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Sex-role bias and the clinical referral process : an attributional analysis.

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SEX-ROLE BIAS AND THE CLINICAL REFERRAL PROCESS: AN ATTRIBUTIONAL ANALYSIS

A Dissertation Presented

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SEX-ROLE BIAS AND THE CLINICAL REFERRAL PROCESS:
AN ATTRIBUTIONAL ANALYSIS

September, 1982

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An analogue study was conducted to examine the impact of sex-role appropriate versus sex-role inappropriate behavior on clinical assessments. Twenty-four male and 24 female masters level clinicians were asked to read hypothetical case descriptions which varied according to sex of the client, sex of the clinician, behavior of client (passive versus aggressive), and type of client problem (personal versus vocational). Clinicians then responded to a number of dependent variables including: 1) causal attributions, 2) client assessments, and 3) referral recommendations. It was hypothesized that sex-role inappropriate client behavior (i.e., passive male, aggressive female) would elicit a greater number of causal attributions and unfavorable clinical assessments than would sex-role appropriate behavior (i.e., passive female, aggressive male). This hypothesis was marginally supported by the findings. There was a tendency for the passive male client to be judged more severely than the passive female client, but this held true only for male clinicians. Contrary to expectation, there was a tendency for the aggressive male client to be judged more severely than the aggressive female client, but this held true only for female clinicians. Overall, female clinicians rated aggressive behavior more severely than passive behavior; while male clinicians rated passive

behavior more severely than aggressive behavior. The results are discussed and the implications considered.

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CHAPTER I

INTRODUCTION

During the past decade there have been a host of studies on gender effects in counseling and psychotherapy. This research has focused on a number of areas, including: 1) clinicians' attitudes and sex-role stereotypes about men and women, particularly in their role as mental health clients (e.g., Broverman, Broverman, Clarkson, Rosenkrantz, & Vogal, 1970; Engelhard, Jones, and Stiggins, 1976; Neulinger, Stein, Schillinger, & Welkowitz, 1970), 2) influence of such attitudes and sex-role stereotypes on clinicians' evaluations of, and behavior toward, clients (e.g., Abramowitz, Abramowitz, Weitz, & Tittler, 1976; Bowman, 1976), and 3) influence of sex of the clinician and sex of the client on clinical evaluations and behavior (e.g., Abramowitz, Abramowitz, Jackson, & Gomes, 1973; Abramowitz, Roback, Schwartz, Yasuna, Abramowitz, & Gomes, 1976; Hayes & Wolleat, 1978).

Recent reviews of gender effects and sex-role stereotyping in counseling and psychotherapy (Abramowitz & Dorecki, 1977; Delk, 1977; Maracek & Johnson, 1980; Sherman, 1980; Stricker, 1977; Zeldow, 1978) cite contradictory evidence. Zeldow's (1978) conclusion seems to aptly describe the array of findings from gender and psychotherapy research, "The results of the above studies are sufficiently diverse and ambiguous as to be interpretable both as strong and weak evidence for sexism in the mental health field, depending on the viewpoint of the interpreter" (p. 93).

In an effort to provide an unbiased appraisal of findings on gender effects in psychotherapy, Smith (1980) applied statistical meta-analytic techniques to the results of twenty-five counseling and psychotherapy sex bias studies. She concludes that, taken as a whole, these findings do not confirm the presence of sex bias effects. As she states:

> Empirical support for the contention that counseling and psychotherapy are sexist and bad for women is extremely weak. Studies that demonstrate a bias of counselors against women or against nonstereotyped roles for women are balanced by an equal number of studies that showed the opposite condition - that counselors have the same standards of mental health for women as they have for men, the same recommendations for jobs, educational plans, and personal decisions (p. 406).

Given these equivocal findings, most review authors urge more thoughtful consideration of the nature and intent of this fairly new, and increasingly popular, area of research. They suggest that answers to the following questions are needed: What type of information is sought from these studies? What are the methodological and theoretical bases for this research? Given the muddled array of findings, should researchers continue to study the effects of gender and sex-role stereotypes on counseling and psychotherapy? If so, what future research directions are likely to clarify the existing contradictions?

There are no definitive answers to these questions. The issues are complex and will not be given a comprehensive review in this paper. Nevertheless, the major methodological and theoretical problems in gender and psychotherapy research will be discussed. A dissertation project which attempts to address some of these problems will then be described.

Methodological Considerations

As Orlinsky and Howard (1980) note, a comprehensive study of psychotherapy examines: 1) therapeutic input (i.e., the perceptions and behaviors which clients and clinicians bring into the therapy setting), 2) therapeutic process (i.e., the behavioral changes which occur during a therapy session), and 3) therapeutic outcome (i.e., the influence of therapy on clients' cognitive, emotional, and social world).

Most gender and psychotherapy researchers wish to understand the impact of sex-related variables on each of these therapeutic aspects. However, constraints on time, money, and accessibility to clinical material have dampened gender researchers' enthusiasm for studying therapeutic process and outcome. Consequently, most gender and psychotherapy research has focused on therapeutic input variables, as these "potential determinants of therapeutic process and potential predictors of therapeutic outcome" (Orlinsky & Howard, 1980, p. 5) are more easily studied.

The clinical analogue is the research approach most often used to study therapeutic input variables. Borrowed from experimental social psychology, the analogue method enables researchers to study clinicians' evaluations and/or behavior toward hypothetical clients, usually on a single occasion (e.g., intake interview). The clinical analogue study creates, in essence, an artificial therapy setting, in which several independent variables (e.g., sex of clinician, sex of client, and/or other gender-related client characteristics) are manipulated, while other significant characteristics are held constant.

In a typical analogue study of gender effects, male and female clinicians (or persons in training to be clinicians) are exposed to a case description of a hypothetical male or female client. The case description is usually presented to clinicians via videotape, audiotape, or narration. Occasionally, persons recruited and coached by the experimenter serve as "live" clients in a study.

Following presentation of the case description, clinicians are asked to evaluate the hypothetical client along a number of dimensions. Diagnosis of the client's problem, assessment of the problem's severity, and prognosis are among the dependent variables frequently included in analogue studies of gender effects. Most analogue researchers view these measures as indicators of clinicians' attitudes toward, and treatment of, actual mental health clients. As a consequence, the presence or absence of significant differences in assessments of male versus female analogue clients, often prompts researchers to draw conclusions about sex bias in actual clinical practice.

Some (e.g., Abramowitz & Dorecki, 1977; Maracek & Johnson, 1980; Sherman, 1980; Stricker, 1977; Zeldow, 1978) argue that such conclusions are unwarranted. Maracek and Johnson (1980) note that most analogue studies assess clinicians' attitudes rather than their behavior. For this reason, Maracek and Johnson and others (e.g., Stricker, 1977) doubt the applicability of clinical analogue data to actual therapy settings and recommend less reliance on the analogue approach. They encourage researchers to conduct clinical process studies, so that a more valid assessment can be made of clinicians' behavior during real therapy sessions.

As previously noted, researchers who conduct clinical process studies are often faced with enormous practical difficulties. Zeldow (1978) observes that, in light of these difficulties, a large number of clinical process studies are not likely to be conducted in the near future. He recommends that clinical analogue research be continued, but with more sound experimental methods, implemented within a clear conceptual framework. In his view, these changes will provide more valid conclusions, which can perhaps bring order to the array of contradictory findings. Others (e.g., Maracek & Johnson, 1980; Sherman, 1980; Smith, 1980; Stricker, 1977) also pinpoint weaknesses in the design of clinical analogue studies and offer suggestions to researchers who are interested in using the analogue method. A brief summary of their methodological recommendations follows:

1) Researchers are advised to carefully select and manipulate independent variables and to ensure that extraneous variables are held constant. For example, Sherman (1980) notes that sex of the clinician is frequently confounded with other clinician variables, such as level of training. This invalidates any conclusions that attribute the results to sex of the clinician. Others (Maracek & Johnson, 1980; Smith, 1980; Stricker, 1977) note that employing sex of the client and/or sex of the clinician as the only independent variables is neither interesting nor illuminating. Stricker (1977) states:

> All women are not the same. No attempts have been made to distinguish among women at different age levels, class levels, and education levels, or among women of different races, marital statuses, or careers. More important, no attempt has been made to determine whether the variance contributed by sex differences exceeds that contributed by age, class, education, race, marital status, or career (p. 20).

Though Stricker ignores some studies which attempt to make such distinctions (e.g., Hill, Tanney, Leonard, & Reiss, 1977; Schwartz & Abramowitz, 1975), his statement is an accurate representation of most analogue research on gender effects. Smith (1980) supports the suggestion that a greater complexity of independent variables be given consideration. She recommends that future analogue research focus on the interaction of client gender and other client characteristics (e.g., personality traits).

2) More thoughtful consideration in the selection of dependent variables is recommended. Zeldow (1978) observes that many studies of gender effects and sex-role bias in psychotherapy seem to be based on a "shotgun empirical approach involving numerous dependent variables of unknown reliability" (p. 92). Researchers should decide what information they want to know and select a limited number of dependent variables which are accurate and reliable measures of this information. As Sherman (1980) states, "Collecting data on many irrelevant variables merely adds confusion" (p. 61).

3) Researchers are advised to construct experimental designs with greater care. Case summary materials should be pretested, and manipulation checks should be included as part of the experimental session. Whenever possible, several types of case summary material should be presented to subjects. This will allow researchers to discern whether significant effects are due to sex of the client or to other characteristics of the case summary.

