also prove to be a fruitful research endeavor, particularly since the present results suggest the tendency to ignore the father-child relationship. With an increasing number of fathers becoming involved in the birth of their children (e.g. the Lamaze method of childbirth), it would be possible to explore both the sexual identity and overall mental health of active fathers who have opted for an active parental role in the rearing of their children. Undoubtedly the number of fathers who play an active role in the parent-child relationship will increase in the next couple of years and research in this area is necessary to insure that clinicians conducting family assessments do not continue to exclude the father-child relationship in the assessment of family relationships.

Since no significant results were generated in clinical impressions and ranking of problem areas for the child, it would seem useful to develop a scale whereby the influence of the relational context on

clinical impressions of the child could be further delineated. This is particularly important given the fact that family therapy usually involves children and given the differential clinical attention awarded to sons as opposed to daughters. Exploration of the influence of relational context on assessment of the child could also reveal how a clinician's assessment reinforces both parental expectations of appropriate gender role behavior for children and actual gender role behavior of the child in question.

Stereotyping of the marital relationship is also a crucial area warranting further investigation. If a clinician's orientation toward women is significant with respect to the assessment of the mother-child relationship, then a clinician with a traditional orientation toward women may also be stereotyping the marital relationship involved. While this conclusion is made on a conceptual level of abstraction, it can easily be determined through exploration of a clinician's clinical impression of various marital relationships in differing relational contexts.

Finally, further investigation of the differences in clinical impressions and judgments of male and female clinicians need to be investigated with respect to particular relational contexts. The present study strongly suggests that these types of differences in judgment with respect to relational context and sex of the clinician do occur. While these results currently can only be considered as biases in clinical judgment, how these biases play a part in countertransference phenomena once treatment is underway remains to be ascertained. Such a line of inquiry would be important if clinicians are to provide high-quality direct services to the currently changing

family unit in contemporary American society.

The results presented in this study strongly suggest that relational context influences clinical impressions and judgments of family members and their corresponding intrafamilial relationships. Significant differences between male and female respondents also suggest that relational context and sex of the clinician may influence the assessment of the parent, the child, and the corresponding mother-child relationship. Further, there is some indication that family members and family relationships which conform to the traditional model of the nuclear family unit elicit more favorable clinical impressions and judgment. This is particularly the case for the assessment of the mother-child relationship, the assessment of which was found to be significantly related to the respondent's orientation toward women. These preliminary results indicate the utility of further exploring the influence of gender role bias in the assessment of family members and their corresponding intrafamilial relationships.

APPENDICES

APPENDIX A

CASE VERSIONS

CASE VERSION #1

THE "P" FAMILY

Identifying Information

Mr. P, age 30 - Graduate student in Business Administration
Mrs. P, age 28 - Legal secretary
Don, age 6 - First Grade at Baily Elementary School

Referral Reason: The school social worker referred this family to Family and Child Services because the school was having some behavioral problems with Don. She indicated that she felt this might be a "family problem" but she was not certain. She went on to explain that Don's teacher had complained about his behavior. While Don was progressing normally academically in school, he was prone to temper tantrums, is easily distracted, and frequently wanders around the room poking at the other children and distrupting class sessions. At times, Don was seen pushing and fighting with other children during recess and after school. The school social worker also explained that she and Don's teacher had met yesterday with Don's parents in a regularly scheduled conference. She described Mr. P as being domineering, aggressive, and overpowering, and frequently speaking in a punitive manner. She stated that both she and the teacher found it very hard to work with him. Mrs. P was described as the "shy, quiet, somewhat reticent type." The school social worker ended by explaining that both parents had agreed that a family assessment might help everyone understand why Don was behaving this way, and that they would contact the agency for a family assessment session.

Telephone contact with: Mr. P (two weeks later)
Mr. P began the conversation by angrily stating that he had called earlier in the morning and had left a message for him to be contacted. I explained that I had been on a home visit earlier and that I had just returned to the office. I wondered out loud what our agency could do for him now that we had the opportunity to talk. Mr. P asked if the school had contacted this agency about his son Don. I explained that while I was not the individual who spoke with the school social worker, a referral form had been completed by one of the other workers. Mr. P remarked that that did not sound like a very efficient way of handling requests but that he guessed he might as well talk to me. He explained that Don's teacher and social worker both thought it might help if his family were seen by someone and that he was calling for an appointment so that they wouldn't pick on Don anymore. I asked him if he could help me understand what he meant by Don not being picked on anymore. He stated that he felt if he did not call for an appointment, then the teacher and the social worker would start picking on Don and singling him out since they obviously felt it was necessary. I asked Mr. P how he felt about a family session and he defensively explained that he did not say they would not come. I then asked Mr. P if he ever felt "picked on and singled out." Mr. P replied no, then immediately asked if he could make an appointment for his family to come in. I asked him what times during the week could we compare our time schedules on as possible appointment times. Mr. P stated that his work kept him very busy during the day and well into the night, and that he had to schedule around his work. He stated that Thursday afternoon at one would be a good time. I replied that I had that appointment slot open, and would he and his family like to come in this week. Mr. P then suddenly remembered that he had an important appointment for lunch that time this week, and wanted to know if he could make an appointment for the following week. The appointment was confirmed and we hung up.

Family Session:
Mr. and Mrs. P and Don came into the office together and sat down. Mr. P and Don sat on the devan while Mrs. P sat near Don on a chair next to the devan. Don seemed quite excited when they first came in, but then became shy and somewhat withdrawn when they were asked why each of them thought they were here this afternoon. I stated that Don seemed a little uncomfortable, and that I was wondering why he thought he was here today. Don glanced at Mr. P and shrugged his shoulders. I asked him if he felt uncomfortable talking right now and he nodded his head yes. Mr. P then stated that he could understand why Don felt the way he did about "it", and I asked Mr. P if he could explain what he meant by "it". Mr. P then stated that Don was having some problems with his teacher at school and that he felt "picked on". I then asked Don if this was how he felt. Don again quickly glanced at Mr. P and nodded his head yes.

I then turned to Mrs. P, who had been sitting quietly with her eyes downcast, and asked her how she saw them being here today. Mrs. P cleared her throat before she began to speak, and I noticed Don glancing at Mr. P. Mrs. P stated that she also thought that Don was having some problems at school and she quietly insisted that they were open to any criticism I may have about the way they were raising Don. Mr. P immediately began explaining that he knew how Don felt because he had felt the same way when he was a child, and that the way schools were nowadays, the quality of teachers was pretty low. I then stated that it seemed as though Mr. and Mrs. P saw things differently as to what might be contributing to Don's school behavior. Mr. P defensively insisted that he did not say nothing in the home was contributing to Don's behavior.

Mrs. P then looked at me in what I felt was a beseeching manner, and said that she was not disagreeing with Mr. P, and that she really didn't know what was happening at school. I reflected that she seemed to feel pretty helpless about the situation, and Mrs. P allowed that she frequently felt that way with Don. Mr. P then explained that Don was a pretty active child. He hastily added that Don wasn't a hyperactive child, but that he had a lot of energy and was always wanting to be on the move. Mrs. P smiled briefly and said that Don takes after Mr. P on that point. When Don heard this, he gave a big smile, and I noticed that he seemed pretty pleased when Mrs. P said he was like Mr. P. Don glanced at Mr. P, smiled shyly and said yes.

I then asked them if they could tell me what it was like for each of them to live in this household. Mr. P asked, with a somewhat suspicious look, what I meant. Mrs. P then explained that I was asking them what it was like for them to live together. She then turned to me and timidly asked if that was what I meant and I said yes. At this point Don loudly and proudly stated that neither he nor Mr. P liked to clean around the house, and he then turned to Mr. P and asked, "Right?". Mr. P replied, "Right!". I asked them if both were working, and Mr. P stated in a challenging manner that with the high prices of food and other household bills, it was necessary that they both worked for a while. I asked how long both of them had been working and Mr. P replied, "since Don started school." I then asked Don if he went home after school and Mr. P quickly explained that Don stayed with one of his friends until he or Mrs. P. I then asked Don how he felt about staying with his friend and Don, again glancing at his father, replied that it was ok.

Mr. P looked at his watch, then asked me what they needed to do now that they had made an appointment. I wondered out loud why he had glanced at his watch and he explained that he still had a lot of work to do. I asked them what it was like for them to be here today and Don immediately said he liked it but then quickly glanced at Mr. P. Mrs. P stated that she felt that it was important for people to express their feelings and Mr. P stated that he would do anything

to help Don. I explained that I would present the case to our staff tomorrow morning and that a worker would be assigned to their case and would call them tomorrow afternoon. I asked them how they felt about coming back and exploring some of the things we talked about today.

Mr. P quickly and suspiciously asked who the worker would be, and if they would be assigned a man or a woman. I explained that I could not answer his questions since it depended on who had openings in their case load. I asked Mr. P if he had any feelings about that that he would like to share now. He brushed my question aside with a wave of his hand, and asked when the worker would be calling. I assured him the worker would call sometime tomorrow afternoon. He said ok but that they needed to go now. I thanked them for coming and shook everyone's hand. As they left the office, Mr. P was muttering that "it didn't seem like a very efficient way of doing things."

