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THE RELATIONSHIP BETWEEN MALE CLINICIANS' SELF-PERCEIVED SEX-ROLE IDENTIFICATION AND THEIR CLINICAL JUDGEMENTS OF PROSPECTIVE WOMEN CLIENTS

by

Scott Baum

A dissertation submitted to the Graduate Faculty in Clinical Psychology in partial fulfillment of the requirements for the degree of Doctor of Philosophy, The City University of New York.

1977

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Chapter I

Introduction:

This study seeks to determine the relationship between the self-perception of sex-role identity, as defined by the Bem Sex Role Identity Scale (this will be elaborated below) of male interviewers and their ratings of prospective psychotherapy clients.

History:

During the 1960's and early 1970's a good deal of critical examination of social and personal attitudes that were discriminatory against women and other sub-groups in the population took place. (Friedman 1963; Gornick and Moran, 1971.) Some of this was related to issues of personal and institutional racism against Black people, for example (Fanon, 1967), and some was directed at issues of the role of, and attitudes toward, women. As part of this process, the field of psychology, and the area of psychotherapy in particular, came under attack as a process which tended to perpetuate the restriction of women's roles in society. The criticisms leveled by such authors as Greer (1970) and Millett (1970) focused, at least in part, on the theoretical underpinnings of psychotherapy and their effect; both in treatment, and in general influence of psychologists and psychotherapists -- in their writing, teaching and other public activities. The criticism made was that the theoretical

models, and their practical implementation, often served to suppress women and pressure them into an acceptance of secondary roles in life; if not always directly, that at least through a lack of vigorous commitment to the realization of women's potential as the equal of men.

No formal rebuttals of these attacks have been made in the literature. In graduate seminars, or in discussions among graduate level clinical students and faculty, one can hear two kinds of argument used to contend with the criticisms levelled. One argument is constructive, stressing the power of empathy, and pointing to the general motivation of most clinicians to help and not hinder growth. The second argument is destructive and usually takes the form of casting aspersions on the originators of the criticism. However, no empirical scientific investigations have so far been undertaken, or at least published, to demonstrate that in fact no bias or discriminatory attitude exists on the part of clinicians against women seeking to grow past traditional sex-role boundaries. On the other hand, some studies such as Broverman, et. al. (1970), have yielded provocative evidence of the existence of markedly different attitudes toward men and women on the part of clinicians. Broverman, using clinically trained psychologists, psychiatrists, and social workers, all actively functioning in clinical settings, and ranging from brief to extensive experience, determined that clinicians have demonstrably different concepts of psychological or emotional

health for men and women; and that those concepts conform to sex-role stereotypes prevalent in society. So, healthy women are more likely to be:

> more submissive, less independent, less adventurous, more easily influenced, less aggressive, less competitive, more excitable in minor crises, having their feelings more easily hurt, . . . (p.4)

than healthy men, according to the clinicans asked. Also, it appeared that overall, these clinicians' conception of a mature healthy adult of 'sex unspecified', did not differ from the conception that they had of a healthy adult man, but did differ in significant ways from their conception of a healthy adult woman.

Mednick and Weisman, writing in the Annual Review of Psychology (1975), noted that there is far more speculation than empirical research on the changing role of women, especially in relation to psychotherapy. This scarcity of research was noted also by Brown and Hellinger (1975), who themselves discovered that some 50% of a sample of professionals, both men and women, held "traditional" views (i.e. women as less autonomous and less assertive) about women and their role in society. The authors of both this study and the review noted above also pointed out that while the implications of role change and society's changing conceptions of masculinity have received some attention, little empirical work has been done to assess the effects, if any, of these changes. At the

same time, Feigan-Fasteau, in his book The Male Machine (1974), writes at length about the ways in which the socialization and enculturation of men are likely to contribute to the kinds of attitudes in the studies cited above. The bind created for women by these attitudes, is that if they become assertive, they are not being feminine, and if they are not assertive they are not seen as mature adults, (Broverman, 1972). In the view of Chessler (1972), it is this bind which is part of the structure maintaining women in the roles they have been in.

While studies of the influence of theoretical orientation of therapists on their actual work with people (Bordin, 1974; Raskin, 1974; Strupp, 1958) do attempt to evaluate such factors as therapist's warmth, congruence, emphasis on the unconscious and ability to inspire confidence, none, however, has examined self-perceived masculinity-femininity, or specific attitudes toward women -- especially during the past ten years of rapid change -- as variables affecting treatment. Indeed, it seems reasonable to presume that a psychotherapist's personality may have a direct influence on treatment (Bordin, 1974), and that psychodynamic conflicts within the therapist may interfere and detract from empathic understanding of the client. Conversely, a therapist's empathy, sensitivity and supportiveness may be enhanced to the degree that he is not in a fixed stereotypical sex-role, but has been able to integrate both masculine and feminine traits in himself.