4) Conclusions about statistical effects should accurately reflect the findings. Statements about the applicability of findings

to other settings should be made with restraint. As Smith (1980) observes, in research articles on gender effects in psychotherapy, "small but statistically significant effects became sweeping, and categorical conclusions, widely disseminated" (p. 406).

Theoretical Considerations

Many of the methodological weaknesses which have been described are clearly tied to an inadequate, and sometimes nonexistent, conceptual framework. As noted, independent and dependent variables are often selected with little forethought as to the potential effect of one variable upon another. The independent variables of sex of the clinician and sex of the client are presumed to influence any number of clinician attitudes and behaviors. As support for these assumptions, researchers cite societal standards which prescribe differential treatment of men and women and promote the dominance of men over women. Many researchers assume that these societal standards are supported by clinicians and that this support necessarily leads to sexist behavior toward women clients.

These assumptions are certainly not unreasonable. Societal attitudes and treatment of women have begun to be recognized as prejudicial. Concern that this prejudice may enter into therapist-client relationships came sharply into focus when Broverman et al (1970) provided evidence that clinicians hold different standards of mental health for male and female clients.

However, attempts to determine the effects of gender and sex-role stereotypes on counseling and psychotherapy are often based solely on

the rather broad, amorphous term "sexism". Many researchers ask, "are therapists sexist," and leap from this fairly abstract question into concrete experimental manipulations (e.g., sex of the clinician and sex of the client). It is not surprising that evidence of the presence or absence of sex bias in such studies tempts researchers to make global statements about sexism in clinical practice. Such studies lack a conceptual framework which transforms sexism from an abstraction into a set of explicit concepts that can generate more concise, well-delineated hypotheses. As Smith (1980) notes, reliance on "sexism" as the basis for hypothesis generation belies the complexity of sex-related attitudes and behavior.

The dissertation study described in this paper was designed to address some of the theoretical and methodological shortcomings in analogue research on gender effects in psychotherapy. Consistent with past analogue research on sex bias effects, the present study varied sex of the clinician and sex of the client. The interaction of gender with other sex-related characteristics was also examined, in light of recommendations that a more complex set of variables be studied. Specifically, sex of the clinician and sex of the client were varied, along with sex-role appropriateness of client's behavior (passive versus aggressive) and nature of the client's problem (personal versus vocational).

Some of the dependent variables commonly used in analogue studies of gender effects were included in the present research. Seriousness of the client's problem, healthiness of the client's approach to the problem, and amount of help needed, were among the dependent variables

included in this study. As previously stated, analogue researchers view such measures as indicators of clinicians' attitudes toward clients, as well as potential predictors of clinicial behavior. However, some (e.g., Maracek & Johnson, 1980) question whether attitudinal measures are valid predictors of actual clinicial behavior. In response to this concern, the present study included a behavioral measure (i.e., referral recommendation) as well as attitudinal measures.

In an attempt to provide a more precise conceptual framework within which to study sex bias in clinical practice, elements of social psychological attribution theory were integrated into this analogue research. In the next section, the basic elements of attribution theory are outlined, and their link to the present study is described.

Attribution Theory and Sex Bias Research

Attribution theory is concerned with questions of causation (Heider, 1958; Jones & Davis, 1965; Jones, Kanouse, Kelley, Nisbett, Valins, & Weiner, 1972; Kelley, 1967; Weiner, 1974). Specifically, attribution theorists seek to understand causal perceptions of events, particularly along the dimension of internal (dispositional) causality versus external (situational) causality. Attribution theorists also seek to assess the impact of antecedent information on causal perceptions as well as the behavioral consequences of such perceptions.

Implicit in the attribution approach is the assumption that all persons are "scientists" (Heider, 1958) who search for the causes of

events which surround them and then act upon their causal attributions in ways they consider appropriate. It is likely that clinicians also engage in such cause-effect analyses. Assuming this to be so, the general questions raised by attribution theorists can be rephrased in more clinicial terms. One can ask:

1) What causal interpretations do clinicians make about clients' behavior? Are clinicians more likely to attribute clients' problems to internal factors (dispositions) or to external factors (situations)?

2) How does antecedent information (e.g., information about sex-role appropriateness of client behavior) affect clinicians' interpretations and causal attributions? Does a clinician's perception of the source of a client's problem vary according to the amount and/or type of information known about the client?

3) What are the behavioral consequences of clinical interpretations and causal attributions? Does a clinician's behavior vary according to his or her perception of the source of the client's problem?

In the following pages, these questions are addressed and their relationship to the present research is discussed.

Clinical perceptions of causality: the dispositional bias. There is evidence (e.g., Batson, 1975; Batson & Marz, 1979; Snyder, 1977; Snyder, Shenkel, & Schmidt, 1976) to suggest that clinicians are more likely to attribute clients' problems to dispositional factors than to situational factors. Batson (1975) found that dispositional perceptions were made even when clients claimed there were situational

reasons for their problems. This supports general attribution findings (e.g., Jones & Harris, 1967; Ross, Amabile, & Steinmetz, 1977) which suggest that observers are likely to attribute an actor's behavior to stable, personal dispositions, even when the actor's behavior is under severe external constraints.

The present study sought to replicate these findings. After reading a case description of a hypothetical male or female client, clinicians were asked to respond to several Likert-type scales, designed to tap the dispositional versus situational dimension. Clinicians were asked: 1) whether they perceived the source of the client's problem to be dispositional or situational, and 2) whether they perceived that change was needed within the client (dispositional attribution) or within the client's social situation (situational attribution).

Also included in this study were several Likert-type scales designed to tap the stability versus changeability dimension of causality. Specifically, clinicians were asked whether they perceived the source of the client's problem to be: 1) characterological (i.e., stable or due to an unchangeable part of the client's character), or 2) behavioral (i.e., changeable or due to behavior in which the client has or has not engaged). This stability-changeability dimension was included, since it has been recognized to be an important attributional distinction (Janoff-Bulman, 1979; Weiner, Frieze, Kukla, Reed, Rest, & Rosenbaum, 1972).

Antecedent information: its impact on clinicians' causal perceptions and client assessments. The present research was designed to address one key question: how does antecedent information (e.g., sex of the clinician, sex of the client, sex-role appropriateness of the client's behavior, and/or type of client problem) affect clinicians' causal perceptions and client assessments?

The general attribution literature provides little evidence to suggest that attributions vary simply on the basis of sex of the perceiver and/or sex of the perceived. Similarly, clinical analogue research has provided no consistent evidence of sex of clinician and/or sex of client main effects. Though a few clinical analogue studies have reported sex of clinician main effects (e.g., Zeldow, 1975), most have not (e.g., Fischer, Dulaney, Fazio, Hudak, & Zivotofsky, 1976; Schwartz & Abramowitz, 1975). The relatively small number of sex of clinician main effects reported in the literature may, in part, be linked to societal socialization processes whereby boys and girls are taught the same set of assumptions about males and females.

Analogue studies which report sex of the client main effects can be cited (e.g., Abramowitz, Roback, Schwartz, Ysuna, Abramowitz, & Gomes, 1976; Miller, 1974). Other analogue studies have yielded no such effects (e.g., Gomes & Abramowitz, 1976; Johnson, 1978).

It is not likely that the sex of client variable will be found to affect clinical perceptions unless its relationship to other client characteristics is considered.

A model proposed by Deaux (1976) suggests that in making interpretations or causal attributions, an observer employs two general types of information: 1) behavioral information (i.e., what is the actor doing in a given situation?), and 2) information based on the expectancies which the observer had for the actor's behavior. According to Deaux (1976), an observer combines the behavioral data and the expectancies and forms an interpretation or causal attribution based upon the "match or mismatch between these two sets of information" (p. 336).

Deaux (1976) notes that a sex-role stereotype can be viewed as a set of expectancies about the behavior of males and females. She states:

> We are assuming that, in general, observers have expectancies for the behavior of an individual male or female which derive from the stereotyped assumptions made of men and women as groups. Consequently, the behavior of the female or male is judged in conjunction with this set of stereotyped expectancies, and the resultant attributions differ to the extent that the stereotyped expectancies differ (p. 336).

This suggests that in sex bias research, presenting clinicians with information about the sex of the client, as well as information about the sex-role appropriateness of the client's behavior, is likely to yield more meaningful results. Studies which have provided such information suggest that there may be attributional and behavioral consequences for sex-role inappropriate behavior. Costrich, Feinstein, Kidder, Maracek, and Pascale (1975) found that, among undergraduate students, passive-dependent males and aggressive-assertive females received lower popularity ratings and lower psychological adjustment ratings than did persons whose behavior was more sex-role appropriate.

A few clinical analogue studies have also varied the sex-role appropriateness of behavior along the passivity-aggressiveness dimension. Magnus (1975)) and Bowman (1976) report that "activity" in women clients was discouraged by clinicians. Feinblatt and Gold (1976) found that children with sex-role inappropriate symptoms (passive boys, aggressive girls) were judged as more maladjusted and less likely to have future success than were children with sex-role appropriate symptoms. Johnson (1978) and Fischer et al (1976) report no difference in clinicians' assessments of male and female clients as a function of the sex-role appropriateness of their behavior (i.e., passivity versus aggressiveness).

The present study was designed as a further test of the effect of sex-role appropriate (or inappropriate) male and female client behavior on clinicians' perceptions. As in previous studies, the behavior of hypothetical male and female clients was varied along the passivity-aggressiveness dimension. Descriptions of client behavior were presented via written case descriptions. Clinicians' reactions to the hypothetical clients were then measured by a number of dependent variables.