CASE VERSION #2

THE "P" FAMILY

Identifying Information

Mr. P, age 30 - Graduate student in Business Administration
Mrs. P, age 28 - Legal secretary
Dawn, age 6 - First Grade at Baily Elementary School

Place: Family and Child Services

Referral Reason: The school social worker referred this family to Family and Child Services because the school was having some behavioral problems with Dawn. She indicated that she felt this might be a "family problem" but she was not certain. She went on to explain that Don's teacher had complained about her behavior. While Dawn was progressing normally academically in school, she was prone to temper tantrums, is easily distracted, and frequently wanders around the room poking at the other children and disrupting class sessions. At times Dawn was seen pushing and fighting with other children during recess and after school. The school social worker also explained that she and Dawn's teacher had met yesterday with Dawn's parents in a regularly scheduled conference. She described Mr. P as being domineering, aggressive, and overpowering, and frequently speaking in a punitive manner. She stated that both she and the teacher found it very hard to work with him. Mrs. P was described as the "shy, quiet, somewhat reticent type." The school social worker ended by explaining that both parents had agreed that a family assessment might help everyone understand why Dawn was behaving this way, and that they would contact the agency for a family assessment session.

Telephone contact with: Mr. P (two weeks later)
Mr. P began the conversation by angrily stating that he had called earlier in the morning and had left a message for him to be contacted. I explained that I had been on a home visit earlier and that I had just returned to the office. I wondered out loud what our agency could do for him now that we had the opportunity to talk. Mr. P asked if the school had contacted this agency about his daughter Dawn. I explained that while I was not the individual who spoke with school social worker, a referral form had been completed by one of the other workers. Mr. P remarked that that did not sound like a very efficient way of handling requests but that he guessed he might as well talk to me. He explained that Dawn's teacher and social worker both thought it might help if his family were seen by someone and that he was calling for an appointment so that they wouldn't pick on Dawn anymore. I asked him if he could help me understand what he meant by Dawn not being picked on anymore. He stated that he felt if he did not call for an appointment, then the teacher and the social worker would start picking on Dawn and singling her out since they obviously felt it was necessary. I asked Mr. P how he felt about a family session and he defensively explained that he did not say they would not come. I then asked Mr. P if he ever felt "picked on and singled out." Mr. P replied no, then immediately asked if he could make an appointment for his family to come in. I asked him what times during the week could we compare our time schedules on as possible appointment times. Mr. P stated that his work kept him very busy during the day and well into the night, and that he had to schedule around his work. He stated that Thursday afternoon at one would be a good time. I replied that I had that appointment slot open, and would he and his family like to come in this week. Mr. P then suddenly remembered that he had an important appointment for lunch that time this week, and wanted to know if he could make an appointment for the following week. The appointment was confirmed and we hung up.

Family Session:
Mr. and Mrs. P and Dawn came into the office together and sat down. Mr. P and Dawn sat on the devan while Mrs. P sat near Dawn on a chair next to the devan. Dawn seemed quite excited when they first came in, but then became shy and somewhat withdrawn when they were asked why each of them thought they were here this afternoon. I stated that Dawn seemed a little uncomfortable, and that I was wondering why she thought she was here today. Dawn glanced at Mr. P and shrugged her shoulders. I asked her if she felt uncomfortable talking right now and she nodded her head yes. Mr. P then stated that he could understand why Dawn felt the way she did about "it", and I asked Mr. P if he could explain what he meant by "it". Mr. P then stated that Dawn was having some problems with her teacher at school and that she felt "picked on". I then asked Dawn if this was how she felt. Dawn again quickly glanced at Mr. P and nodded her head yes.

I then turned to Mrs. P, who had been sitting quietly with her eyes downcast, and asked her how she saw them being here today. Mrs. P cleared her throat before she began to speak, and I noticed Dawn glancing at Mr. P. Mrs. P stated that she also thought that Dawn was having some problems at school and she quietly insisted that they were open to any criticism I may have about the way they were raising Dawn. Mr. P immediately began explaining that he knew how Dawn felt because he had felt the same way when he was a child, and that the way schools were nowadays, the quality of teachers was pretty low. I then stated that it seemed as though Mr. P and Mrs.P saw things differently as to what might be contributing to Dawn's school behavior. Mr. P defensively insisted that he did not say nothing in the home was contributing to Dawn's behavior.

Mrs. P then looked at me in what I felt was a beseeching manner, and said that she was not disagreeing with Mr. P, and that she really didn't know what was happening at school. I reflected that she seemed to feel pretty helpless about the situation, and Mrs. P allowed that she frequently felt that way with Dawn. Mr. P then explained that Dawn was a pretty active child. He hastily added that Dawn wasn't a hyperactive child, but that she had a lot of energy and was always wanting to be on the move. Mrs. P smiled briefly and said that Dawn takes after Mr. P on that point. When Dawn heard this, she gave a big smile, and I noticed that she seemed pretty pleased when Mrs. P said she was like Mr. P. Dawn glanced at Mr. P, smiled shyly and said yes.

I then asked them if they could tell me what it was like for each of them to live in this household. Mr. P asked, with a somewhat suspicious look, what I meant. Mrs. P then explained that I was asking them what it was like for them to live together. She then turned to me and timidly asked if that was what I meant, and I said yes. At this point Dawn loudly and proudly stated that neither she nor Mr. P liked to clean around the house, and she then turned to Mr. P and asked, "Right?". Mr. P replied, "Right!". I asked them if both were working, and Mr. P stated in a challenging manner that with the high prices of food and other household bills, it was necessary that they both work for a while. I asked how long both of them had been working, and Mr. P replied, "since Dawn started school." I then asked Dawn if she went home after school and Mr. P quickly explained that Dawn stayed with one of her friends until he or Mrs.P picked her up. I then asked Dawn how she felt about staying with her friends and Dawn, again glancing at her father, replied that it was ok.

Mr. P looked at his watch, then asked me what they needed to do now that they had made an appointment. I wondered out loud why he had glanced at his watch and he explained that he still had a lot of work to do. I asked them what it

was like for them to be here today and Dawn immediately said she liked it but then quickly glanced at Mr. P. Mrs. P stated that she felt it was important for people to express their feelings and Mr. P stated that he would do anything to help Dawn. I explained that I would present the case to our staff tomorrow morning and that a worker would be assigned to their case and would call them tomorrow afternoon. I asked them how they felt about coming back and exploring some of the things we talked about today.

Mr. P quickly and suspiciously asked who the worker would be, and if they would be assigned a man or a woman. I explained that I could not answer his questions since it depended on who had openings in their caseload. I asked Mr. P if he had any feelings about that that he would like to share now. He brushed my question aside with a wave of his hand, and asked when the worker would be calling. I assured him the worker would call sometime tomorrow afternoon. He said ok but that they needed to go now. I thanked them for coming and shook everyone's hand. As they left the office, Mr. P was muttering that "it didn't seem like a very efficient way of doing things."

CASE VERSION #3

THE "P" FAMILY

Identifying Information

Mr. P, age 30 - Graduate student in Business Administration
Mrs. P, age 28 - Legal secretary
Don, age 6 - First Grade at Baily Elementary School

Place: Family and Child Services

Referral Reason: The school social worker referred this family to Family and Child Services because the school was having some behavioral problems with Don. She indicated that she felt this might be a "family problem" but she was not certain. She went on to explain that Don's teacher had complained about his behavior. While Don was progressing normally academically in school, he was prone to temper tantrums, is easily distracted, and frequently wanders around the room poking at the other children and disrupting class sessions. At times Don was seen pushing and fighting with other children during recess and after school. The school social worker also explained that she and Don's teacher had met yesterday with Don's parents in a regularly scheduled conference. She described Mrs. P as being domineering, aggressive, and overpowering, and grequently speaking in a punitive manner. She stated that both she and the teacher found it very hard to work with her. Mr. P was described as the "shy, quiet, somewhat reticent type." The school social worker ended by explaining that both parents had agreed that a family assessment might help everyone understand why Don was behaving this way, and that they would contact the agency for a family assessment session.