It would seem valuable, then, at this time, to investigate at least one aspect of the interaction between patient and professional; at the point at which initial judgements of character and disturbance are made. The goal of such a study would be to determine the nature and effect of one aspect of the therapist's personality, namely androgyny, that is, a high degree of integration of desirable masculine and feminine traits, on his ratings of two different prospective psychotherapy patients. One of the interviewees will represent the traditional profile of a woman seeking psychotherapy, feeling somewhat depressed, having some difficulties with schoolwork, and a relatively unsatisfactory social life. The other interviewee will present herself with these difficulties, but will add some thoughts and feelings about being a woman, and her experience of sexism and its effects on her.

For some time, criticisms have been levelled in the literature at various personality tests measuring, among other things, the subject's masculinity or femininity. These criticisms have been made on a number of grounds (Constantinople, 1974; Bem, 1972) -- that they are bi-polar, requiring an individual to be either masculine or feminine each to the exclusion of the other as if they were completely separate clusters of traits, and that their standardization samples were both very small and hardly representative of the range of characteristics of American men and women, for example -- and have

resulted in efforts to create scales which would more accurately reflect the presence, in any one person, of traits which have traditionally been considered at either one of the two poles, masculinity or femininity (Bem, 1974).

In recent research it was found that college students who fell in the range of self-perception characterized as androgynous were more likely to perform actions and behaviors considered to be more 'appropriate' for the opposite sex; and tended to be, in general, more flexible, spontaneous, and responsive in various novel situations, than students who rated themselves at either the masculine or feminine poles of the scale (Bem, 1972; Bem & Lenney, in press). It was also found, that ratings of masculinity and femininity varied independently of each other, and of items tapping a social desirability response set (Bem, 1974). So, the undergraduates comprising the standardization sample for the Bem Sex Role Inventory (BSRI), were not simply responding as they thought would be appropriate, but rather as they experienced themselves.

<u>Hypotheses</u>:

The hypotheses flow from research cited above which suggests that men with different sex-role identification will respond differently from each other. As Bordin (1974), after a thorough review of the literature states the issue more generally:

> We have to say that the evidence

> thus far suggests that experience
> and training, although influential,
> do not in themselves fully account
> for the therapist's behavior and
> his effect on his patient. (p.163)

It is logical to suppose, therefore, that interviewers' ratings of prospective patients are likely to be influenced in some way, by their own sexual identity. Given the research to date, this influence will be most evident in the judgements of men rating women interviewees.

Hypothesis I: "Masculine" identified men will tend to rate an interviewee who expresses feelings about her treatment as a woman, and her anger about that, as more severely psychologically disturbed than a woman interviewee who does not raise those issues. It is recognized that this trend may not appear on all the ratings, and so each question will be examined independently.

Hypothesis II: "Androgynous" men will tend to rate an interviewee raising issues about her treatment as a woman as less severely psychologically disturbed than a woman who does not raise those issues. Again each question will be evaluated independently to ascertain any effects of such a bias.

Hypothesis III: The two groups of men will not only react to the two interviewees differently, their responses will be different from each other to the same interviewee condition.

It is hypothesized that masculine identified men will rate the interviewee who does not raise issues of her treatment as a woman as less severely disturbed than will the androgynous men. Conversely, androgynous men will tend to rate the women who do raise these issues as less severely disturbed than will the masculine men.

Chapter II

Subjects:

Ss were 24 men -- 12 masculine identified and 12 androgynous based on their ratings of themselves on the BSRI (see Appendix A). In each group 10 Ss were upperclass (2nd semester Junior and Senior) undergraduate psychology majors, all planning to enter a clinical field (psychology, psychiatry or social work). One masculine S was a first year graduate clinical student, and one a first year graduate social work student. Two androgynous Ss were first year graduate social work students. Ss were selected from these groups because they represent prospective male clinicians who are likely to be making, as professionals, the kinds of judgements that were investigated in this study. It was hoped that this study would be relevant to actual clinical practice since these men would actually be making judgements, or for a number of them, were already making judgements of people, identical with or very similar to the judgements asked of them here. All Ss came from urban universities.

Method:

In order to investigate the effect of prospective male clinicians' sex-role identities on their ratings of women interviewees, undergraduate male Senior psychology majors who anticipate entering the helping professions (i.e.

psychology, psychiatry, social work, etc.), and so will very shortly be asked to make clinical judgements -- on such questions as severity of psychological disturbance -- on a regular basis, were asked to rate two women based on videotaped interviews. One of these women presented herself with complaints traditionally associated with college age psychotherapy patients. The second woman presented those same complaints, plus a number of additional statements about her self-perception as a woman, and her desire that her anger and experience of oppression not be 'interpreted away'.