As stated earlier, causal attribution ratings were among the dependent variables included in this study. Given evidence from the attribution literature (e.g., Batson, 1975), it was expected that clinicians' causal attributions would reflect a dispositional bias. However, this effect was expected to be more pronounced for sex-role inappropriate behavior. This expectation was based upon findings which suggest that out-of-role behavior elicits a greater number of

dispositional attributions than does in-role behavior (e.g., Jones & Davis, 1965; Jones & Harris, 1967).

Jones and Davis (1965) offer an explanation for this effect. They suggest that out-of-role (e.g., sex-role inappropriate) behavior provides more personal information about an individual than does in-role (e.g., sex-role appropriate behavior). In other words, because out-of-role behavior violates external constraints (e.g., sex-role stereotypes), information about the uniqueness of the actor is revealed. According to Jones and Davis, this information leads an observer to feel quite confident that the out-of-role behavior reflects the actor's "true" nature. Jones and Davis argue that, as a consequence, observers tend to make more dispositional attributions when an actor's behavior is out-of-role versus in-role. The present study tested for this effect by comparing clinicians' causal attributions when client behavior was described as sex-role appropriate (passive female, aggressive male) versus sex-role inappropriate (passive male, aggressive female).

The present study employed several dependent variables to examine the impact of sex-role appropriate versus sex-role inappropriate behavior on clinical assessments. Clinicians were asked to evaluate the seriousness of the client's problem, the healthiness of the client's approach to the problem, and the client's need for help. Clinicians were also asked to estimate the level of comfort, or discomfort, they might have felt, had they conducted an intake session with the client.

It was hypothesized that the problems of a passive male and aggressive female client (sex-role inappropriate condition) would be judged as more serious and more unhealthy than the problems of a

passive female and aggressive male client (sex-role appropriate condition). Similarly, it was hypothesized that passive male and aggressive female clients would be judged to need more help than passive female and aggressive male clients. It was hypothesized that, overall, clinicians would indicate greater discomfort about conducting an intake session with a passive male or aggressive female client than with a passive female or aggressive male client.

These expectations were based, in part, upon evidence from Costrich et al (1975) and Feinblatt and Gold (1976) which suggests that passive males and aggressive females are judged more severely than passive females and aggressive males. Evidence from attribution research also served as a basis for these predictions. This evidence suggests that, not only are observers likely to make more dispositional attributions when an actor's behavior is out-of-role (e.g., Jones & Harris, 1967), but they are also more likely to evaluate out-of-role behavior extremely favorably or unfavorably (Aronson & Linder, 1965). Given societal sex-role stereotypes, one can predict that sex-role inappropriate behavior is judged unfavorably, since it violates the norm. The extent to which such evaluations may be extremely unfavorable is difficult to predict.

Critics of the analogue method (e.g., Sherman, 1980) suggest that the validity of an analogue study can be improved by including several types of case summaries. Given this recommendation, the present study included case descriptions which varied, not only along the sex-role appropriateness dimension, but along the type of problem dimension. Thus, in each case description, a client's problem was identified as

personal or vocational and the client's approach to the problem was described as passive or aggressive.

Numerous studies have investigated the impact of personal versus vocational problems on clinical assessments. For example, Melnick (1975) found that personal-emotional concerns were judged more serious than vocational concerns. Many studies have also focused on counselors' reactions to males and females who aspire to success in a male-dominated vocation, such as medicine (Abramowitz, Weitz, Schwartz, Amira, Gomes, & Abramowitz, 1975; Pringle, 1973). Though results are equivocal, there is evidence that females who aspire to success in a male-dominated field are judged somewhat more negatively than males who aspire to such success.

Despite this large body of research, few studies have examined the effect of sex of the client on clinical assessments of personal versus vocational problems. In a pair of related studies, Hill et al (1977) and Helms (1978) assessed male and female clinicians' perceptions of personal versus vocational problems - but for female clients only. Hill et al conducted an analogue study, and Helms attempted a naturalistic replication of the Hill et al findings.

Both Hill et al and Helms found that the personal problems of two 20-year-old women and two 35-year-old women were regarded as more serious and in need of more help than their vocational problems. Hill et al found that the vocational problems of the 35-year-old women were judged more serious than the vocational problems of the 20-year-old women. In the Helms study, this effect was reversed. That is, the vocational problems of the 20-year-old women were judged more serious

than the vocational problems of the 35-year-old women. Helms also reported that female clinicians perceived the female clients as having more problems than did the male clinicians.

Few other studies have examined clinical assessments of male and/or female clients with personal versus vocational problems. As a consequence, in the present study, there were few bases for hypothesis generation about the Sex of Client X Type of Problem interaction. However, it was predicted that the personal problems of both male and female clients would be judged more serious, less healthy, and in need of more help than would their vocational problems. This expectation was based on Melnick's (1975) finding that personal problems are judged more serious than vocational problems.

Further, it was predicted that the vocational problems of a male client would be judged more severely than the vocational problems of a female client. This expectation was based on the assumption that society sets higher standards of vocational success and competence for males than for females. Surveys of societal socialization mechanisms (e.g., Finz & Waters, 1976; Lee, 1974 cited by Thorne and Henley, 1975; Saario, Jacklin, & Tittle, 1973; Walstedt, 1975) indicate that males are most often presented in work settings, demonstrating competence in problem-solving activities, while females are most often presented in home settings, engaging in socio-emotional activities. Given these differences, it was predicted that the consequences of having a vocational problem would be more severe (i.e., yield higher ratings of seriousness, unhealthiness) for a male client than for a female client. Further, it was expected that these consequences would

be more severe when the male client's behavior was passive rather than aggressive.

No predictions were made about differences in the severity ratings of male and female clients who are identified to have personal problems. One could hypothesize that the consequences of having a personal problem are more severe for a female than a male client, since societal sex-role standards demand that women display competence in the socio-emotional, interpersonal area. However, it would also be hypothesized that the consequences of having a personal problem are less severe for a female client than for a male client, since it is more culturally acceptable for women to present emotional, interpersonal concerns.

Behavioral consequences of antecedent information. In an attempt to assess the behavioral impact of information about sex of the client, sex-role appropriateness of client's behavior, and type of problem, clinicians were given a list of referral options and asked to choose the one most appropriate for the client. The referral options represented resources familiar to the clinicians in the study.

After selecting a referral option, clinicians were asked to state the reason for their choice. Clinicians were also asked to rate the likelihood that their referral choice could alleviate the client's problem. Finally, clinicians were asked to recommend: 1) individual versus group treatment, 2) male versus female therapist, 3) short-term versus long-term treatment, and 4) medication versus no medication. It was hypothesized that the more serious a client's problem was perceived to be, the greater the likelihood that: 1) long-term

rather than short-term treatment and 2) medication rather than no medication would be recommended.

Summary. Male and female clinicians were asked to read case descriptions which varied according to sex of the client, sex-role appropriateness of client behavior (passive versus aggressive) and type of client problem (personal versus vocational). Clinicians then responded to a number of dependent variables designed to assess: 1) causal attributions, 2) client assessments, and 3) referral recommendations.

CHAPTER II

METHOD

Subjects

Subjects were 24 male and 24 female masters level practicing mental health professionals from Franklin, Hampshire, and Hampden Counties, Massachusetts. The subject sample was limited to clinicians working in community settings (e.g., mental health center, private practice). Clinicians working at local state hospitals, Veteran's Administration hospitals, or other psychiatric inpatient hospitals were not included in the study.

In an effort to obtain a sample of clinicians with equivalent amounts of clinical experience, high priority was given to the recruitment of mental health professionals with between two and five years post-graduate school clinical experience.

During a five-month period (July - November, 1980), clinicians were contacted and invited to participate in the study. It was necessary to contact 76 clinicians (36 males, 40 females) in order to obtain a sample of 24 males and 24 females. This represents a 63% acceptance rate. The sample is described in the following sections.

Job setting. Of the 48 clinicians in the study, 29 (16 males, 13 females) held jobs in community-based, federally funded and state funded mental health programs. Four clinicians (all female) held jobs in privately funded agencies. Eight clinicians (4 males, 4 females) worked exclusively in private practice, while seven clinicians (4

males, 3 females) worked in both community-based mental health programs and private practice.

Professional degree. The professional degrees held by the 48 clinicians are as follows: 20 M.S.W. (11 males, 9 females); 17 M.A./M.S. in counseling or psychology (8 males, 9 females); 10 M.Ed. (5 males, 5 females); 1 M.S.N. (female).

Clinical experience. The experience level of 36 clinicians (17 males, 19 females) fell within the two-to-five year criterion established by the experimenter. The experience level of five clinicians (2 males, 3 females) fell below this criterion. Thus, 41 of the 48 clinicians in the study reported a post-graduate school experience level of five years or less. Of the remaining seven clinicians, three (all male) reported having six years post-graduate school experience. The other four clinicians were more experienced. Of these four clinicians, two (1 male, 1 female) reported having eight years post-graduate school experience, and two (1 male, 1 female) reported having between 12 and 14 years post-graduate school experience.

Age. The age of the male clinicians ranged from 28 to 50 years with a mean of 34.0 and a standard deviation of 5.13. The age of the female clinicians ranged from 26 to 55 years with a mean of 32.12 and a standard deviation of 6.39.

Procedure

The experimenter telephoned clinicians and asked them to participate in her doctoral study. The study was described as a research project designed to examine the mental health referral process. Clinicians were told that participation in the study would involve reading through a booklet containing several case descriptions. It was explained that the task of participants would be to make referral recommendations for each of the cases.