Telephone contact with: Mrs. P (two weeks later)
Mrs. P began the conversation by angrily stating that she had called earlier in the morning and had left a message for her to be contacted. I explained that I had been on a home visit earlier and that I had just returned to the office. I wondered out loud what our agency could do for her now that we had the opportunity to talk. Mrs. P asked if the school had contacted this agency about her son Don. I explained that while I was not the individual who spoke with the school social worker, a referral form had been completed by one of the other workers. Mrs. P remarked that that did not sound like a very efficient way of handling requests but that she guessed she might as well talk to me. She explained that Don's teacher and social worker both thought it might help if her family were seen by someone and that she was calling for an appointment so that they wouldn't pick on Don anymore. I asked her if she could help me understand what she meant by Don not being picked on anymore. She stated that she felt if she did not call for an appointment, then the teacher and the social worker would start picking on Don and singling him out since they obviously felt it was necessary. I asked Mrs. P how she felt about a family session and she defensively explained that she did not say they would not come. I then asked Mrs. P if she ever felt "picked on and singled out," Mrs. P replied no, then immediately asked if she could make an appointment for her family to come in. I asked her what times during the week could we compare our time schedules on as possible appointment times. Mrs. P stated that her work kept her very busy during the day and well into the night, and that she had to schedule around her work. She stated that Thursday afternoon at one would be a good time. I replied that I had that appointment slot open, and would she and her family like to come in this week. Mrs. P then suddenly remembered that she had an important appointment for lunch that time this week, and wanted to know if she could make an appointment for the following week. The appointment was confirmed and we hung up.

Family Session:

Mr. and Mrs. P and Don came into the office together and sat down. Mrs. P and Don sat on the devan while Mr. P sat near Don on a chair next to the devan. Don seemed quite excited when they first came in, but then became shy and somewhat withdrawn when they were asked why each of them thought they were here this afternoon. I stated that Don seemed a little uncomfortable, and that I was wondering why he thought he was here today. Don glanced at Mrs. P and shrugged his shoulders. I asked him if he felt uncomfortable talking right now and he nodded his head yes. Mrs. P then stated that she could understand why Don felt the way he did about "it", and I asked Mrs. P if she could explain what she meant by "it". Mrs. P then stated that Don was having some problems with his teacher at school and that he felt "picked on". I then asked Don if this was how he felt. Don again quickly glanced at Mrs. P and nodded his head yes.

I then turned to Mr. P, who had been sitting quietly with his eyes downcast, and asked him how he saw them being here today. Mr. P cleared his throat before he began to speak, and I noticed Don glancing at Mrs. P. Mr. P stated that he also thought that Don was having some problems at school and he quietly insisted that they were open to any criticism I may have about the way they were raising Don. Mrs. P immediately began explaining that she knew how Don felt because she had felt the same way when she was a child, and that the way schools were nowadays, the quality of teachers was pretty low. I then stated that it seemed as though Mr. and Mrs. P saw things differently as to what might be contributing to Don's school behavior. Mrs. P defensively insisted that she did not say nothing in the home was contributing to Don's behavior.

Mr. P then looked at me in what I felt was a beseeching manner, and said that he was not disagreeing with Mrs. P and that he really didn't know what was happening at school. I reflected that he seemed to feel pretty helpless about the situation, and Mr. P allowed that he frequently felt that way with Don. Mrs. P then explained that Don was a pretty active child. She hastily added that Don wasn't a hyperactive child but that he had a lot of energy and was always wanting to be on the move. Mr. P smiled briefly and said that Don takes after Mrs. P on that point. When Don heard this, he gave a big smile, and I noticed that he seemed pretty pleased when Mr. P said he was like Mrs. P. Don glanced at Mrs. P, smiled shyly and said yes.

I then asked them if they could tell me what it was like for each of them to live in this household. Mrs. P asked, with a somewhat suspicious look, what I meant. Mr. P then explained that I was asking them what it was like for them to live together. He then turned to me and timidly asked if that was what I meant and I said yes. At this point Don loudly and proudly stated that neither he nor Mrs. P liked to clean around the house, and he then turned to Mrs. P and asked, "Right?". Mrs. P replied, "Right!". I asked them if both were working, and Mrs. P stated in a challenging manner that with the high prices of food and other household bills, it was necessary that they both worked for awhile. I asked how long both of them had been working and Mrs. P replied, "since Don started school". I then asked Don if he went home after school and Mrs. P quickly explained that Don stayed with one of his friends until she or Mr. P picked him up. I then asked Don how he felt about staying with his friend and Don, again glancing at his mother, replied that it was ok.

Mrs. P looked at her watch, then asked me what they needed to do now that they had made an appointment. I wondered out loud why she had glanced at her watch and she explained that she still had a lot of work to do. I asked them what it was like for them to be here today and Don immediately said he liked it but

then quickly glanced at Mrs. P. Mr. P stated that he felt it was important for people to express their feelings and Mrs. P stated that she would do anything to help Don. I explained that I would present the case to our staff tomorrow morning and that a worker would be assigned to their case and would call them tomorrow afternoon. I asked them how they felt about coming back and exploring some of the things we talked about today.

Mrs. P quickly and suspiciously asked who the worker would be and if they would be assigned a man or a woman. I explained that I could not answer her questions since it depended on who had openings in their caseload. I asked Mrs. P if she had any feelings about that that she would like to share now. She brushed my question aside with a wave of her hand and asked when the worker would be calling. I assured her the worker would call sometime tomorrow afternoon. She said ok but that they needed to go now. I thanked them for coming, and shook everyone's hand. As they left the office, Mrs. P was muttering that "it didn't seem like a very efficient way of doing things."

CASE VERSION #4

THE "P" FAMILY

Identifying Information

Mr. P, age 30 - Graduate student in Business Administration
Mrs. P, age 28 - Legal secretary
Dawn, age 6 - First Grade at Baily Elementary School

Place: Family and Child Services

Referral Reason: The school social worker referred this family to Family and Child Services because the school was having some behavioral problems with Dawn. She indicated that she felt this might be a "family problem" but she was not certain. She went on to explain that Dawn's teacher had complained about her behavior. While Dawn was progressing normally academically in school, she was prone to temper tantrums, is easily distracted, and frequently wanders around the room poking at the other children and disrupting class sessions. At times Dawn was seen pushing and fighting with other children during recess and after school. The school social worker also explained that she and Dawn's teacher had met yesterday with Dawn's parents in a regularly scheduled conference. She described Mrs. P as being domineering, aggressive, and overpowering, and frequently speaking in a punitive manner. She stated that both she and the teacher found it very hard to work with her. Mr. P was described as the "shy, quiet, somewhat reticent type." The school social worker ended by explaining that both parents had agreed that a family assessment might help everyone understand why Dawn was behaving this way, and that they would contact the agency for a family assessment session.

Telephone contact with: Mrs. P (two weeks later)
Mrs. P began the conversation by angrily stating that she had called earlier in the morning and had left a message for her to be contacted. I explained that I had been on a home visit earlier and that I had just returned to the office. I wondered out loud what our agency could do for her now that we had the opportunity to talk. Mrs. P asked if the school had contacted this agency about her daughter Dawn. I explained that while I was not the individual who spoke with the school social worker, a referral form had been completed by one of the other workers. Mrs. P remarked that that did not sound like a very efficient way of handling requests but that she guessed she might as well talk to me. She explained that Dawn's teacher and social worker both thought it might help if her family were seen by someone and that she was calling for an appointment so that they wouldn't pick on Dawn anymore. I asked her if she could help me understand what she meant by Dawn not being picked on anymore. She stated that she felt if she did not call for an appointment, then the teacher and social worker would start picking on Dawn and singling her out since they obviously felt it was necessary. I asked Mrs. P how she felt about a family session and she defensively explained that she did not say they would not come. I then asked Mrs. P if she ever felt "picked on and singled out." Mrs. P replied no, then immediately asked if she could make an appointment for her family to come in. I asked her what times during the week could we compare our time schedules on as possible appointment times. Mrs. P stated that her work kept her very busy during the day and well into the night, and that she had to schedule around her work. She stated that Thursday afternoon at one would be a good time. I replied that I had that appointment slot open, and would she and her family like to come in this week. Mrs. P then suddenly remembered that she had an important appointment for lunch that time this week, and wanted to know if she could make an appointment for the following week. The appointment was confirmed and we hung up.

Family Session:

Mr. and Mrs. P and Dawn came into the office together and sat down. Mrs. P and Dawn sat on the devan while Mr. P sat near Dawn on a chair next to the devan. Dawn seemed quite excited when they first came in, but then became shy and somewhat withdrawn when they were asked why each of them thought they were here this afternoon. I stated that Dawn seemed a little uncomfortable, and that I was wondering why she thought she was here today. Dawn glanced at Mrs. P and shrugged her shoulders. I asked her if she felt uncomfortable talking right now and she nodded her head yes. Mrs. P then stated that she could understand why Dawn felt the way she did about "it", and I asked Mrs. P if she could explain what she meant by "it". Mrs. P then stated that Dawn was having some problems with her teacher at school and that she felt "picked on". I then asked Dawn if this was how she felt. Dawn again quickly glanced at Mrs. P and nodded her head yes.

I then turned to Mr. P, who had been sitting quietly with his eyes downcast, and asked him how he saw them being here today. Mr. P cleared his throat before he began to speak, and I noticed Dawn glaning at Mrs. P. Mr. P stated that he also thought that Dawn was having some problems at school and he quietly insisted that they were open to any criticism I may have about the way they were raising Dawn. Mrs. P immediately began explaining that she knew how Dawn felt because she had felt the same way when she was a child, and that the way schools were nowadays, the quality of teachers was pretty low. I then stated that it seemed as though Mr. and Mrs. P saw things differently as to what might be contributing to Dawn's school behavior. Mrs. P defensively insisted that she did not say nothing in the home was contributing to Dawn's behavior.