Procedure:

The Ss were initially administered the BSRI (see Appendix A), which is a list of adjectives on which the Ss rated themselves using a 7 point scale ranging from "never or almost never true" to "always or almost always true". The items used in the BSRI were selected by two independent samples of undergraduates, who chose them as representing traits most desirable in American society; for men to construct the 'masculinity' scale, and for women to construct the 'femininity' scale. Originally, a t-ratio was used as the index of androgyny, based on the difference between the masculinity and femininity scales (Bem, 1974); however, Bem and Watson (1976) now recommend using median scores to arrive at a classification of androgyny. This method was used here, whereby Ss' mean scores on masculinity and

femininity scales constituted those scale scores, and then their placement with respect to overall median scores constituted their classification. Thus, those falling above the median on both masculinity <u>and</u> femininity were considered androgynous; those scoring themselves above the masculinity median and below the femininity median were considered as masculine.

Significant work validating the BSRI empirically has been done (Bem, 1974). Also psychometric analysis of the scale revealed that:

> the Masculinity and Femininity Scales are empirically as well as logically independent (average r = -.03), and even more importantly, that the Androgyny score . . . is uncorrelated with the tendency to describe oneself in a socially desirable direction (average r = -.06). (Bem, 1975; p. 636)

According to Bem (1974), test-retest reliability revealed all four scores obtained on the BSRI to be highly reliable (Masculinity r = .90; Femininity r = .90; Androgyny r = .93; Social Desirability r = .89). Since median scores on the femininity scale were necessary, the BSRI was administered to equal numbers of men and women in the classes from which the <u>Ss</u> were drawn.

<u>Ss</u> heard a brief (5 to 10 minute) statement on the nature of clinical interviewing and the kinds of judgements which must be made (see Appendix D). They then observed a 10 to

12 minute videotaped interview. They were able to hear the interviewer's voice, but saw only the interviewee.

The videotapes were made using professional actresses who were confederates of the experimenter's. Each confederate made one tape in the traditional condition and one in the non-traditional condition. Three different women were used to make the films, and the order of presentation was counter-balanced as to confederate, so that an equal number of masculine and androgynous men saw each actress in each condition against every other actress in each condition. Presentation of condition was randomized. Each interview was different in that three particular phrases were used to create the traditional condition, and three additional phrases were used for the non-traditional condition (see Appendix B).

Confederates were instructed to maintain all other aspects of the two interviews as identical as possible while still keeping the simulation credible.

At the end of each film, Ss were asked to fill out a rating form (see Appendix C).

Chapter III

Results:

Means and standard deviations were computed for both BSRI groups (masculine and androgynous), for each rating in each of the two conditions. Mean differences on demographic variables for all 24 Ss were subjected to t-tests. Table 1 shows the means and standard deviations obtained for these variables. No significant differences were found between masculine and androgynous groups in age ($\underline{M}_m$ = 26.00 vs. $\underline{M}_a$ = 26.60 years), and in years of post-secondary education ($\underline{M}_m$ = 4.00 vs. $\underline{M}_a$ = 3.58); also, no significant differences were found in the grade-point averages of the two groups (the means for both groups fell between 3.00 and 4.00, or between grades of B and A). On the BSRI there was no significant difference found between groups on the Masculine scale of the inventory ($\underline{M}_m$ - 52.33 vs. $\underline{M}_a$ = 55.25); there was a significant difference between the groups on the Feminine scale of the inventory ($\underline{M}_m$ = 44.25 vs. $\underline{M}_a$ = 50.25), t(22) = -6.13 p .001. This last finding was expectable given the design of this study, which was to select two groups of men both with relatively high masculine identification with one of the two groups having relatively low feminine identification, and the other relatively high feminine identification. An examination of the means and standard deviations obtained on the Feminine scale further suggests that the two groups of Ss are significantly discriminable, and that few, if any, of the Ss were on the

Table 1

Means and Standard Deviations
for Two BSRI Groups for
Demographic Variables

	Age	Education[a] in years	G.P.A.[b]	Masc. BRSI	Fem. BRSI
Masc. M s.d.	26.00 4.57	4.00 0.60	2.58 0.51	52.33 4.76	44.25 1.92
And. M s.d.	26.67 8.78	3.58 0.90	2.41 0.67	55.25 5.61	50.42 2.91
t-value for difference between means	-0.23	1.33	0.68	-1.37	-6.13*

a) These means are based on a code where 1 = Freshman; 2 = Sophomore; 3 = Junior; 4 = Senior; 5 = 1st year graduate.
b) These means are based on a code where 1 = a G.P.A. of 2.5-3.0; 2 = a G.P.A. of 3.0-3.5; and 3 = a G.P.A. of 3.5-4.0.
*$p < .001$

borderline of criteria for assignment to another group. The question of interviewee effect was examined for all three interviewees by means of one-way ANOVAs, as a check on the design. An analysis was done of both groups' responses to each item in each condition, Traditional and Non-traditional, and on the composite scores computed (see below); so that a total of 20 two-way ANOVAs were done for three actresses and two conditions, and there

were no effects of either, or any interaction between them that were significant at the .05 level.