Clinicians were told that the study would be administered in individual sessions and would require no more than 45 minutes to complete. Each clinician was assured that the research session could be scheduled at a time and place of his/her choosing.

Though many clinicians expressed interest in participating, a substantial number were unable or unwilling to schedule time for a research session with the experimenter. Many clinicians cited crowded work schedules and/or numerous personal committments. It seemed evident that many clinicians might agree to participate if they could complete the study at their own convenience. For this reason, the experimenter decided that those clinicians who declined to participate in a research session would be offered an opportunity to complete the study via mail. Thus, two data gathering procedures were employed. Clinicians completed the study: 1) in a research session conducted by the experimenter, or 2) at their own convenience - via mail. These two procedures are described in the following section.

Procedure I: Scheduled Research Session. A clinician completed the research booklet during a scheduled research session conducted by the experimenter. At the beginning of the session, the experimenter reminded the clinician that the purpose of the study was to better understand the process by which mental health professionals make referrals. Clinicians were then given a booklet containing the case descriptions and dependent measures.

While the clinician worked through the booklet, the experimenter waited in an adjoining room. After completing the study, the clinician was debriefed as to the nature and purpose of the research. Informal feedback about the study was solicited, including information about any hypotheses or "suspicions" the clinician may have had as to the intent of the research.

Of the 48 clinicians in the study, 20 (8 males, 12 females) completed the study via this research session method.

Procedure II: Mail-In Method. The research booklet was mailed, or in some cases hand-delivered, to the clinician's office or home. During a telephone conversation prior to the mailing of the booklet, clinicians were reminded that the purpose of the study was to better understand the process by which mental health professionals make referrals. Clinicians were instructed to complete the booklet during a single session and to return the completed booklet in the stamped, self-addressed envelope provided by the experimenter.

If a booklet was not returned to the experimenter within two weeks after it had been mailed, a postcard reminder was sent to the

clinician. When the experimenter received the completed booklet, the clinician was telephoned and debriefed as to the nature and purpose of the research. Informal feedback was also solicited, including information about any hypotheses or "suspicions" the clinician may have held as to the intent of the research.

Of the 48 clinicians in the study, 28 (16 males, 12 females) completed the study via the mail-in method. It should be noted that 32 clinicians agreed to participate in the study via the mail-in method. However, two of these 32 clinicians failed to return the booklet that had been mailed to them. A third clinician returned the booklet, uncompleted, along with comments which indicated dissatisfaction with the amount of information provided in the case descriptions. A fourth clinician also returned the booklet uncompleted, along with a note stating that the research topic was not pertinent to her clinical interests.

Instrument

The research instrument was a 19-page booklet containing: 1) case descriptions, 2) dependent measures, including manipulation checks, and 3) questions about the clinician's professional training, work experience, etc. The booklet included a cover story which states:

> As you are probably aware, mental health professionals must sometimes make referral recommendations based on minimal contact with a person and/or limited information about him/her. This study seeks to understand the process by which mental health professionals make such referrals.
>
> Please try to imagine that you have been asked to make referral recommendations for several persons.

When you open the booklet, you will find a brief description of an intake session. Please read this description carefully - keeping in mind that it is your task to make a referral recommendation for the client.

When you have finished reading the intake description, please respond to the questions which follow it. Then follow the same procedure with the second intake description.

Case descriptions. Four case descriptions of hypothetical intake clients were developed. These case descriptions were intended to portray: 1) a male or female client responding passively to a personal problem, 2) a male or female client responding passively to a vocational problem, 3) a male or female client responding aggressively to a personal problem, and 4) a male or female client responding aggressively to a vocational problem. The sex of the client designation was easily accomplished by altering a few words in the case description.

Prior to the study, a pretest was conducted to assess the content validity of the case descriptions. The pretest was carried out with a small group of subjects (3 female, 2 male), naive to the purpose of the study. Pretest subjects were asked to read the four case descriptions and judge each on several 8-point Likert-type scales. These scales assessed: 1) behavioral content (passive versus aggressive), 2) problem content (personal versus vocational), 3) emotional content (sad versus angry), 4) amount of emotional content (very little versus a great deal), 5) clarity of content (very clear versus very unclear), and 6) masculinity-femininity of content (very masculine versus very feminine). Given the pretest data, revisions in the case descriptions were made. The four case descriptions which were used in the study appear in Appendix A (see p.72).

Dependent variable. After reading each case description, clinicians were asked to respond to a set of dependent variables which included: 1) two open-ended questions pertaining to source of the problem and short-term advice to the client, 2) four causal attribution measures, 3) four client assessment measures, 3) seven referral recommendation measures, and 4) five manipulation checks. The dependent measures, as they appeared in the study, are included in Appendix B (see p. 98).

Clinician's professional history. A series of questions pertaining to a clinician's age, sex, professional training, work experience, and clinical interests was included at the end of the booklet. These questions are included in Appendix C (see p. 104).

Design

The experimental design included one between-factor (male versus female clinician) and three within factors (male versus female client; passive versus aggressive behavior; personal versus vocational problem). It should be noted that this was not a complete mixed design, as each clinician was assigned to only two of the eight possible "within" conditions.

This was done for the following reasons: 1) It seemed likely that asking clinicians to read a case description for each of the eight "within" conditions (i.e., repeated measures over eight case descriptions) would produce "fatigue" effects. 2) Further, it seemed a certainty that exposure to all possible "within" conditions would lead clinicians to discover the purpose of the study. This might have yielded biased responses.

To avoid these consequences, each clinician was assigned to only two of the "within" cells. Cells were paired so that each clinician was exposed to all levels of the "within" factors (i.e., male client, female client; passive behavior, aggressive behavior; personal problem, vocational problem).

Table 1 (see p. 29) more clearly illustrates the cell-pairs to which male and female clinicians were randomly assigned.

Each clinician read two case descriptions (one for each cell-pair). Within each cell-pair, the order of presentation of the two case descriptions was counterbalanced across subjects.

TABLE 1

Experimental Design*

	MALE CLIENT		FEMALE CLIENT	
	Personal	Vocational	Personal	Vocational
Aggressive	A	C	D	B
Passive	B	D	C	A

*Six male and six female clinicians were randomly assigned to each of the cell-pairs represented above (i.e., AA, BB, CC and DD).

(Total N = 24 male and 24 female clinicians)

CHAPTER III

RESULTS

Results will be reported for each of the following categories: 1) clinician awareness of study's purpose (debriefing data), 2) relationship among the causal attribution measures, client assessment measures, and manipulation checks (correlational data), 3) analyses of variance on manipulation checks, causal attribution measures, and client assessment measures, 4) open-ended questions, and 5) referral recommendations. It should be noted that Appendix D (see p. 108) contains a brief description of each statistical symbol appearing in this chapter.

Clinician Awareness of Study's Purpose

Debriefing data indicate that nine of the 48 clinicians had a definite idea, or in some cases at least a notion, of the study's intent to assess clinician reactions to male versus female clients. This represents approximately 19% of the sample.

Relationship Among the Dependent Measures

Pearson correlation coefficients (r) were computed to assess the relationship among the causal attribution and client assessment measures. Results indicate that, with the exception of the behavioral causality and uncomfortableness measures, there was a significant positive relationship among the causal attribution and client assessment measures. For example, the source of problem causality measure was found to be

positively related to: 1) the seriousness measure (r = .36, p < .001), 2) the unhealthiness measure (r = .35, p < .001), 3) the amount of help needed measure (r = .34, p < .001), and 4) the alleviation of problem unlikely measure (r = .25, p < .01).

To assess the effectiveness of the passivity versus aggressiveness manipulation, Pearson correlation coefficients (r) were computed for the passivity ratings with the aggressiveness ratings and for the depression ratings with the anger ratings. Results indicate a significant negative relationship between the passivity versus aggressiveness ratings (r = -.75, p < .001) and depression versus anger ratings (r = -.37, p < .001). These correlations indicate that the passivity-aggressiveness manipulation was effective.

Pearson correlation coefficients (r) were also computed to test the hypothesis that the more serious the client's problem was perceived to be, the more likely a clinician would be to recommend long-term rather than short-term treatment and medication versus no medication. There was a significant positive relationship between the seriousness measure and: 1) length of treatment (short-term versus long-term), r = .45, p < .01, and 2) amount of medication (no medication versus medication), r = .31, p < .02. Thus the hypothesis was supported.

Analyses of Variance: An Overview

Analyses of variance were performed to assess the impact of sex of clinician, sex of client, client behavior (passive versus aggressive), and type of problem (personal versus vocational) on responses to the: 1) manipulation checks, 2) causality scales, and 3) client assessment

scales. Results will be reported for each of these three sets of dependent measures.

As noted previously, male and female clinicians were randomly assigned to only two of the eight possible "within" cells. However, cells were paired so that every clinician was exposed to both levels of each "within" factor (i.e., male and female client; passive and aggressive behavior; personal and vocational problem). This permitted the main effects of sex of client, behavior of client, and type of problem to be analyzed as "within" factors. The second-order interaction of Sex of Client X Behavior of Client X Type of Problem was also analyzed as a "within" effect.

Random assignment of male and female clinicians to only two of the eight "within" cells meant that each clinician was not exposed to every possible combination of the within factors. Thus, tests of the first-order interactions (i.e., Sex of Client X Behavior of Client; Sex of Client X Type of Problem; Behavior of Client X Type of Problem) involved "between" rather than "within" comparisons. For example, to determine whether there was an interaction of Sex of Client X Type of Problem, the two groups of clinicians exposed to the male-vocational and female-personal case descriptions were compared with the two groups exposed to the male-personal and female-vocational case descriptions.