Mr. P then looked at me in what I felt was a beseeching manner, and said that he was not disagreeing with Mrs. P, and that he really didn't know what was happening at school. I reflected that he seemed to feel pretty helpless about the situation, and Mr. P allowed that he frequently felt that way with Dawn. Mrs. P then explained that Dawn was a pretty active child. She hastily added that Dawn wasnt a hyperactive child, but that she had a lot of energy and was always wanting to be on the move. Mr. P smiled briefly and said that Dawn takes after Mrs. P on that point. When Dawn heard this, she gave a big smile, and I noticed that she seemed pretty pleased when Mr. P said she was like Mrs. P. Dawn glanced at Mrs. P, smiled shyly and said yes.

I then asked them if they could tell me what it was like for each of them to live in this household. Mrs. P asked, with a somewhat suspicious look, what I meant. Mr. P then explained that I was asking them what it was like for them to live together. He then turned to me and timidly asked if that was what I meant and I said yes. At this point Dawn loudly and proudly stated that neither she nor Mrs. P liked to clean around the house, and she then turned to Mrs. P and asked, "right?". Mrs. P replied, "Right!". I asked them if both were working, and Mrs. P stated in a challenging manner that with the high prices of food and other household bills, it was necessary that they both worked for a while. I asked how long both of them had been working and Mrs. P replied, "since Dawn started school." I then asked Dawn if she went home after school and Mrs. P quickly explained that Dawn stayed with one of her friends until she or Mr. P picked her up. I then asked Dawn how she felt about staying with her friend, and Dawn, again glancing at her mother, replied that it was ok.

Mrs. P looked at her watch, then asked me what they needed to do now that they had made an appointment. I wondered out loud why she had glanced at her watch, and she explained that she still had a lot of work to do. I asked them what it was like for them to be here today and Dawn immediately said she liked it but then quickly glanced at Mrs. P. Mr. P stated that he felt it was

important for people to express their feelings and Mrs. P stated that she would do anything to help Dawn. I explained that I would present the case to our staff tomorrow morning and that a worker would be assigned to their case and would call them tomorrow afternoon. I asked them how they felt about coming back and exploring some of the things we talked about today.

Mrs. P quickly and suspiciously asked who the worker would be , and if they would be assigned a man or a woman. I explained that I could not answer her questions since it depended on who had openings in their caseload. I asked Mrs. P if she had any feelings about that that she would like to share now. She brushed my question aside with a wave of her hand, and asked when the worker would be calling. I assured her the worker would call sometime tomorrow afternoon. She said ok but that they needed to go now. I thanked them for coming and shook everyone's hand. As they left the office, Mrs. P was muttering that "it didn't seem like a very efficient way of doing things."

APPENDIX B

INSTRUMENT SCALES

Please respond to the following items about the FATHER. Do not refer back to the case history as you complete the items but rely totally on your clinical impressions.

1) Father's emotional maturity

(1) _____ Extremely mature

(2) _____ Mature

(3) _____ Somewhat mature

(4) _____ Somewhat immature

(5) _____ Immature

(6) _____ Extremely immature

2) Father's overall degree of stability

(1) _____ Extremely stable

(2) _____ Stable

(3) _____ Somewhat stable

(4) _____ Somewhat unstable

(5) _____ Unstable

(6) _____ Extremely unstable

3) Father's general level of intelligence

(1) _____ Extremely intelligent

(2) _____ Intelligent

(3) _____ Somewhat intelligent

(4) _____ Somewhat unintelligible

(5) _____ Unintelligible

(6) _____ Extremely unintelligible

4) Self-reliance does not seem to be one of the father's major problems.

(1) _____ Strongly agree

(2) _____ Agree

(3) _____ Somewhat agree

(4) _____ Somewhat disagree

(5) _____ Disagree

(6) _____ Strongly disagree

5) Father's individual prognosis

(1) _____ Extremely good

(2) _____ Good

(3) _____ Somewhat good

(4) _____ Somewhat bad

(5) _____ Bad

(6) _____ Extremely bad

6) Personal reaction to the father

(1) _____ Very positive

(2) _____ Positive

(3) _____ Somewhat positive

(4) _____ Somewhat negative

(5) _____ Negative

(6) _____ Extremely negative

7) Extent of your eagerness to have the father as an actual client

(1) _____ Extremely eager

(2) _____ Eager

(3) _____ Somewhat eager

(4) _____ Somewhat reticent

(5) _____ Reticent

(6) _____ Extremely reticent

8) The father will probably need to be encouraged to be more self-reliant during treatment

(1) _____ Strongly agree

(2) _____ Agree

(3) _____ Somewhat agree

(4) _____ Somewhat disagree

(5) _____ Disagree

(6) _____ Strongly disagree

FATHER CONTINUED

9) The father will probably need a directive worker during treatment

(1) _____ Strongly agree

(2) _____ Agree

(3) _____ Somewhat agree

(4) _____ Somewhat disagree

(5) _____ Disagree

(6) _____ Strongly disagree

10) The father will probably need a considerable amount of warmth and support during treatment

(1) _____ Strongly agree

(2) _____ Agree

(3) _____ Somewhat agree

(4) _____ Somewhat disagree

(5) _____ Disagree

(6) _____ Strongly disagree

11) The father should be encouraged to be more family-oriented

(1) _____ Strongly agree

(2) _____ Agree

(3) _____ Somewhat agree

(4) _____ Somewhat disagree

(5) _____ Disagree

(6) _____ Strongly disagree

12) The father needs to be encouraged be more emotionally expressive

(1) _____ Strongly agree

(2) _____ Agree

(3) _____ Somewhat agree

(4) _____ Somewhat disagree

(5) _____ Disagree

(6) _____ Strongly disagree

13) Extent you would be non-directive vs. directive with the father

(1) _____ Extremely non-directive

(2) _____ Non-directive

(3) _____ Somewhat non-directive

(4) _____ Somewhat directive

(5) _____ Directive

(6) _____ Extremely directive

14) Based entirely on your clinical impressions (do not refer back to case history), please rank the problem areas presented in the following categories. In other words, assign a value of one to the problem area you feel is the father's most problematic problem area and a value of five to the problem area that is the least problematic for the father. Be certain to rank <u>each</u> problem area once and only once, and be certain to include <u>all</u> of the possible categories in your rankin

(1) _____ Immature sexual identity

(2) _____ Limited object relations

(3) _____ Environmental and social problems

(4) _____ Passivity

(5) _____ Underdeveloped ego skills

Please respond to the following items about the MOTHER. Do not refer back to the case history as you complete the items but rely totally on your clinical impressions.

1) Mother's emotional maturity

(1) ____ Extremely mature

(2) ____ Mature

(3) ____ Somewhat mature

(4) ____ Somewhat immature

(5) ____ Immature

(6) ____ Extremely immature

2) Mother's overall degree of stability

(1) ____ Extremely stable

(2) ____ Stable

(3) ____ Somewhat stable

(4) ____ Somewhat unstable

(5) ____ Unstable

(6) ____ Extremely unstable

3) Mother's general level of intelligence

(1) ____ Extremely intelligent

(2) ____ Intelligent

(3) ____ Somewhat intelligent

(4) ____ Somewhat untelligible

(5) ____ Unintelligible

(6) ____ Extremely unintelligible

4) Self-reliance does not seem to be one of the Mother's major problems.