Besides the analysis of each rating item, analyses of a composite score were also conducted. This composite score was generated to determine if there was a difference between masculine and androgynous groups when all narrower more specific judgements were combined to yield an overall judgement. It was thought that this would resemble more closely a single unified judgement, if Ss had been asked to make one, than did the score on the item judging severity of disturbance, since were such a judgement requested it would probably contain within it the other judgements which were explicitly solicited on the questionnaire each S filled out.

To generate this score, items 1, 2, and 8, were added together. These were items judging severity of disturbance, degree of impairment in adjustment to society, and projected length and intensity of treatment. On the rating form, the judgements available to each S on these questions were ordered in increasing severity (1-3). Items 3, 4, 5, 6, 7 and 9, were also added together. These are judgements assessing the interviewee's insight into her problems; how much discomfort she experiences with her problems (that is, whether they appear ego-dystonic); the difficulty anticipated working with the interviewee; the willingness

of the S to work with her; and the interviewee's prognosis. These items were added together because the judgements offered the Ss were listed in descending order of severity. The first group of items was then subtracted from the second group, in order to yield a positive composite score. Because of the method of computation a high score indicates less severe psychological disturbance than does a low score. Table 2 shows the means and standard deviations of the composite scores for both masculine and androgynous Ss in both Traditional and Non-traditional conditions.

There may be some question about the inclusion, or the grouping, of judgements relating to impairment of adjustment to society, and willingness of the S to work with a given interviewee. It is arguable whether impaired adjustment to society represents more severe disturbance or less severe; and if willingness to work with a prospective client is indicative of a judgement of less severe disturbance, one would not necessarily assume so if working with experienced clinicians. However, it was felt that since these Ss were not experienced clinicians, their willingness to work with an interviewee would reflect their perception that she was likely to respond well to treatment with them, and was already demonstrating a greater proclivity to change and a more hopeful prognosis. Also,

Table 2

Means and Standard Deviations for Two BSRI Groups for Composite Judgements for Two Interviewee Conditions

	Cond. I	Cond. II	Total combined
Masc. M	9.67	7.75	8.71
s.d.	2.33	4.30	3.39
And. M	8.91	10.75	9.83
s.d.	1.96	1.47	1.87
Total M	9.29	9.25	
combined s.d.	2.07	3.37	

it seemed that if these Ss saw an interviewee as severely impaired in her adjustment to society, that that reflected their sense of her as unable to function well in it, rather than as choosing an autonomous course apart from social convention. Although including these items makes the composite scores somewhat less clear-cut in meaning, it was felt it was appropriate with these Ss. In this way, an overall score encompassing all the elements of the individual judgements made, could be determined. Conclusions could be drawn from that information without the risk of using a judgement containing the label of 'severity' which may have caused Ss to react in particular ways, or simply, in their inexperience, to exclude from that judgement some of the factors which were

embodied in later questions.

Only one significant difference was found, tested by a series of t-tests, in the masculine Ss mean ratings of interviewees between the two conditions, Traditional and Non-traditional (Hypothesis I). Table 3 shows the means and standard deviations of the judgements made by both masculine and androgynous groups comparing the Traditional with the Non-traditional interviewees. As can be seen, the masculine Ss rated the two conditions as essentially the same, except for their responses to question 7 where they indicate that they would be significantly more willing to work with the interviewees in the Traditional condition, rather than in the Non-traditional condition, $t(11) = 1.91$ $p < .05$. Among androgynous Ss there were a number of significant differences in their ratings of the two conditions (Hypothesis II). On question 1, asking Ss to rate the severity of psychological disturbance, androgynous Ss saw the interviewees in the Non-traditional condition as less disturbed than interviewees in the Traditional condition, $t(11) = 3.02$ $p < .01$. On the other hand, the androgynous Ss saw the interviewees in the Traditional condition as experiencing significantly more discomfort with their problems (question 4), $t(11) = 2.16$ $p < .05$; but, the androgynous Ss saw the interviewees in the Non-traditional condition as more willing to work toward their own change (question 5), $t(11) = 2.17$ $p < .05$. Based on the composite disturbance

Table 3

Means, Standard Deviations and t-values for Judgements Made by Masculine and Androgynous Ss in Traditional and Non-traditional Conditions

	Masc. Ss			And. Ss		
Item:	Trad.	N.T.	t	Trad.	N.T.	t
1. Severity M	1.67	1.67	0.00	1.92	1.33	3.02***
s.d.	0.49	0.78		0.51	0.49	
2. Adjustment M	1.75	1.83	-0.32	1.91	1.58	1.17
s.d.	0.45	0.83		0.67	0.67	
3. Insight M	2.25	1.83	1.45	1.92	2.17	-0.90
s.d.	0.75	0.72		0.51	0.72	
4. Discomfort M	2.33	2.42	-0.43	2.91	2.50	2.16*
s.d.	0.49	0.67		0.29	0.52	
5. Change M	2.50	2.42	0.32	2.25	2.75	-2.17*
s.d.	0.52	0.67		0.62	0.45	
6. Difficult M	2.33	2.08	1.00	2.25	2.42	-0.80
s.d.	0.65	0.79		0.62	0.51	
7. Work with M	2.75	2.50	1.91*	3.00	2.92	0.00
s.d.	0.66	0.67		0.00	0.29	
8. Treatment M	1.67	2.00	-1.48	1.92	1.67	1.00
s.d.	0.65	0.60		0.79	0.49	
9. Prognosis M	2.50	2.17	1.48	2.42	1.67	-1.39
s.d.	0.52	0.71		0.51	0.49	
10. Composite M	9.67	7.75	1.38	8.91	10.75	-2.66**
s.d.	2.33	2.40		1.96	1.47	