Table 2 (see p. 33) illustrates the complete analysis of variance table that was used in the study.

Myers (note 1) observes that eight groups of six clinicians (six females and six males assigned to the four different cell-pairs)

TABLE 2

Analysis of Variance Table

SV	df
Between Ss	8n-1
D (Sex of Subject)	1
AB (Behavioral Style X Type of Problem)	1
BC (Sex of Client X Type of Problem)	1
AC (Sex of Client X Behavioral Style)	1
ABD	1
BCD	1
ACD	1
Ss/Cells	8(n-1)
Within Ss	8n
A (Behavioral Style)	1
B (Type of Problem)	1
C (Sex of Client)	1
ABC	1
AD	1
BD	1
CD	1
ABCD	1
Error	8(n-1)

provides 40 error degrees of freedom (df). He suggests that this yields a powerful test of the "within" effects and an adequate, but less powerful test, of the "between" effects.

It should be noted that on only three of the nine Likert-type causal attribution and client assessment measures were there 48 clinician responses: 1) seriousness of the problem, 2) unhealthiness of the client's approach to the problem, and 3) uncomfortableness. Although the experimenter instructed clinicians to answer all questions, some chose not to do so. Number of clinicians (N) responding to each of the other six Likert-type measures were as follows: 1) perception of source of problem, N = 47; 2) perception of needed change, N = 47; 3) characterological nature of problem source, N = 43; 4) behavioral nature of problem source, N = 43; 5) amount of help needed, N = 46; 6) likelihood of alleviating problem, N = 45. A number of clinicians reported difficulty in understanding the characterological and behavioral questions. The relatively low number of clinicians who responded to these two measures reflects this problem.

Analyses of Variance: Manipulation Checks

Analysis of variance was conducted on each of the five manipulation checks: 1) passivity (not at all passive versus extremely passive); 2) aggressiveness (not at all aggressive versus extremely aggressive); 3) depression (not at all depressed versus extremely depressed), 4) anger (not at all angry versus extremely angry), and 5) personal versus vocational type of problem.

Results indicate that the passive versus aggressive behavior descriptions were perceived differently. A passive client was judged to be significantly more passive than an aggressive client, F (1, 40) = 237.40, $p < .000$, means = 6.76 and 3.12. A passive client was also judged to be significantly more depressed than an aggressive client, F (1, 40) = 75.72, $p < .000$, means = 6.77 and 4.21. An aggressive client was perceived to be significantly more aggressive than a passive client, F (1, 40) = 221.91, $p < .000$, means 6.14 and 2.73. An aggressive client was also judged to be more angry than a passive client, F (1, 40) = 55.68, $p < .000$, means = 7.08 and 4.99.

On the type of problem manipulation check, means ratings for both the personal and vocational descriptions fell at the "personal" end of the 8-point scale, means = 1.50 and 3.02. However, clinicians' ratings for the personal problem fell significantly closer to the "personal" end of the scale than did the rating for the vocational problem, F (1, 38) = 14.84, $p < .000$. A significant interaction of Behavior of Client X Type of Problem, F (1, 38) = 7.39, $p < .01$, indicates that a passive approach to a vocational problem was rated as a personal problem.

Analyses of Variance: Causal Attributions

Analysis of variance was conducted on each of the four causal measures: 1) perception of source of the problem (within the client's social situation versus within the client), 2) perception of needed change (within the client's social situation versus within the client), 3) characterological nature of problem source (not at all characterological

versus completely characterological), and 4) behavioral nature of problem source (completely behavioral versus not at all behavioral).

Consistent with the findings of Batson (1975) and others, clinicians' perceptions of source of the problem and perceptions of needed change reflected a slight dispositional bias. On an 8-point scale (situational = 1; dispositional = 8), the mean rating for perception of needed change was 5.46.

The mean ratings for the characterological and behavioral causal measures fell on or near the midpoint of the 8-point scale. The mean rating on the characterological scale (not at all characterological = 1; completely characterological = 8) was 4.51. The mean rating on the behavioral scale (completely behavioral = 1; not at all behavioral = 8) was 4.30.

Sex of clinician main effects. There was no sex of client main effect on any of the four causal measures. However, there was a sex of clinician main effect for: 1) perception of source of the problem, F (1, 39) = 8.50, $p < .01$, 2) perception of needed change, F (1, 39) = 5.25, $p < .03$, and 3) characterological nature of problem source, F (1, 35) = 4.18, $p < .05$. Female clinicians' ratings on these three scales were significantly more dispositional than were male clinicians' ratings (source of problem: means = 5.37 and 4.52; change needed: means = 5.79 and 5.13; characterological: means = 4.94 and 4.09).

In other words, female clinicians were significantly more inclined than male clinicians to perceive the source of the client's problem as within the individual and to regard the source as characterological.

Female clinicians were also significantly more inclined than male clinicians to perceive the locus of needed change as within the individual.

Behavior of client main effect. There was a behavior of client main effect on the behavioral causality scale. Clinicians were significantly less likely to perceive the source of a client's problem as behavioral when the client's behavior was described as passive versus aggressive, F (1, 35) = 5.84, $p < .000$, means = 3.72 and 5.84.

Type of problem main effect. There was a type of problem main effect for: 1) perception of source of the problem, F (1, 39) = 11.50, $p < .000$, and 2) perception of needed change, F (1, 39) = 10.16, $p < .000$. Clinicians' ratings on these two scales were significantly more dispositional when the problem was described as personal versus vocational (source of problem: means = 5.40 and 4.53; change needed: means = 5.81 and 5.12).

Interaction effects: perception of source of the problem. There was a significant interaction of Behavior of Client X Type of Problem on the source of problem measure, F (1, 39) = 4.25, $p < .05$. As shown in Table 3 (see p. 38), perceptions of source of the problem were significantly more dispositional for an aggressive client with a personal problem than for: 1) an aggressive client with a vocational problem, or 2) a passive client with a personal problem.

There was also a significant Sex of Clinician X Sex of Client X Type of Problem interaction on the source of problem measure,

TABLE 3

Mean Source of Problem Ratings for Behavior of Client X Type of Problem*

	Personal	Vocational
Passive	19.7	18.5
Aggressive	23.5	17.5

*Means represent average source of problem ratings for passive and aggressive behavior and personal and vocational problems, summed across sex of clinician and sex of client.

The higher the mean, the more dispositional the rating.

N = 47

F (1, 34) = 5.50, $p < .02$. Table 4 (see page 40) shows that female clinicians' perceptions of source of the problem were significantly more dispositional than male clinicians' perceptions on the: 1) male client - vocational problem condition, and 2) female client - personal problem condition. Further, male clinicians' perceptions of source of the problem were significantly more dispositional for a male client with a personal problem than for a female client with a personal problem. There was no significant difference between female clinicians' source of problem ratings for a male client with a personal problem versus a female client with a personal problem.

Table 4 also shows that, when male and female clinicians evaluated the personal versus vocational problem of a same-sex client (i.e., male clinician-male client; female clinician-female client), their source of problem ratings were significantly more dispositional for the personal problem than for the vocational problem.

Interaction effects: perception of needed change. On the perception of needed change measure, there was a significant interaction of Sex of Clinician X Type of Problem, F (1, 39) = 7.71, $p < .01$. As shown in Table 5 (see p. 41), when a problem was identified as personal, female clinicians' perceptions of needed change were significantly more dispositional than male clinicians' perceptions.

A significant Sex of Clinician X Behavior of Client X Type of Problem interaction on the perception of needed change measure, F (1, 39) = 8.39, $p < .01$, indicates that only for the aggressive behavior-personal problem condition were female clinicians' perceptions of

TABLE 4

Mean Source of Problem Ratings for Sex of Clinician X Sex of Client X Type of Problem*

	MALE CLIENT		FEMALE CLIENT	
	Personal	Vocational	Personal	Vocational
Male Clinician	11.5	8.00	8.66	8.00
Female Clinician	10.83	10.66	12.66	9.32

*Means represent average source of problem ratings for male and female clinicians, male and female clients, and personal and vocational problems, summed across behavior of client.

The higher the mean, the more dispositional the rating.

N = 47

TABLE 5
Mean Needed Change Ratings for
Sex of Clinician X Type of Problem*

	Personal	Vocational
Male Clinician	20.7	20.3
Female Clinician	25.8	20.5

*Means represent average needed change ratings for male and female clinicians and personal and vocational problems, summed across sex of client and behavior of client.

The higher the mean, the more dispositional the rating.

N = 47

needed change significantly more dispositional than male clinicians' perceptions. As shown in Table 6 (see p. 43), male clinicians' perceptions of needed change were significantly more dispositional for the passive behavior-personal problem condition than for the aggressive behavior-personal problem condition. For female clinicians, there was a reverse tendency. That is, female clinicians' perceptions of needed change were more dispositional for the aggressive behavior-personal problem condition than for the passive behavior-personal problem condition. However, this difference was not significant, t (22) = 1.84, $p < .08$.

A significant Sex of Clinician X Sex of Client X Type of Problem interaction on the perception of needed change measure, F (1, 39) = 8.39, $p < .02$, indicates that only for the female client-personal problem condition were female clinicians' perceptions of needed change significantly more dispositional than male clinicians' perceptions. As shown in Table 7 (see p. 44), male clinicians' perceptions of needed change were significantly more dispositional for the male client-personal problem condition than for the female client-personal problem condition. For female clinicians there was a reverse tendency. That is, female clinicians' perceptions of needed change were more dispositional for the female client-personal problem condition than for the male client-personal problem condition. However, this difference was not significant, t (22) = 1.84, $p < .08$.