(1) ____ Strongly agree

(2) ____ Agree

(3) ____ Somewhat agree

(4) ____ Somewhat disagree

(5) ____ Disagree

(6) ____ Strongly disagree

5) Mother's individual prognosis

(1) ____ Extremely good

(2) ____ Good

(3) ____ Somewhat good

(4) ____ Somewhat bad

(5) ____ Bad

(6) ____ Extremely bad

6) Personal reaction to the mother

(1) ____ Very positive

(2) ____ Positive

(3) ____ Somewhat positive

(4) ____ Somewhat negative

(5) ____ Negative

(6) ____ Extremely negative

7) Extent of your eagerness to have the mother as an actual client

(1) ____ Extremely eager

(2) ____ Eager

(3) ____ Somewhat eager

(4) ____ Somewhat reticent

(5) ____ Reticent

(6) ____ Extremely reticent

8) The mother will probably need to be encouraged to be more self-reliant during treatment

(1) ____ Strongly agree

(2) ____ Agree

(3) ____ Somewhat agree

(4) ____ Somewhat disagree

(5) ____ Disagree

(6) ____ Strongly disagree

MOTHER CONTINUED

9) The mother will probably need a directive worker during treatment

(1) ____ Strongly agree

(2) ____ Agree

(3) ____ Somewhat agree

(4) ____ Somewhat disagree

(5) ____ Disagree

(6) ____ Strongly disagree

10) The mother will probably need a considerable amount of warmth and support during treatment

(1) ____ Strongly agree

(2) ____ Agree

(3) ____ Somewhat agree

(4) ____ Somewhat disagree

(5) ____ Disagree

(6) ____ Strongly disagree

11) The mother should be encouraged to be more family-oriented

(1) ____ Strongly agree

(2) ____ Agree

(3) ____ Somewhat agree

(4) ____ Somewhat disagree

(5) ____ Disagree

(6) ____ Strongly disagree

12) The mother needs to be encouraged to be more emotionally expressive

(1) ____ Strongly agree

(2) ____ Agree

(3) ____ Somewhat agree

(4) ____ Somewhat disagree

(5) ____ Disagree

(6) ____ Strongly disagree

13) Extent you would be non-directive vrs. directive with the mother

(1) ____ Extremely non-directive

(2) ____ Non-directive

(3) ____ Somewhat non-directive

(4) ____ Somewhat directive

(5) ____ Directive

(6) ____ Extremely directive

14) Based entirely on your clinical impressions (do not refer back to case history), please rank the problem areas presented in the following categories. In other words, assign a value of one to the problem area you feel is the mother's most problematic problem area and a value of five to the problem area that is the least problematic for the mother. Be certain to rank <u>each</u> problem area once and only once, and be certain to include <u>all</u> of the possible categories in your ranking:

(1) ____ Immature sexual identity

(2) ____ Limited object relations

(3) ____ Environmental and social problems

(4) ____ Passivity

(5) ____ Underdeveloped ego skills

Please respond to the following items about the CHILD. Do not refer back to the case history as you complete the items but rely totally on your clinical impressions.

1) Child's emotional maturity

(1) ____ Extremely mature
(2) ____ Mature
(3) ____ Somewhat mature
(4) ____ Somewhat immature
(5) ____ Immature
(6) ____ Extremely immature

2) Child's overall degree of stability

(1) ____ Extremely stable
(2) ____ Stable
(3) ____ Somewhat stable
(4) ____ Somewhat unstable
(5) ____ Unstable
(6) ____ Extremely unstable

3) Child's general level of intelligence

(1) ____ Extremely intelligent
(2) ____ Intelligent
(3) ____ Somewhat intelligent
(4) ____ Somewhat unintelligible
(5) ____ Unintelligible
(6) ____ Extremely unintelligible

4) Self-reliance does not seem to be one of the child's major problems.

(1) ____ Strongly agree
(2) ____ Agree
(3) ____ Somewhat agree
(4) ____ Somewhat disagree
(5) ____ Disagree
(6) ____ Strongly disagree

5) Child's individual prognosis

(1) ____ Extremely good
(2) ____ Good
(3) ____ Somewhat good
(4) ____ Somewhat bad
(5) ____ Bad
(6) ____ Extremely bad

6) Personal reaction to the child

(1) ____ Very positive
(2) ____ Positive
(3) ____ Somewhat positive
(4) ____ Somewhat negative
(5) ____ Negative
(6) ____ Extremely negative

7) Extent of your eagerness to have the child as an actual client

(1) ____ Extremely eager
(2) ____ Eager
(3) ____ Somewhat eager
(4) ____ Somewhat reticent
(5) ____ Reticent
(6) ____ Extremely reticent

8) The child will probably need to be encouraged to be more self-reliant during treatment

(1) ____ Strongly agree
(2) ____ Agree
(3) ____ Somewhat agree
(4) ____ Somewhat disagree
(5) ____ Disagree
(6) ____ Strongly disagree

CHILD CONTINUED

9) The child will probably need a directive worker during treatment

(1) ____ Strongly agree

(2) ____ Agree

(3) ____ Somewhat agree

(4) ____ Somewhat disagree

(5) ____ Disagree

(6) ____ Strongly disagree

10) The child will probably need a considerable amount of warmth and support during treatment

(1) ____ Strongly agree

(2) ____ Agree

(3) ____ Somewhat agree

(4) ____ Somewhat disagree

(5) ____ Disagree

(6) ____ Strongly disagree

11) The child should be encouraged to be more family-oriented

(1) ____ Strongly agree

(2) ____ Agree

(3) ____ Somewhat agree

(4) ____ Somewhat disagree

(5) ____ Disagree

(6) ____ Strongly disagree

12) The child needs to be encouraged to be more emotionally expressive

(1) ____ Strongly agree

(2) ____ Agree

(3) ____ Somewhat agree

(4) ____ Somewhat disagree

(5) ____ Disagree

(6) ____ Strongly disagree

13) Extent you would be non-directive vrs. directive with the child

(1) ____ Extremely non-directive

(2) ____ Non-directive

(3) ____ Somewhat non-directive

(4) ____ Somewhat directive

(5) ____ Directive

(6) ____ Extremely directive

14) Based entirely on your clinical impressions (do not refer back to case history), please rank the problem areas presented in the following categories. In other words, assign a value of one to the problem area you feel is the child's most problematic problem area and a value of five to the problem area that is the least problematic for the child. Be certain to rank <u>each</u> problem area once and only once, and be certain to include <u>all</u> of the possible categories in your ranking:

(1) ____ Immature sexual identity

(2) ____ Limited object relations

(3) ____ Environmental and social problems

(4) ____ Passivity

(5) ____ Underdeveloped ego skills

Based entirely on your clinical impressions (do not refer back to the case history), please rank the following problem areas of a marital relationship you feel would illustrate the marital relationship you have just read about. Again, assign a value of 1 (first position) to the marital problem area considered most problematic and a value of 5 (fifth position) to the marital problem you sense is the least problematic Be certain to rank <u>each</u> problem area once and only once, and be certain to include <u>all</u> of the possible categories in your ranking:

(1) _____ Companionship

(2) _____ Handling of finances

(3) _____ Household tasks

(4) _____ Sex

(5) _____ Relations with children

What is your impression of the father-child relationship:

(1) _____ Extremely healthy

(2) _____ Healthy

(3) _____ Somewhat healthy

(4) _____ Somewhat problematic

(5) _____ Problematic

(6) _____ Extremely problematic

What is your impression of the mother-child relationship:

(1) _____ Extremely healthy

(2) _____ Healthy

(3) _____ Somewhat healthy

(4) _____ Somewhat problematic

(5) _____ Problematic

(6) _____ Extremely problematic

Prognosis of this family for family therapy:

(1) _____ Extremely good

(2) _____ Good

(3) _____ Somewhat good

(4) _____ Somewhat bad

(5) _____ Bad

(6) _____ Extremely bad

Please respond to the following items:

Sex: (1) _____ Male
(2) _____ Female

Graduate level: (1) _____ First year
(2) _____ Second year

Age: (1) _____ 18 - 20
(2) _____ 21 - 23
(3) _____ 24 - 26
(4) _____ 27 - 29
(5) _____ Over 29

Is your major social work?

(1) _____ Yes
(2) _____ No
(3) _____ Undecided

Educational status: (1) _____ Freshman
(2) _____ Sophomore
(3) _____ Junior
(4) _____ Senior
(5) _____ Graduate

Marital status: (1) _____ Single
(2) _____ Married
(3) _____ Divorced
(4) _____ Widowed
(5) _____ Other

Have you ever had any course work or training in family therapy?

(1) _____ Yes
(2) _____ No

Please respond to the following items:

1) The wife who proves to be the better breadwinner should use extraordinary tact in handling her situation.

(1)_____ Strongly Agree

(2)_____ Agree

(3)_____ Mildly Agree

(4)_____ Undecided

(5)_____ Mildly Disagree

(6)_____ Disagree

(7)_____ Strongly Disagree

2) No man will ever fully understand a woman's sexual responses.

(1)_____ Strongly Agree

(2)_____ Agree

(3)_____ Mildly Agree

(4)_____ Undecided

(5)_____ Mildly Disagree

(6)_____ Disagree

(7)_____ Strongly Disagree

3) A woman is capable of handling the responsibilities of a career, marriage, and family simultaneously.

(1)_____ Strongly Agree

(2)_____ Agree

(3)_____ Mildly Agree

(4)_____ Undecided

(5)_____ Mildly Disagree

(6)_____ Disagree

(7)_____ Strongly Disagree

4) The need to have orgasms for a satisfactory sex life is greater for a man than for a woman.

(1)_____ Strongly Agree

(2)_____ Agree

(3)_____ Mildly Agree

(4)_____ Undecided

(5)_____ Mildly Disagree

(6)_____ Disagree

(7)_____ Strongly Disagree

5) The child of a woman who works will have less maternal emotional support.

(1)_____ Strongly Agree

(2)_____ Agree

(3)_____ Mildly Agree

(4)_____ Undecided

(5)_____ Mildly Disagree

(6)_____ Disagree

(7)_____ Strongly Disagree

6) The maternal instinct is a myth.