* $p < .05$
** $p < .02$
*** $p < .01$

score, the androgynous Ss judged the interviewees in the Non-traditional condition as less severely disturbed than the interviewees in the Traditional condition, $t(11) = -2.66$ $p < .02$. It is noteworthy that in seeing the two conditions as relatively the same, the masculine Ss confirmed that with the exception of the phrases written by E, the two interview conditions were probably very alike.

To determine if masculine Ss rate interviewees differently from androgynous Ss (Hypothesis III), a series of t-tests were performed on the differences in the mean ratings of both groups for both the Traditional and Non-traditional conditions (see Table 4). In the Traditional condition, there was only one significant difference between the two groups. On the question of interviewee's discomfort with her problems (question 4), the androgynous Ss saw the interviewees in the Traditional condition as experiencing more discomfort with their problems than did the masculine Ss, $t(22) = 3.54$ $p < .01$. On all other judgements the two groups did not significantly differ in their perception of the interviewees in the Traditional condition. In the Non-traditional condition the androgynous Ss were significantly more willing to work with the interviewees (question 7) than were the masculine Ss, $t(22) = 1.97$ $p < .05$. Androgynous Ss saw the prognosis (question 9) as better for the interviewees in the Non-traditional condition than did the masculine Ss, $t(22) = 1.99$ $p < .05$.

Table 4

Means, Standard Deviations and t-values for Judgements Made by Masculine and Androgynous Groups Within Both Interviewee Conditions

	Traditional			Non-traditional		
Item:	Masc.	And.	t	Masc.	And.	t
1. Severity M	1.67	1.92	-1.22	1.67	1.33	1.25
s.d.	0.49	0.51		0.78	0.49	
2. Adjustment M	1.75	1.92	-0.72	1.83	1.58	0.81
s.d.	0.45	0.67		0.83	0.67	
3. Insight M	2.25	1.92	1.26	1.83	2.17	-1.14
s.d.	0.75	0.51		0.72	0.72	
4. Discomfort M	2.33	2.92	-3.54****	2.42	2.50	-0.39
s.d.	0.49	0.29		0.51	0.52	
5. Change M	2.50	2.25	1.07	2.42	2.75	-1.43
s.d.	0.52	0.62		0.67	0.45	
6. Difficult M	2.33	2.25	0.32	2.08	2.42	-1.22
s.d.	0.65	0.62		0.79	0.51	
7. Work with M	2.75	3.00	-1.39	2.50	2.92	-1.97*
s.d.	0.62	0.00		0.67	0.29	
8. Treatment M	1.67	1.92	-0.84	2.00	1.67	1.48
s.d.	0.65	0.79		0.60	0.49	
9. Prognosis M	2.50	2.42	0.39	2.17	2.67	-1.99*
s.d.	0.52	0.51		0.72	0.49	
10. Composite M	9.67	8.91	0.88	7.75	10.75	2.32**
s.d.	2.33	1.96		4.30	1.47	

* $p < .05$
** $p < .02$
**** $p < .005$

Finally, the androgynous Ss saw the interviewees in the Non-traditional condition as less severely disturbed overall (based on the composite score) than did the masculine Ss, $t(22) = 2.32$ $p < .02$. In relation to this last finding, it is interesting to note that the masculine Ss showed greater variability in their ratings than did the androgynous Ss, and greater variability than in their ratings in the Traditional condition. This suggests the possibility that the masculine were indeed affected by the difference in the two conditions, and, also that they are less homogeneous than the androgynous men in their judgements.

Chapter IV

Discussion

The results of this study point toward a relationship between the sex-role identity of men clinicians and their judgements about women clients. This relationship was reflected here both in the differential responses of two groups of men with distinguishably different sex-role identities, to two different interviewees, and from each other with the same interviewee.

It was hypothesized that men who are masculinely identified would reveal a difference in their reactions to two women interviewees. It was suggested that they would tend to perceive a woman who presents herself as dissatisfied with her treatment as a woman as more severely psychologically disturbed than a woman who expresses no such dissatisfaction. This difference in reactions to these two different women did materialize, but only on one judgement among all the judgements the masculine men made. The responses of the masculinely identified men indicated that they would be significantly more willing to work with women who did not, in the interview, raise issues related to being women, than they would be with women who did raise those issues. In this way, the masculine men reacted to the more feminist women by indicating that although they did not perceive them as significantly more disturbed than their more traditional counterparts, they would be less willing to work

with them. The masculine men in rating both interviewees they observed relatively alike, seemed to be insensitive to the feelings which the more feminist interviewee expressed, taking them neither as a sign of health or disturbance. This is somewhat odd in itself in this time of public discussion of women's roles in society. But, these men may be indicating by their responses that these issues are irrelevant to questions of psychological disturbance.