Causal attributions and sex-role appropriateness of client behavior. To assess the impact of sex-role appropriateness of client behavior on

TABLE 6

Mean Needed Change Ratings for
Sex of Clinician X Behavior of Client X Type of Problem*

	PASSIVE		AGGRESSIVE	
	Personal	Vocational	Personal	Vocational
Male Clinicians	11.86	10.16	8.83	10.16
Female Clinicians	11.99	11.66	13.83	9.32

*Means represent average needed change ratings for male and female clinicians, passive and aggressive behavior, and personal and vocational problems, summed across sex of client.

The higher the mean, the more dispositional the rating.

N = 47

TABLE 7

Mean Needed Change Ratings for
Sex of Clinician X Sex of Client X Type of Problem*

	MALE CLIENT		FEMALE CLIENT	
	Personal	Vocational	Personal	Vocational
Male Clinicians	12.03	10.16	8.66	10.16
Female Clinicians	11.99	10.99	13.83	9.49

*Means represent average needed change ratings for male and female clinicians, male and female clients, and personal and vocational problems, summed across behavior of client.

The higher the mean, the more dispositional the rating.

N = 47

clinicians' causal attributions, the Sex of Client X Behavior of Client interaction was examined. This interaction did not approach significance on any of the four causal attribution measures.

Analyses of Variance: Client Assessments

Analysis of variance was computed on each of the five client assessment scales: 1) seriousness of the client's problem (not at all serious versus very serious), 2) unhealthiness of the client's approach to the problem (very healthy versus not at all healthy), 3) amount of help needed (very little help versus a great deal of help), 4) uncomfortableness with client (very comfortable versus very uncomfortable), and 5) unlikelihood of alleviating problem (extremely likely versus not at all likely).

Mean ratings on each of these 8-point assessment scales were as follows: 1) seriousness (very serious = 8): 5.39, 2) unhealthiness (not at all healthy = 8): 5.98; 3) amount of help needed (a great deal of help = 8): 5.33; 4) uncomfortableness (very uncomfortable = 8): 2.38; and 5) unlikelihood of alleviating problem (not at all likely = 8): 2.38. Thus, clinicians' ratings of seriousness, unhealthiness, and amount of help needed fell above the midpoint on the 8-point scale, while their ratings of uncomfortableness and unlikelihood of alleviating problem fell below the midpoint on the 8-point scale.

Sex of client main effects. There was no sex of clinician main effect on any of the five client assessment scales. However, there was a sex

of client main effect on: 1) unhealthiness of the client's approach to the problem, F (1, 40) = 4.30, $p < .04$, 2) amount of help needed, F (1, 38) = 7.42, $p < .01$, 3) uncomfortableness, F (1, 40) = 4.44, $p < .04$.

A male client's approach to the problem was judged significantly more unhealthy than a female client's approach to the problem, means = 6.23 and 5.75. A male client was judged to be in significantly greater need of help than a female client, means = 5.72 and 4.97. Clinicians also indicated that they would feel significantly more uncomfortable in an intake session with a male client than with a female client, means = 4.16 and 3.2. Further, clinicians judged the problem of a male client as significantly less likely to be alleviated than the problem of a female client, means = 2.55 and 2.2.

Behavior of client main effects. There was a behavior of client main effect on: 1) seriousness of the client's problem, F (1, 40) = 10.61, $p < .002$, 2) amount of help needed, F (1, 38) = 6.07, $p < .02$, and 3) uncomfortableness, F (1, 40) = 6.02, $p < .02$. The problems of a passive client were judged to be significantly more serious and in need of significantly more help than were the problems of an aggressive client (seriousness, means = 5.81 and 4.98; amount of help needed, means 5.69 and 4.99). However, clinicians' discomfort ratings were significantly higher for an aggressive client than for a passive client, means = 4.02 and 3.35.

Type of problem main effects. There was a main effect for type of problem on: 1) seriousness of problem, F (1, 40) = 6.79, $p < .01$, and

2) amount of help needed, F (1, 38) = 4.60, $p < .04$. Personal problems were judged to be significantly more serious and in need of significantly more help than were vocational problems (seriousness, means = 5.73 and 5.06; amount of help needed, means = 5.63 and 5.06).

Behavior of Client X Type of Problem interactions. There was a significant Behavior of Client X Type of Problem interaction on the measures of: 1) seriousness of the client's problem, F (1, 40) = 7.51, $p < .01$, 2) unhealthiness of the client's approach to the problem, F (1, 40) = 4.73, $p < .04$, and 3) amount of help needed, F (1, 38) = 5.14, $p < .03$.

On these three measures, the Behavior of Client X Type of Problem interaction yielded similar effects. To summarize, on the seriousness, unhealthiness and amount of help needed measures, clinicians' ratings were significantly lower for the aggressive client-vocational problem condition than for: 1) the aggressive client-personal problem condition, and 2) the passive client-vocational problem condition. The Behavior of Client X Type of Problem interaction for seriousness is shown in Table 8 (see p. 48). The Behavior of Client X Type of Problem interaction for unhealthiness is shown in Table 9 (see p. 49). The Behavior of Client X Type of Problem interaction for amount of help needed is shown in Table 10 (see p. 50).

Sex of Clinician X Behavior of Client interactions. There was a significant Sex of Clinician X Behavior of Client interaction on: 1) unhealthiness of the client's approach to the problem, F (1, 40) = 4.30, $p < .04$, 2) amount of help needed, F (1, 38) = 7.42, $p < .01$,

TABLE 8

Mean Seriousness of Problem Rating for Behavior of Client X Type of Problem*

	Personal	Vocational
Passive	22.99	23.49
Aggressive	22.82	16.99

*Means represent average seriousness of problem ratings for passive and aggressive behavior and personal and vocational problems, summed across sex of clinicians and sex of client.

The higher the mean, the higher the seriousness rating.

N = 48

TABLE 9

Mean Unhealthiness Rating for
Behavior of Client X Type of Problem*

	Personal	Vocational
Passive	23.83	24.82
Aggressive	24.66	22.49

*Means represent average unhealthiness ratings for passive and aggressive behavior and personal and vocational problems, summed across sex of clinician and sex of client.

The higher the mean, the higher the unhealthiness rating.

N = 48

TABLE 10

Mean Amount of Help Needed Ratings for Behavior of Client X Type of Problem*

	Personal	Vocational
Passive	22.49	23.13
Aggressive	22.73	17.22

*Means represent average amount of help needed ratings for passive and aggressive behavior and personal and vocational problems, summed across sex of clinician and sex of client.

The higher the mean, the higher the amount of help needed rating.

N = 46

3) uncomfortableness with client, F (1, 40) = 4.12, $p < .05$, and 4) unlikelihood of alleviating problem, F (1, 37) = 4.06, $p < .05$.

The Sex of Clinician X Behavior of Client interaction on the unhealthiness measure is shown in Table 11 (see p. 52). When client behavior was described as aggressive, female clinicians' ratings of unhealthiness were significantly higher than male clinicians' ratings. Further, female clinicians judged aggressive behavior as significantly more unhealthy than passive behavior. Though male clinicians ratings of unhealthiness were higher for passive behavior than for aggressive behavior, this difference was not significant, t (46) = 1.81, $p < .08$.

The Sex of Clinician X Behavior of Client interaction for amount of help needed is shown in Table 12 (see page 53). Female clinicians' ratings of amount of help needed were not significantly different for aggressive behavior versus passive behavior. However, male clinicians' ratings of amount of help needed were significantly higher for passive behavior than for aggressive behavior.

A nonsignificant Sex of Clinician X Behavior of Client X Type of Problem interaction adds a further dimension of the Sex of Clinician X Behavior of Client interaction on amount of help needed, F (1, 38) = 3.94, $p < .05$. As Table 13 (see p. 54) shows, for both personal problems and vocational problems, male clinicians' ratings of amount of help needed tended to be higher for passive behavior than for aggressive behavior. Female clinicians' ratings of amount of help needed also tended to be higher for the passive behavior-vocational problem condition than for the aggressive behavior-vocational problem

TABLE 11

Mean Unhealthiness Ratings for
Sex of Clinician X Behavior of Client*

	Passive	Aggressive
Male Clinicians	24.49	22.83
Female Clinicians	23.15	25.32

*Means represent average unhealthiness ratings for male and female clinicians and passive and aggressive behavior, summed across sex of client and type of problem.

The higher the mean, the higher the unhealthiness rating.

N = 48

TABLE 12

Mean Amount of Help Needed Ratings for Sex of Clinician X Behavior of Client*

	Passive	Aggressive
Male Clinicians	24.0	18.03
Female Clinicians	21.59	21.9

*Means represent average amount of help needed ratings for male and female clinicians and passive and aggressive behavior, summed across sex of client and type of problem.

The higher the mean, the higher the amount of help needed rating.

N = 46

TABLE 13

Mean Amount of Help Needed Ratings for
Sex of Clinician X Behavior of Client X Type of Problem*

	PASSIVE		AGGRESSIVE	
	Personal	Vocational	Personal	Vocational
Male Clinician	12.5	11.5	9.83	8.2
Female Clinician	9.99	11.6	12.9	9.0

*Mean represent average amount of help needed ratings for male and female clinicians, passive and aggressive behavior, and personal and vocational problems, summed across sex of client.