(1)_____ Strongly Agree

(2)_____ Agree

(3)_____ Mildly Agree

(4)_____ Undecided

(5)_____ Mildly Disagree

(6)_____ Disagree

(7)_____ Strongly Disagree

7) My initial response to a woman is affected by her physical attractiveness.

(1)_____ Strongly Agree

(2)_____ Agree

(3)_____ Mildly Agree

(4)_____ Undecided

(5)_____ Mildly Disagree

(6)_____ Disagree

(7)_____ Strongly Disagree

8) A woman is necessarily dependent on a man to provide her with complete sexual satisfaction.

(1)_____ Strongly Agree

(2)_____ Agree

(3)_____ Mildly Agree

(4)_____ Undecided

(5)_____ Mildly Disagree

(6)_____ Disagree

(7)_____ Strongly Disagree

9) In situations in which both husband and wife are working, housework should be equally shared between them.

(1)_____ Strongly Agree

(2)_____ Agree

(3)_____ Mildly Agree

(4)_____ Undecided

(5)_____ Mildly Disagree

(6)_____ Disagree

(7)_____ Strongly Disagree

10) One of the greatest contributions society that a woman can make is t successful rearing of normal well-adjusted children.

(1)_____ Strongly Agree

(2)_____ Agree

(3)_____ Mildly Agree

(4)_____ Undecided

(5)_____ Mildly Disagree

(6)_____ Disagree

(7)_____ Strongly Disagree

11) Women who conform to society's view of the traditional female role will be more satisfied as individuals than those who do not conform.

(1)_____ Strongly Agree

(2)_____ Agree

(3)_____ Mildly Agree

(4)_____ Undecided

(5)_____ Mildly Disagree

(6)_____ Disagree

(7)_____ Strongly Disagree

12) Women and men are equally capable of sexual pleasure and satisfacti

(1)_____ Strongly Agree

(2)_____ Agree

(3)_____ Mildly Agree

(4)_____ Undecided

(5)_____ Mildly Disagree

(6)_____ Disagree

(7)_____ Strongly Disagree

13) Women's freer role in marriage, sex and the family will produce negative results for society in future generations.

(1)_____ Strongly Agree

(2)_____ Agree

(3)_____ Mildly Agree

(4)_____ Undecided

(5)_____ Mildly Disagree

(6)_____ Disagree

(7)_____ Strongly Disagree

14) A woman with a 2 year-old child should not be involved in fulltime work outside the home.

(1)_____ Strongly Agree

(2)_____ Agree

(3)_____ Mildly Agree

(4)_____ Undecided

(5)_____ Mildly Disagree

(6)_____ Disagree

(7)_____ Strongly Disagree

15) The relinquishing of traditional sex roles is likely to lead to a decrease in sexual interest.

(1)_____ Strongly Agree

(2)_____ Agree

(3)_____ Mildly Agree

(4)_____ Undecided

(5)_____ Mildly Disagree

(6)_____ Disagree

(7)_____ Strongly Disagree

16) A husband should take it for grante that his wife will be responsible for bringing up their children.

(1)_____ Strongly Agree

(2)_____ Agree

(3)_____ Mildly Agree

(4)_____ Undecided

(5)_____ Mildly Disagree

(6)_____ Disagree

(7)_____ Strongly Disagree

17) A certain amount of male dominance is essential for a woman to feel adequately feminine.

(1)_____ Strongly Agree

(2)_____ Agree

(3)_____ Mildly Agree

(4)_____ Undecided

(5)_____ Mildly Disagree

(6)_____ Disagree

(7)_____ Strongly Disagree

18) The sexual life of a woman is as important or urgent as the sexual life of a man.

(1)_____ Strongly Agree

(2)_____ Agree

(3)_____ Mildly Agree

(4)_____ Undecided

(5)_____ Mildly Disagree

(6)_____ Disagree

(7)_____ Strongly Disagree

19) It feels stranger when I meet a woman who is dominant and aggressive than when I meet a man who has the same characteristics.

(1)_____ Strongly Agree

(2)_____ Agree

(3)_____ Mildly Agree

(4)_____ Undecided

(5)_____ Mildly Disagree

(6)_____ Disagree

(7)_____ Strongly Disagree

20) The desire to have children is part of a woman's nature.

(1)_____ Strongly Agree

(2)_____ Agree

(3)_____ Mildly Agree

(4)_____ Undecided

(5)_____ Mildly Disagree

(6)_____ Disagree

(7)_____ Strongly Disagree

21) It is not desirable for a woman to derive her identity from her mate.

(1)_____ Strongly Agree

(2)_____ Agree

(3)_____ Mildly Agree

(4)_____ Undecided

(5)_____ Mildly Disagree

(6)_____ Disagree

(7)_____ Strongly Disagree

22) Because of a woman's nature, it is worse for her to be single than it is for a man.

(1)_____ Strongly Agree

(2)_____ Agree

(3)_____ Mildly Agree

(4)_____ Undecided

(5)_____ Mildly Disagree

(6)_____ Disagree

(7)_____ Strongly Disagree

23) The female's sexual desire may be greater than that of the male.

(1)_____ Strongly Agree

(2)_____ Agree

(3)_____ Mildly Agree

(4)_____ Undecided

(5)_____ Mildly Disagree

(6)_____ Disagree

(7)_____ Strongly Disagree

24) The married woman should adapt her career plans to meet the needs of her husband's career.

(1)_____ Strongly Agree

(2)_____ Agree

(3)_____ Mildly Agree

(4)_____ Undecided

(5)_____ Mildly Disagree

(6)_____ Disagree

(7)_____ Strongly Disagree

25) It is in a man's nature to assume a dominant-aggressive role and in a woman's to assume a submissive-passive role during sexual intercourse.

(1)_____ Strongly Agree

(2)_____ Agree

(3)_____ Mildly Agree

(4)_____ Undecided

(5)_____ Mildly Disagree

(6)_____ Disagree

(7)_____ Strongly Disagree

26) It would be better if therapists thought of some women as "oppressed" rather than "neurotic."

(1)_____ Strongly Agree

(2)_____ Agree

(3)_____ Mildly Agree

(4)_____ Undecided

(5)_____ Mildly Disagree

(6)_____ Disagree

(7)_____ Strongly Disagree

27) The sex-role stereotypes inhibit a woman from expressing her full range of sexual and sensual responses.

(1)_____ Strongly Agree

(2)_____ Agree

(3)_____ Mildly Agree

(4)_____ Undecided

(5)_____ Mildly Disagree

(6)_____ Disagree

(7)_____ Strongly Disagree

28) If women and men were to be truly equal, then men would find women less appealing.

(1)_____ Strongly Agree

(2)_____ Agree

(3)_____ Mildly Agree

(4)_____ Undecided

(5)_____ Mildly Disagree

(6)_____ Disagree

(7)_____ Strongly Disagree

29) In the long run, liberation will occur at the expense of men.

(1)_____ Strongly Agree

(2)_____ Agree

(3)_____ Mildly Agree

(4)_____ Undecided

(5)_____ Mildly Disagree

(6)_____ Disagree

(7)_____ Strongly Disagree

25) It is in a man's nature to assume a dominant-aggressive role and in a woman's to assume a submissive-passive role during sexual intercourse.

(1)_____ Strongly Agree

(2)_____ Agree

(3)_____ Mildly Agree

(4)_____ Undecided

(5)_____ Mildly Disagree

(6)_____ Disagree

(7)_____ Strongly Disagree

26) It would be better if therapists thought of some women as "oppressed" rather than "neurotic."

(1)_____ Strongly Agree

(2)_____ Agree

(3)_____ Mildly Agree

(4)_____ Undecided

(5)_____ Mildly Disagree

(6)_____ Disagree

(7)_____ Strongly Disagree

27) The sex-role stereotypes inhibit a woman from expressing her full range of sexual and sensual responses.

(1)_____ Strongly Agree

(2)_____ Agree

(3)_____ Mildly Agree

(4)_____ Undecided

(5)_____ Mildly Disagree

(6)_____ Disagree

(7)_____ Strongly Disagree

28) If women and men were to be truly equal, then men would find women less appealing.

(1)_____ Strongly Agree

(2)_____ Agree

(3)_____ Mildly Agree

(4)_____ Undecided

(5)_____ Mildly Disagree

(6)_____ Disagree

(7)_____ Strongly Disagree

29) In the long run, liberation will occur at the expense of men.