Yet, these men reveal, as a group, a lesser willingness to work with women who do raise these issues, even while seeing those women as no more disturbed than those who do not. It seems subtle evidence of a difference in their responses to these two women, which at least suggests the possibility of their holding a negative attitude toward women who express feelings of anger and resentment about their treatment as women. This attitude, if it is indeed present, did not emerge in an overt way on questions of severity of disturbance, either because the men are not aware of their attitude, or because they have learned not to reveal it, but rather appears in their unwillingness to become involved working with that woman who expressed feminist feelings. This raises the question of the effect of this attitude on clinical decisions in a case where a woman expressing these kinds of feelings is involved, and the clinician is a man who is masculinely identified. It also raises the issue of the influence of an interviewer's feeling

of unwillingness to work with someone, on colleagues where group decisions (in a clinic or hospital, for example) of acceptability for treatment are being raised.

Androgynous men also revealed differences in their responses to the two interviewees they observed. They saw the interviewee who talked of her feelings about being a woman as less severely disturbed. They perceived those feelings and the need to struggle with them as a sign of health, and as an indication of the struggle to change already begun. That apparently indicated to them that this prospective psychotherapy client was in some ways healthier than the interviewee for whom these feelings had not emerged into the foreground of their perceptions of themselves and their difficulties. In keeping with this attitude, androgynous men saw the women in the second, more feminist, condition as more willing to work toward their own change, more aware of themselves and so more committed to changing. Interestingly, these same men saw the women in the Traditional condition as experiencing more discomfort with their problems. They were evidently not insensitive to these women, but saw them as more defensive and less aware of themselves.

The two groups of men in this study reacted differently to two women representing two different kinds of women appearing for an initial interview. They also differed from each other as groups in the ways in which they reacted

to each condition, Traditional and Non-traditional. In their ratings of the women in the Traditional condition, only one significant difference emerged between the two groups. The androgynous men rated the women in that condition as experiencing more discomfort with their problems than did the masculine men, indicating thereby that they sensed that those interviewees did experience their difficulties as ego-dystonic and recognized them as problems in living. In this dimension, the androgynous men appeared to be somewhat more sensitive to the interviewees in the Traditional condition than were the masculine men. On all other judgements, however, including the composite score which took into account the combined effect of all ratings, the masculine men and the androgynous men did not differ significantly in their judgements of disturbance for the women in this condition.

In their judgements of the interviewees in the Non-traditional condition the masculine and androgynous men differed significantly on a number of items. The androgynous subjects were, as a whole, more willing to work with the women in this condition than were the masculine subjects. Also, the androgynous men judged the prognosis for the women in this condition to be better than did the masculine men. On the basis of the composite scores, the androgynous men perceived the more feminist women as less severely disturbed. Although the masculine men judged the interviewees in both Traditional

and Non-traditional conditions as virtually the same with regard to each other, and although they did not differ from the androgynous men in their overall (composite) judgements of the women in the Traditional condition, they did rate the women in the feminist condition as more severely disturbed than did the androgynous men. These differences between the two groups suggest that the androgynous men were no less sensitive and responsive to the women in the Traditional condition than were the masculine men, if anything, perhaps in one respect more sensitive. However, with women in the Non-traditional condition, they were in some way aware of, and responded to, issues which they saw as evidence of less severe psychological disturbance and holding hope for better prognosis, which the masculine men did not perceive, or which did not affect their judgements.

Masculinely identified and androgynous men make different clinical judgements, that is evident. The differences revealed are surely a serious matter when decisions affecting people's lives are being made, and the effect of these differences would not be the same for these two groups. One can, of course, argue that raising feminist issues in an initial interview is a sign of psychological disturbance, more so than not raising such issues or not expressing such feelings. In that case, the criticisms of psychotherapy, referred to above, as a process which ignores or even inhibits women's growth and development have some validity, without exploring the issue any farther.

However, if one argues that the goal of psychotherapy is, among other things, to foster the development of assertiveness and autonomy in all who wish them, then the differences between the two groups of men in this study become important.