The higher the mean, the higher the amount of help needed rating.

N = 46

condition. However, when a problem was identified as personal, female clinicians' ratings of amount of help needed tended to be higher for aggressive behavior than for passive behavior.

The Sex of Clinician X Behavior of Client interaction for uncomfortableness is shown in Table 14 (see p. 56). Male clinicians' ratings of uncomfortableness did not differ significantly for aggressive versus passive behavior. However, female clinicians' ratings of uncomfortableness were significantly lower for passive than aggressive behavior.

There was a significant Sex of Clinician X Behavior of Client interaction on the alleviation of problem measure, F (1, 37) = 4.22, $p < .05$. While male clinicians' ratings on the alleviation of problem scale were not significantly different for aggressive versus passive behavior, female clinicians judged the problems of an aggressive client as significantly less likely to be alleviated than the problems of a passive client.

Clinical assessments and sex-role appropriateness of client behavior. To assess the impact of sex-role appropriateness of client behavior on clinicians' assessments, the Sex of Client X Behavior of Client interaction was examined. This interaction did not reach significance on any of the five client assessment scales. However, the Sex of Client X Behavior of Client interaction approached significance on the unhealthiness scale, F (1, 40) = 3.91, $p < .06$. Table 15 (see p. 57) shows that there was a tendency for clinicians to rate the aggressive behavior of a male client as more unhealthy than the aggressive behavior of a female client. A nonsignificant Sex of Clinician X Sex of

TABLE 14

Mean Rating of Uncomfortableness for Sex of Clinician X Type of Behavior*

	Passive	Aggressive
Male Clinician	15.49	15.99
Female Clinician	11.33	16.15

*Means represent average uncomfortableness ratings for male and female clinicians and passive and aggressive behavior, summed across sex of client and type of problem.

The higher the mean, the higher the uncomfortableness rating.

N = 48

TABLE 15

Mean Rating of Unhealthiness for
Sex of Client X Behavior of Client*

	Passive	Aggressive
Male Client	23.65	26.16
Female Client	23.99	21.99

*Means represent average unhealthiness ratings for male and female clients and passive and aggressive behavior, summed across sex of clinician and type of problem.

The higher the mean, the higher the rating of unhealthiness.

N = 48

Client X Behavior of Client interaction on the unhealthiness scale, F (1, 40) = 3.91, $p < .06$, indicates that clinicians' tendency to make higher unhealthiness ratings for aggressive males was due to the ratings of female clients. As shown in Table 16 (see p. 59), female clinicians tended to judge aggressive male behavior as more unhealthy than did male clinicians.

A nonsignificant interaction of Sex of Clinician X Sex of Client X Behavior of Client on the amount of help needed measure, F (1, 38) = 3.52, $p < .08$) reveals a similar tendency. As shown in Table 17 (see p. 60), female clinicians tended to judge an aggressive male client as in greater need of help than did male clinicians, while male clinicians tended to judge a passive male client as in greater need of help than did female clinicians.

Open-Ended Questions

A content analysis was performed on responses to the open-ended questions about: 1) source of the problem, 2) short-term advice to the client, and 3) justification of referral choice. No discernable patterns emerged as a function of sex of client, sex of clinician, sex-role appropriateness of behavior or type of problem.

Referral Recommendations

Chi-square analyses were performed to assess the relationship between each of the independent variables and referral recommendation measures. The following relationships were found to be significant:

TABLE 16

Mean Ratings of Unhealthiness for
Sex of Clinician X Sex of Client X Behavior of Client*

	MALE CLIENTS		FEMALE CLIENTS	
	Passive	Aggressive	Passive	Aggressive
Male Clinicians	12.66	11.83	11.83	11.00
Female Clinicians	10.99	14.33	12.16	10.99

*Means represent average unhealthiness ratings for male and female clinicians, male and female clients, and passive and aggressive behavior, summed across type of problem.

The higher the mean, the higher the unhealthiness rating.

N = 48

TABLE 17

Mean Amount of Help Needed Ratings for
Sex of Clinician X Sex of Client X Behavior of Client*

	MALE CLIENTS		FEMALE CLIENTS	
	Passive	Aggressive	Passive	Aggressive
Male Clinicians	13.5	9.5	10.5	8.53
Female Clinicians	10.76	12.0	10.83	9.9

*Means represent amount of help needed ratings for male and female clinicians, male and female clients, and passive and aggressive behavior, summed across type of problem.

The higher the mean, the higher the amount of help needed rating.

N = 46

1) A female client was recommended for group treatment more often than a male client, chi-square (1) = 9.94, $p < .001$.

2) Female clinicians recommended group treatment for a female client more often than did male clinicians, chi-square (1) = 3.83, $p < .05$.

3) Long-term treatment and medication were more often recommended for a passive client than for an aggressive client (long-term treatment: chi-square (1) = 6.34, $p < .01$; medication: chi-square (1) = 4.88, $p < .03$).

There was no evidence that the referral options, chosen by the clinicians from the list, varied according to sex of the clinician, sex of the client, sex-role appropriateness of client behavior, and/or type of problem.

CHAPTER IV

DISCUSSION

The central question in this study focuses on how sex-role appropriate versus sex-role inappropriate client behavior influences clinicians' causal attributions and clinical judgments. It was hypothesized that clinicians perceive the problems of a passive male and aggressive female (sex-role inappropriate condition) as more dispositional in nature and more severe than the problems of a passive female and aggressive male (sex-role appropriate condition).

It was also hypothesized that clinicians' responses to the type of problem presented by the client (personal versus vocational) vary according to client gender. Specifically, it was hypothesized that clinicians perceive the vocational problem of a male client as more dispositional in nature and more severe than the vocational problem of a female client. No predictions were made about differences in clinicians' assessments of male versus female clients identified as having a personal problem.

Sex of the clinician was also varied in the present study. No sex of clinician main effects were expected, given evidence from prior research (e.g., Fischer et al, 1976; Schwartz & Abramowitz, 1975). However, it was expected that sex of the clinician might interact with the other independent variables (sex of the client, client behavior, and type of client problem) to yield significant effects.

The major hypothesis, focusing on clinicians' assessments of sex-role appropriate versus sex-role inappropriate behavior, was only

marginally supported by the findings. Though the passive behavior of the male client (sex-role inappropriate condition) tended to be judged as more unhealthy and in need of greater help than the passive behavior of the female client (sex-role appropriate condition), this held true only for the male clinicians. For aggressive client behavior, the findings contradicted the hypothesis. That is, the aggressive male client (sex-role appropriate condition) tended to be judged as more unhealthy and in need of greater help than the aggressive female client (sex-role inappropriate condition). This tendency held true only for the female clinicians.

These Sex of Clinician X Sex of Client X Type of Behavior interactions contributed to Sex of Clinician X Type of Behavior interactions on several of the dependent variables. Overall, female clinicians were found to rate aggressive behavior as more unhealthy than passive behavior. Further, female clinicians indicated that they would feel more uncomfortable in an intake session with an aggressive client than with a passive client. Male clinicians, on the other hand, rated passive behavior more severely than aggressive behavior. They tended to view passive behavior as more unhealthy than aggressive behavior and to perceive passive behavior as in need of significantly greater help than aggressive behavior.

In regard to the type of problem presented by the client, the hypothesis that the vocational problem of a male client is perceived to be more severe than the vocational problem of a female client was not supported. Overall, the causal attributions and clinical assessments of the male versus female client did not vary according to type

of problem. Contrary to expectation, there was a sex of clinician main effect on several of the dependent variables. On three of the four causal attribution ratings, female clinicians' ratings were significantly more dispositional than were male clinicians' ratings.

Given this summary of the findings, one can ask: 1) how do the results confirm (or dispute) previous analogue research on gender effects in psychotherapy, 2) what new perspectives on gender and psychotherapy are suggested, and 3) what are the implications of the results to actual clinical practice?

As in the present study, other clinical analogue researchers have varied sex-role appropriateness of client behavior along the passivity-aggressiveness dimension. Contrary to the trends indicated in the present research, Johnson (1978) and Fischer et al (1976) did not find that male and female clinicians' assessments of male and female clients varied as a function of sex-role appropriateness of client behavior. Feinblatt and Gold (1976) found that clinicians' assessments of sex-role inappropriate behavior were more severe than for sex-role appropriate behavior, while in the present study, this was a trend only in the passive client condition - and only for male clinicians. The surprising trend in the present study, not reported in previous research, indicates that female clinicians tend to view an aggressive male client as more maladjusted than an aggressive female client. The interaction effects reported in the present study, indicating that, overall, male clinicians rate passive client behavior more severely than aggressive client behavior, while female clinicians rate aggressive client behavior more severely than passive client behavior, are also new findings.

In the present study, the higher severity ratings of the passive male client by the male clinicians and of the aggressive male client by the female clinicians yielded a significant sex of client main effect on several of the client assessment measures. It was found that, overall, the male client was perceived to be more unhealthy and to need more help than the female client. Further, a sex of client main effect on the uncomfortableness rating indicates feelings of greater discomfort toward the male rather than female client.

Though, overall, the male client received more severe ratings than did the female client, one should not interpret this more "positive" bias toward the female client as evidence of the absence of "sexism" in clinicians' perceptions. Indeed, if one defines "sexism" as adherence to a double standard of mental health for male and female clients, then male clinicians in this study may have revealed such a bias - at least on the passive behavior dimension - since they indicated greater acceptance of passivity in the female than the male client.