(1)_____ Strongly Agree

(2)_____ Agree

(3)_____ Mildly Agree

(4)_____ Undecided

(5)_____ Mildly Disagree

(6)_____ Disagree

(7)_____ Strongly Disagree

APPENDIX C

STATISTICAL TABLES

TABLE 1

SUMMARY DATA FOR FINN'S ANALYSIS OF COVARIANCE

MEAN CLINICAL IMPRESSION SCORES FOR FATHER

SEX	CASE VERSION 1	2	3	4	
MALE	3.36 (.44)	3.94 (.20)	3.14 (.45)	2.98 (.66)	3.38
FEMALE	3.60 (.51)	3.70 (.51)	2.92 (.49)	3.14 (.38)	3.34
	3.54	3.89	2.90	3.10	

NOTE: MS_E = .23

TABLE 2

SUMMARY DATA FOR FINN'S ANALYSIS OF COVARIANCE

MEAN CLINICAL IMPRESSION SCORES FOR MOTHER

SEX	CASE VERSION 1	2	3	4	
MALE	2.83 (.48)	3.28 (.50)	3.21 (.82)	3.88 (.95)	3.33
FEMALE	3.00 (.47)	3.17 (.47)	3.65 (.43)	3.33 (.39)	3.29
	2.95	3.21	3.58	3.50	

NOTE: MS_E = .28

TABLE 3

SUMMARY DATA FOR FINN'S ANALYSIS OF COVARIANCE

MEAN CLINICAL IMPRESSION SCORES FOR CHILD

SEX	CASE VERSION 1	2	3	4	
MALE	3.02	3.29	3.54	3.29	3.26
	(.53)	(.53)	(.14)	(.39)	
FEMALE	3.05	3.29	3.30	3.11	3.19
	(.33)	(.33)	(.56)	(.46)	
	3.04	3.29	3.34	3.17	

NOTE: MS_E = .19

TABLE 4

SUMMARY DATA FOR FINN'S ANALYSIS OF COVARIANCE

FATHER TECHNIQUE ITEM 88 (SELF-RELIANT)

SEX	CASE VERSION 1	2	3	4	
MALE	3.83	3.71	2.25	2.14	3.04
	(1.17)	(1.25)	(.50)	(.90)	
FEMALE	3.67	3.88	1.84	1.79	2.81
	(1.53)	(1.26)	(.60)	(.70)	
	3.71	3.82	1.91	1.91	

NOTE: MS_E = 1.19

TABLE 5

SUMMARY DATA FOR FINN'S ANALYSIS OF COVARIANCE

FATHER TECHNIQUE ITEM #9
(DIRECTIVE WORKER)

SEX	CASE VERSION 1	2	3	4	
MALE	4.67	4.00	2.20	2.71	3.50
	(1.03)	(1.63)	(.96)	(1.11)	
FEMALE	3.89	3.44	4.05	3.50	3.74
	(1.53)	(1.63)	(1.22)	(1.22)	
	4.10	3.61	3.73	3.24	

NOTE: MS_E = 1.92

TABLE 6

SUMMARY DATA FOR FINN'S ANALYSIS OF COVARIANCE

FATHER TECHNIQUE ITEM #10
(WARMTH AND SUPPORT)

SEX	CASE VERSION 1	2	3	4	
MALE	2.00	1.85	1.75	2.43	2.04
	(.63)	(.69)	(.50)	(.79)	
FEMALE	1.83	2.44	2.00	1.71	2.00
	(.62)	(.89)	(.67)	(.91)	
	1.88	2.26	1.96	1.95	

NOTE: MS_E = .55

TABLE 7

SUMMARY DATA FOR FINN'S ANALYSIS OF COVARIANCE

FATHER TECHNIQUE ITEM #11
(FAMILY ORIENTED)

SEX	CASE VERSION 1	2	3	4	
MALE	2.83	3.00	3.75	3.14	3.13
	(.41)	(1.00)	(.50)	(1.21)	
FEMALE	3.00	2.50	3.37	3.14	3.02
	(1.20)	(.89)	(1.30)	(.95)	
	2.95	2.65	3.44	3.14	

NOTE: MS_E = 1.19

TABLE 8

SUMMARY DATA FOR FINN'S ANALYSIS OF COVARIANCE

FATHER TECHNIQUE ITEM #12
(EMOTIONALLY EXPRESSIVE)

SEX	CASE VERSION 1	2	3	4	
MALE	1.83	1.86	2.50	2.57	2.17
	(.75)	(1.07)	(.58)	(1.13)	
FEMALE	2.11	2.38	1.84	1.93	2.06
	(.68)	(1.45)	(.69)	(.83)	
	2.04	2.21	1.96	2.14	

NOTE: MS_E = .92

TABLE 9

SUMMARY DATA FOR FINN'S ANALYSIS OF COVARIANCE

FATHER TECHNIQUE ITEM #13
(NON-DIRECTIVE VS. DIRECTIVE)

SEX	CASE VERSION 1	2	3	4	
MALE	3.00	2.86	4.25	3.57	3.33
	(.89)	(1.21)	(.50)	(.98)	
FEMALE	3.06	3.19	2.89	3.21	3.08
	(1.66)	(1.22)	(.99)	(.97)	
	3.04	3.09	3.13	3.33	

NOTE: MS_E = 1.16

TABLE 10

SUMMARY DATA FOR FINN'S ANALYSIS OF COVARIANCE

MOTHER TECHNIQUE ITEM #8
(SELF-RELIANT)

SEX	CASE VERSION 1	2	3	4	
MALE	2.33	1.71	5.00	3.28	2.88
	(.52)	(.49)	(.82)	(1.38)	
FEMALE	1.50	2.06	3.78	4.21	2.85
	(.52)	(.85)	(1.32)	(1.19)	
	1.70	1.95	4.00	3.91	

NOTE: MS_E = .98

TABLE 11

SUMMARY DATA FOR FINN'S ANALYSIS OF COVARIANCE

MOTHER TECHNIQUE ITEM #9
(DIRECTIVE WORKER)

		CASE VERSION 1	2	3	4	
SEX	MALE	4.17	5.00	3.25	3.29	4.00
		(.98)	(1.41)	(1.26)	(.95)	
	FEMALE	3.72	4.38	3.26	2.93	3.58
		(1.23)	(1.15)	(1.33)	(1.33)	
		3.83	4.57	3.26	3.05	

NOTE: MS_E = 1.55

TABLE 12

SUMMARY DATA FOR FINN'S ANALYSIS OF COVARIANCE

MOTHER TECHNIQUE ITEM #10
(WARMTH AND SUPPORT)

		CASE VERSION 1	2	3	4	
SEX	MALE	1.67	2.14	1.75	2.00	1.92
		(.52)	(1.46)	(.50)	(.58)	
	FEMALE	1.78	2.13	1.89	2.07	1.95
		(.73)	(.89)	(.81)	(1.21)	
		1.75	2.13	1.87	2.04	

NOTE: MS_E = .83

TABLE 13

SUMMARY DATA FOR FINN'S ANALYSIS OF COVARIANCE

MOTHER TECHNIQUE ITEM #11
(FAMILY-ORIENTED)

		CASE VERSION 1	2	3	4	
SEX	MALE	3.50	5.14	2.50	3.00	3.67
		(.55)	(.69)	(1.00)	(1.53)	
	FEMALE	3.72	4.44	2.74	2.64	3.39
		(1.23)	(.81)	(1.37)	(1.15)	
		3.67	4.65	2.70	2.76	

NOTE: $MS_E = 1.31$

TABLE 14

SUMMARY DATA FOR FINN'S ANALYSIS OF COVARIANCE

MOTHER TECHNIQUE ITEM #12
(EMOTIONALLY EXPRESSIVE)

		CASE VERSION 1	2	3	4	
SEX	MALE	2.67	2.29	2.00	2.86	2.50
		(.52)	(.49)	(.00)	(1.57)	
	FEMALE	1.94	2.38	2.63	2.79	2.42
		(.64)	(1.02)	(1.26)	(1.25)	
		2.12	2.35	2.52	2.81	

NOTE: $MS_E = 1.08$

TABLE 15

SUMMARY DATA FOR FINN'S ANALYSIS OF COVARIANCE

MOTHER TECHNIQUE ITEM 813
(NON-DIRECTIVE VS. DIRECTIVE)

CASE VERSION

SEX	1	2	3	4	
MALE	3.17 (.75)	2.86 (1.35)	3.00 (.82)	3.71 (1.11)	3.21
FEMALE	3.11 (.96)	2.81 (.83)	3.63 (.96)	3.86 (.86)	3.34
	3.13	2.83	3.52	3.81	

NOTE: $MS_E = .90$

TABLE 16

SUMMARY DATA FOR FINN'S ANALYSIS OF COVARIANCE

CHILD TECHNIQUE ITEM 88
(SELF-RELIANT)

CASE VERSION

SEX	1	2	3	4	
MALE	2.33 (.52)	2.29 (.49)	2.75 (.96)	3.14 (1.07)	2.63
FEMALE	1.94 (.99)	2.06 (.92)	1.78 (.97)	2.07 (.91)	1.95
	2.04	2.13	1.96	2.43	

NOTE: $MS_E = .85$

TABLE 17

SUMMARY DATA FOR FINN'S ANALYSIS OF COVARIANCE

CHILD TECHNIQUE ITEM #9
(DIRECTIVE WORKER)

SEX	CASE VERSION 1	2	3	4	
MALE	3.83	3.86	4.75	3.14	3.80
	(1.47)	(1.35)	(.50)	(1.07)	
FEMALE	3.72	4.25	5.05	3.93	4.26
	(1.07)	(1.18)	(1.03)	(1.44)	
	3.75	4.13	5.00	3.66	