The androgynous men in this study were more sensitive to the issues raised and the feelings expressed by the women in the more feminist condition, perhaps because they have had to struggle, from the other side, to integrate and develop characteristics in themselves which are stereotypically feminine. They saw these women as healthier and more aware of themselves, as having already begun the process of change which they are presumably seeking to continue in treatment. At the same time, they were also sensitive to the pain and discomfort of women for whom the bounds of their roles as women had not yet begun to chafe, and they were receptive to them as people, seeing them as a group, as no more disturbed than did the masculine men. While they saw the women in the feminist condition as healthier when compared with their counterparts in the Traditional condition, they are not more likely than their masculine colleagues to rate non-feminist women as severely pschologically disturbed. The masculine men when faced with women angry at their treatment as women seem insensitive to that issue, except that they were less willing to work with such women. Can they then support these women in their

struggle to grow and in their need to assert themselves, and perhaps even more importantly, can they foster and facilitate this struggle if they do not recognize the issues and feelings when they appear, or are covertly rejecting in their presence?

It is possible that the masculine men do not view these issues as important diagnostic or therapeutic issues at all. If that is the case, it would be valuable to determine if they share with other clinicians the attitudes toward women which Broverman et. al. (1970) found, that healthy women were expected to be more passive and less assertive than healthy men; or whether they actually do not see these feminist issues as significantly affecting clinical judgements or treatment. The most important question yet to be answered is whether the differing perceptions in these two groups of men do indeed affect their behavior, in making diagnoses, planning referrals, or in psychotherapy. However, even the findings in this study suggest that these are issues which rightly ought to be raised during clinical training. It is conceivable that formal training and extensive clinical experience can nullify or alter the effects of therapists' sex-role identity on their clinical judgements or practice, this remains to be investigated. The evidence of this study is that judgements are influenced by sex-role identity, at least in inexperienced clinicians; and the nature of these effects raises the possibility that

a large group of women now entering or in treatment, are contending with men who, in part due to their own sex-role identity, have, to some degree, negative attitudes toward their growth into assertive strong people. While another group is working with men who show no evidence suggesting such an attitude. Once again, the effects of these differences between these two groups on treatment remains to be investigated.

Other questions are also raised by this study. Women clinicians, and the form and quality of their responses has not been investigated at all, to see if they differ from each other based on sex-role identity, and to see if they differ from men. It is also possible that androgynous men differ in their judgements of other men, as well as in their judgements of women. In general, the relationship of sex-role identity to clinical judgements and clinical practice has not been investigated, either with novices or experienced professionals. Based on the findings of this study sex-role identity may play a part in a wide range of judgements in clinical work. That role should be elucidated so that it can be openly incorporated in training and supervision of prospective clinicians, if that is indeed warranted.

Appendix A

The Bem Sex-Role Inventory

A copy of the BSRI is appended after this page.

Name____
(Last) (First) (Middle)

Sex__________________ Age__________________

TELEPHONE________________________(If you have no phone, please give us some way of contacting you, e.g., your address)

____

On the back you will be shown a large number of personality characteristics. We would like you to use those characteristics in order to describe yourself. That is, we would like you to indicate, on a scale from 1 to 7, how true of you these various characteristics are. Please do not leave any characteristic unmarked.

Example: sly

Mark a 1 if it is NEVER OR ALMOST NEVER TRUE that you are sly.

Mark a 2 if it is USUALLY NOT TRUE that you are sly.

Mark a 3 if it is SOMETIMES BUT INFREQUENTLY TRUE that you are sly.

Mark a 4 if it is OCCASIONALLY TRUE that you are sly.

Mark a 5 if it is OFTEN TRUE that you are sly.

Mark a 6 if it is USUALLY TRUE that you are sly.

Mark a 7 if it is ALWAYS TRUE OR ALMOST ALWAYS TRUE that you are sly

Thus, if you feel it is sometimes but infrequently true that you are "sly", never or almost never true that you are "malicious", always or almost always true that you are "irresponsible", and often true that you are "carefree", then you would rate these characteristics as follows:

Sly	3
Malicious	1

Irresponsible	7
Carefree	5

DESCRIBE YOURSELF

1	2	3	4	5	6	7
EVER OR ST NEVER TRUE	USUALLY NOT TRUE	SOMETIMES BUT INFREQUENTLY TRUE	OCCASIONALLY TRUE	OFTEN TRUE	USUALLY TRUE	ALWAYS OR ALMOST ALWAYS TRUE

Item	
Self reliant	
Yielding	
Helpful	
Defends own beliefs	
Cheerful	
Moody	
Independent	
Shy	
Conscientious	
Athletic	
Affectionate	
Theatrical	
Assertive	
Flatterable	
Happy	
Strong personality	
Loyal	
Unpredictable	
Forceful	
Feminine	

Item	
Reliable	
Analytical	
Sympathetic	
Jealous	
Has leadership abilities	
Sensitive to the needs of others	
Truthful	
Willing to take risks	
Understanding	
Secretive	
Makes decisions easily	
Compassionate	
Sincere	
Self-sufficient	
Eager to soothe hurt feelings	
Conceited	
Dominant	
Soft-spoken	
Likable	
Masculine	

Item	
Warm	
Solemn	
Willing to take a stand	
Tender	
Friendly	
Aggressive	
Gullible	
Inefficient	
Acts as a leader	
Childlike	
Adaptable	
Individualistic	
Does not use harsh language	
Unsystematic	
Competitive	
Loves children	
Tactful	
Ambitious	
Gentle	
Conventional	

Appendix B

Confederate Phrases in Each Condition

A. Three phrases for use in the traditional condition:

1. "I have been feeling kind of down and tired, having trouble getting my work done."
2. "I feel like it's hard for me to get close to people, my social life isn't very enjoyable."
3. "It is very hard for me to express my feelings, I feel very inhibited, and I'm not even sure I know what some of my feelings are."