NOTE: $MS_E = 1.30$

TABLE 18

SUMMARY DATA FOR FINN'S ANALYSIS OF COVARIANCE

CHILD TECHNIQUE ITEM #10
(WARMTH AND SUPPORT)

SEX	CASE VERSION 1	2	3	4	
MALE	1.83	1.57	2.50	2.57	2.08
	(.75)	(.53)	(1.00)	(1.27)	
FEMALE	1.66	1.88	1.47	1.85	1.70
	(.69)	(.81)	(.61)	(1.17)	
	1.71	1.78	1.65	2.09	

NOTE: $MS_E = .72$

TABLE 19

SUMMARY DATA FOR FINN'S ANALYSIS OF COVARIANCE

CHILD TECHNIQUE ITEM #11
(FAMILY-ORIENTED)

SEX	CASE VERSION 1	2	3	4	
MALE	3.33	3.86	4.00	4.29	3.88
	(.82)	(1.07)	(.82)	(1.60)	
FEMALE	3.61	4.19	4.58	3.86	4.08
	(1.19)	(1.22)	(.69)	(1.29)	
	3.54	4.08	4.48	4.00	

NOTE: MS_E = 1.27

TABLE 20

SUMMARY DATA FOR FINN'S ANALYSIS OF COVARIANCE

CHILD TECHNIQUE ITEM #12
(EMOTIONALLY EXPRESSIVE)

SEX	CASE VERSION 1	2	3	4	
MALE	2.33	2.00	2.50	2.43	2.29
	(.82)	(.00)	(.58)	(.79)	
FEMALE	1.89	2.00	2.21	2.64	2.16
	(.96)	(1.03)	(.85)	(1.01)	
	2.00	2.00	2.26	2.57	

NOTE: MS_E = .77

TABLE 21

SUMMARY DATA FOR FINN'S ANALYSIS OF COVARIANCE

CHILD TECHNIQUE ITEM #13
(NON-DIRECTIVE VS. DIRECTIVE)

CASE VERSION

SEX	1	2	3	4
MALE	2.67 (1.21)	3.00 (1.15)	3.25 (.96)	3.43 (1.13)
FEMALE	2.94 (.99)	3.00 (1.03)	2.26 (.93)	3.07 (1.07)

NOTE: MS_E = 1.06

TABLE 22

SUMMARY DATA FOR FINN'S ANALYSIS OF COVARIANCE

MEAN CLINICAL IMPRESSION SCORES
OF FATHER-CHILD RELATIONSHIP

CASE VERSION

SEX	1	2	3	4	
MALE	4.67 (.82)	4.86 (.38)	4.75 (.50)	4.71 (.49)	4.75
FEMALE	4.78 (.73)	5.00 (.63)	4.32 (1.06)	4.29 (.99)	4.60
	4.75	4.95	4.39	4.43	

NOTE: MS_E = .65

TABLE 23

SUMMARY DATA FOR FINN'S ANALYSIS OF COVARIANCE

MEAN CLINICAL IMPRESSION SCORES OF MOTHER-CHILD RELATIONSHIP

SEX	CASE VERSION 1	2	3	4	
MALE	3.66	4.43	5.00	5.57	4.67
	(1.03)	(.79)	(.82)	(.53)	
FEMALE	4.28	4.75	5.26	5.00	4.82
	(.82)	(1.06)	(.81)	(.78)	
	4.12	4.65	5.22	5.19	

NOTE: $MS_E = .70$

TABLE 24

SUMMARY DATA FOR FINN'S ANALYSIS OF COVARIANCE

MEAN CLINICAL IMPRESSION SCORES OF FAMILY PROGNOSIS

SEX	CASE VERSION 1	2	3	4	
MALE	2.83	3.43	3.50	2.71	3.08
	(.75)	(.98)	(.58)	(.95)	
FEMALE	2.44	2.87	2.63	3.00	2.71
	(.70)	(.62)	(.89)	(.87)	
	2.54	3.04	2.78	2.91	

NOTE: $MS_E = .64$

Table 25

Perceived Major Problem Area Of Child By Case Version

Case Version	Problem Area				
	1	2	3	4	5
1	3	3	10	2	6
2	9	4	5	0	5
3	3	4	5	2	9
4	1	4	8	2	6

N = 91

χ^2 = 14.94

d.f. = 12

p < 0.24

Table 26

Ranking Distribution Of Father Problem (3) By Case Version

Case Version	Ranking Position				
	1	2	3	4	5
1	2	1	5	11	5
2	2	1	10	8	2
3	2	3	4	6	8
4	4	4	2	4	7

N = 91

χ^2 = 18.37

d.f. = 12

p < 0.10

Table 27

Ranking Distribution Of Father

Problem (5) By Case Version

Case Version	Ranking Position 1	2	3	4	5
1	2	11	8	2	1
2	6	7	4	5	1
3	4	5	9	2	3
4	6	8	0	5	2

N = 91

χ^2 = 18.65

d.f. = 2

p < 0.09

Table 28

Ranking Distribution Of Mother

Problem [5] By Case Version

Case Version	Ranking Position 1	2	3	4	5
1	5	5	9	4	1
2	8	6	2	4	3
3	9	9	1	4	0
4	4	7	5	3	2

N = 91

χ^2 = 16.04

d.f. = 12

p < 0.19

Table 29

Ranking Distribution Of Child Problem (1) By Case Version

Case Version	Ranking Position 1	2	3	4	5
1	3	2	7	5	7
2	9	3	4	1	6
3	3	3	7	5	5
4	1	6	3	2	9

N = 91

χ^2 = 19.28

d.f. = 12

p < 0.08

Table 30

Ranking Distribution Of Child Problem (2) By Case Version

Case Version	Ranking Position 1	2	3	4	5
1	3	9	6	3	3
2	4	5	4	8	2
3	4	8	3	2	6
4	4	6	2	5	4

N = 91

χ^2 = 10.61

d.f. = 12

p < 0.56

Table 31

Ranking Distribution Of Child Problem (3) By Case Version

Case Version	Ranking Position 1	2	3	4	5
1	10	2	2	5	5
2	5	3	8	2	5
3	5	3	4	8	3
4	8	4	7	2	0

N = 91

χ^2 = 18.46

d.f. = 12

p < 0.10

Table 32

Ranking Distribution Of Child Problem (4) By Case Version

Case Version	Ranking Position 1	2	3	4	5
1	2	4	4	7	7
2	0	3	2	9	9
3	2	3	7	2	9
4	2	2	4	7	6

N = 91

χ^2 = 10.55

d.f. = 12

p < 0.57

Table 33

Ranking Distribution Of Child Problem (5) By Case Version

Case Version	Ranking Position 1	2	3	4	5
1	6	7	5	4	2
2	5	9	5	3	1
3	9	6	2	6	0
4	6	3	5	5	2

N = 91

X^2 = 9.16

d.f. = 12

p < 0.69

Table 34

Perceived Major Marital Problem Area By Case Version

Case Version	Problem Area 1	2	3	4	5
1	16	0	1	4	3
2	9	0	2	2	10
3	8	0	2	5	8
4	11	1	1	3	5

N = 91

X^2 = 12.73

d.f. = 12

p < 0.39

Table 35

Ranking Distribution Of Marital Problem (1) By Case Version

Case Version	Ranking Position 1	2	3	4	5
1	16	2	3	3	0
2	9	8	2	2	2
3	8	8	4	1	2
4	11	8	0	2	0

N = 91

χ^2 = 16.15

d.f. = 12

p < 0.18

Table 36

Ranking Distribution Of Marital Problem (2) By Case Version

Case Version	Ranking Position 1	2	3	4	5
1	0	1	1	1	21
2	0	3	1	5	14
3	0	0	2	6	15
4	1	1	3	6	10

N = 91

χ^2 = 16.16

d.f. = 12

p < 0.18

Table 37

Ranking Distribution Of Marital Problem (3) By Case Version

Case Version	Ranking Position 1	2	3	4	5
1	1	1	8	12	2
2	2	1	8	9	3
3	2	0	3	12	6
4	1	1	3	11	5

N = 91

χ^2 = 8.99

d.f. = 12

P < 0.70

Table 38

Ranking Distribution Of Marital Problem (4) By Case Version

Case Version	Ranking Position 1	2	3	4	5
1	4	6	8	6	0
2	2	6	6	7	2
3	5	6	8	4	0
4	3	4	7	1	6

N = 91

χ^2 = 19.54

d.f. = 12

P < 0.07

Table 39

Ranking Distribution Of Marital Problem (5) By Case Version

Case Version	Ranking Position 1	2	3	4	5
1	3	14	4	2	1
2	10	5	6	0	2
3	8	9	6	0	0
4	5	7	8	1	0

N = 91

$X^2 = 17.71$

d.f. = 12

$p < 0.12$

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