B. These three phrases were used in addition to those above for the non-traditional condition:

4. "Also, reading and talking to other women has made me aware of things I never thought about."
5. "There are some specific things I know are bothering me; some things about the way I've been treated as a woman."
6. "I know I want to deal with my feelings about being a woman, I know there are things I'm angry at, and I don't want to be told it's just my problem, or it's all in my head -- I know better."

These phrases, just three or all six, will be embedded in the interview and not clustered one after another; although, where logical, they may follow each other fairly rapidly.

Appendix C

Rating Scale for Rating Interviewees

Please answer each of the following questions by indicating the choice which most corresponds to your judgement of the interviewee.

1. What, in your estimation, is the degree to which this person is psychologically disturbed?

A. mildly B. moderately C. severely

2. To what degree is the interviewee's adjustment to society impaired?

A. mildly B. moderately C. severely

3. How much insight does the interviewee show into her difficulties?

A. very little B. some C. a good deal

4. Does the interviewee appear to experience discomfort with her problem?

A. very little B. some C. quite a bit

5. How willing, do you think, is the interviewee to work for her own change?

A. unwilling B. somehat willing C. very willing

6. Will the interviewee be difficult to work with in treatment or relatively easy?

A. difficult B. moderately difficult C. easy

7. Would you be willing to work with this person in treatment?

A. unwilling B. willing but unenthusiastic C. willing

Appendix C (continued)

8. What kind of treatment would you foresee as most beneficial and necessary?

A. brief and problem oriented	B. moderately long term	C. intensive long term

9. Overall, what prognosis would you make?

A. poor	B. fair	C. good

10. What area in the helping professions are you now planning to enter (i.e. psychologist, psychiatrist, etc.)?

11. Do you now lean toward any particular approach to psychotherapeutic treatment (i.e. psychoanalytic, behavioral, gestalt, etc.)?

12. Please indicate your grade point average in Psychology by circling the appropriate range below:

A. 2.5 - 3.0	B. 3.0 - 3.5	C. 3.5 - 4.0

13. <u>Briefly</u> state below what led you to make the judgements you did regarding severity of disturbance, impairment of adjustment, degree of insight, willingness to change and prognosis, for this interviewee. Also please indicate what prompted you to feel you would or would not want to work with this interviewee.

Appendix D

Text of the Statement on Clinical Judgements

One of the tasks most often given clinicians is that of doing a brief interview with a client with varying goals. One of the most common reasons for such interviews is to assess the acceptability of that person for treatment in a given setting. Subsequent to that initial decision, other options must also be evaluated; i.e. referral to another agency, hospitalization, referral to a private practitioner, adjunct social services, nature of treatment, etc.

In order to make such decisions three things must occur as a product of the interview. The interviewer must know certain objective information about the client and his or her life situation. The interviewer must have some idea about the client's subjective view of his or her difficulties in living. And, the interviewer must make certain judgements about the client in order to make appropriate decisions regarding disposition of the case, from the many options available, of which some were noted before.

This is the most difficult aspect of interviewing. It is clear that after a brief interview, or even one of an hour's length, a clinician cannot really know the person being interviewed. So when judgements are made, it is understood that

Appendix D (continued)

they are qualified by the recognition that they are limited by the brevity of the contact. Nevertheless, these judgements must be made in order to secure the best help available for the client, despite the limitations inherent in the situation.

If we assume that the client comes seeking psychotherapy, then at least the following areas must be assessed and evaluated by the interviewer. A general evaluation of the degree to which the client is psychologically disturbed must be made, how severe are his or her difficulties. Is the nature of these difficulties such that the client's adjustment to society, and ability to function in it, is impaired? Does the client show a lack of ease with his or her problems, or does he or she explain them away or seem not perturbed by them; and does the client show an awareness of the nature of the problems whether they are psychological or situational?

Then there are judgements which are directly related to treatment. Does the client show a willingness to work toward changing? Will the client be difficult to work with in treatment due to the nature of his or her characterological defenses, or the particular problems with which he or she has come? What kind of treatment would be most beneficial, i.e. short or long, insight versus behavioral, etc.? And, an overall judgement must be made about the client's prognosis, and the

likelihood that treatment would be beneficial. Additionally, in some cases the interviewer must decide if they would be willing to work with this client.

Once these judgements are made, with the full recognition that they are subjective assessments made by the clinician, and with all the reservations regarding brevity and the lack of depth of information, then informed decisions can be made, which, hopefully, will serve the client best.

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