One might also ask whether female clinicians' greater bias against aggressive behavior in the male than female client also reflects a double standard. It should be noted that differences between male and female clinicians' ratings of aggressive male behavior were most pronounced when the client was identified as having a personal problem. This finding is especially interesting, given the content of the aggressive behavior-personal problem case description. In this condition, the client expresses anger over the break-up of his/her engagement and indicates feelings of hostility toward the former fiancée. As the client states, "I'm so mad I could kill him/her."

The difference between male and female clinicians' severity ratings of the male client in this condition suggests that female clinicians may have taken the male client's threat of violence more seriously than did the male clinicians.

What, then, do these results suggest about actual clinical practice? Though the present research suggests that clinician gender is a key factor in the information of initial clinical assessments, data from the present study do not indicate that, as a consequence, male and female clinicians make significantly different referral recommendations. Thus, the applicability of the results to actual clinical behavior are extremely limited. Nevertheless, the findings of this study may provide a useful springboard for generating hypotheses to be tested in clinical process studies.

Finally, one must assess the usefulness of social psychological attribution theory as a predictor of sex bias in clinical perceptions. In the present study, Jones and Davis' (1965) model was used to generate predictions about the impact of sex-role appropriate versus sex-role inappropriate client behavior on clinical assessments. The predicted differences in causality measures did not obtain. Further, though there were differences on some of the client assessment measures as a function of sex-role appropriateness or sex-role inappropriateness of client behavior, this was true only when clinician gender was considered. Though the Jones and Davis model was not an accurate predictor in the present study, other attribution models may have usefulness and could be explored in future research on gender effects in psychotherapy.

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APPENDIX A

CASE DESCRIPTION

Included in this section are the case descriptions for each of the following conditions:

1) Male client, passive behavior, personal problem
2) Female client, passive behavior, personal problem
3) Male client, aggressive behavior, personal problem
4) Female client, aggressive behavior, personal problem
5) Male client, passive behavior, vocational problem
6) Female client, passive behavior, vocational problem
7) Male client, aggressive behavior, vocational problem
8) Female client, aggressive behavior, vocational problem

MALE/PASSIVE/PERSONAL

Steve, a 28-year-old man, appeared tired and sad at the start of the session. He said that several friends had advised him to contact a counselor. Though he had hesitated at first, Steve eventually agreed to make an appointment. Steve stated that this was the first time he had ever been to see a counselor.

In a subdued voice, Steve said that his fiancée had broken up with him about four months ago. They had been engaged for two years and were planning to be married during the coming year. During the past few months, Steve has felt more and more depressed about the breakup. During the past few weeks, he has become very withdrawn, spending more and more time alone in his bedroom, lying on the bed or sleeping. As a result, he has missed a number of days at work.

As Steve stated during the session, "Right now I don't feel like doing anything or being around anyone. When I think of my life I just feel hopeless. After the breakup, some of my friends told me to at least try to pull myself together and begin to look ahead, but I just don't have the energy. I don't care what happens anymore."

When asked to talk more about his broken engagement, Steve seemed very sad. "Before the breakup, I guess we'd been having our problems, but they didn't seem serious. But one night she just came out and said she didn't want to marry me - that she wanted to break off with me completely and date around. She said she was being fair to me by breaking things off. I couldn't believe it. . .but there was nothing

I could do. She said she wasn't going to marry me. . .so just like that, it was over. I was so hurt, and since then. . .well, life hardly seems worth living."

When asked to talk more about how he has been feeling, Steve spoke haltingly, "I just feel hopeless, like nothing good will ever happen to me again. Before Karen (my fiancée) broke off our engagement, I felt really happy about life. But now, there's nothing for me. . .Karen is out of my life, and I don't think I'll ever get over it."

Asked whether he had ever before experienced such feelings, Steve said he could not recall a time when he had felt "this way". When asked how he had reacted in the days immediately following the breakup, Steve said he had been shocked and upset, "I couldn't believe it was happening. We had been so close and had planned so many things together. Suddenly, it was over. . .and now. . .well, most days I feel like I just can't go on."

Encouraged to talk more, Steve said, "All I ever think about is Karen and what we could have had together. I feel so lost without her. She made me feel like I was really something special. But I don't know. . . maybe I just wasn't good enough for her. It doesn't matter anyway. My life means nothing without her, I don't think anything will ever happen to make things better. I guess good things just aren't meant to happen to me."

As the session neared an end, Steve appeared very drained, "Life has become too difficult for me to deal with. . .I don't have the energy to cope with things. . .I wish someone would just take care of

problems for me, so I wouldn't have to deal with anything. I don't know what's going to happen to me, but it doesn't much matter. . .I'd just like to go off by myself and not have to worry about anything." When asked whether he would like further help, Steve replied, "I don't know. . .I really don't know. . .what do you think I should do?"

NOW TURN TO THE NEXT PAGE. . .

FEMALE/PASSIVE/PERSONAL

Diane, a 28-year-old woman, appeared tired and sad at the start of the session. She said that several friends had advised her to contact a counselor. Though she had hesitated at first, Diane eventually agreed to make an appointment. Diane stated that this was the first time she had ever been to see a counselor.

In a subdued voice, Diane said that her fiancée had broken up with her about four months ago. They had been engaged for two years and were planning to be married during the coming year. During the past few months, Diane has felt more and more depressed about the breakup. During the past few weeks, she has become very withdrawn, spending more and more time alone in her bedroom, lying on the bed or sleeping. As a result, she has missed a number of days at work.

As Diane stated during the session, "Right now I don't feel like doing anything or being around anyone. When I think of my life I just feel hopeless. After the breakup, some of my friends told me to at least try to pull myself together and begin to look ahead, but I just don't have the energy. I don't care what happens anymore."

When asked to talk more about her broken engagement, Diane seemed very sad. "Before the breakup, I guess we'd been having our problems, but they didn't seem serious. But one night he just came out and said he didn't want to marry me - that he wanted to break off with me completely and date around. He said he was being fair to me by breaking things off. I couldn't believe it. . .but there was nothing I

could do. He said he wasn't going to marry me. . .so just like that, it was over. I was so hurt, and since then. . .well, life hardly seems worth living."

When asked to talk more about how she has been feeling, Diane spoke haltingly, "I just feel hopeless, like nothing good will ever happen to me again. Before Alan (my fiancée) broke off our engagement, I felt really happy about life. But now, there's nothing for me. . .Alan is out of my life, and I don't think I'll ever get over it."

Asked whether she had ever before experienced such feelings, Diane said she could not recall a time when she had felt "this way". When asked how she had reacted in the days immediately following the breakup, Diane said she had been shocked and upset, "I couldn't believe it was happening. We had been so close and had planned so many things together. Suddenly, it was over. . .and now. . .well, most days I feel like I just can't go on."

Encouraged to talk more, Diane said, "All I ever think about is Alan and what we could have had together. I feel so lost without him. He made me feel like I was really something special. But I don't know. . . maybe I just wasn't good enough for him. It doesn't matter anyway. My life means nothing without him, I don't think anything will ever happen to make things better. I guess good things just aren't meant to happen to me."

As the session neared an end, Diane appeared very drained, "Life has become too difficult for me to deal with. . .I don't have the energy to cope with things. . .I wish someone would just take care of

problems for me, so I wouldn't have to deal with anything. I don't know what's going to happen to me, but it doesn't much matter. . .I'd just like to go off by myself and not have to worry about anything." When asked whether she would like further help, Diane replied, "I don't know. . .I really don't know. . .what do you think I should do?"

NOW TURN TO THE NEXT PAGE. . .

MALE/AGGRESSIVE/PERSONAL

Steve, a 28-year-old man, appeared anxious and somewhat hostile as the session began. He reported that his decision to see a counselor came after several friends suggested it might be helpful. Steve said he had been somewhat "put off" by their suggestion, but, after thinking about it, decided to "give it a try". Steve said this was the first time he had ever come to see a counselor.

In a somewhat angry tone, Steve stated that his fiancée had broken up with him about four months ago. They had been engaged for two years and were planning to be married during the coming year. Steve reported that during the past few months he's felt more and more upset about the breakup. During the past few weeks he has become agitated and verbally abusive to those around him.

As Steve stated during the session, "I'll never forget what Karen (my fiancée) has done to me! Every time I see her I get so mad! I want to strike out and knock her to the ground! It makes me angry just thinking about her!" Steve said these feelings have been affecting "just about everything I do, including my job. Lately I've been flying off the handle at everyone. . .my friends, people I work with. . .even people I don't know."

When asked to talk more about his broken engagement, Steve appeared quite anxious. "I couldn't believe it! Before the breakup we'd been having our problems, but they didn't seem serious. But one night she just came out and said she didn't want to marry me - that

she wanted to break off with me completely and date around. I tried to tell her she couldn't treat me that way, but she didn't care! She just said she wasn't going to marry me. . .so, like that, it was over! Well, it wasn't over as far as I was concerned!"

When asked to talk more about how he has been feeling, Steve appeared quite distressed, "I don't have much patience with anybody now! Before Karen broke off our engagement, I felt really happy about life, but now I feel mad all the time! Karen has pulled out of my life, but I'm not going to sit back and get dumped on like this! I've just had enough!"

Asked whether he had ever before experienced such feelings, Steve said he could not recall a time when he had felt "this way." When asked how he had reacted in the days immediately following the breakup, Steve said he had been shocked and upset. "I couldn't believe it was happening! We had been so close and had planned so many things together. Suddenly it was over. . .and now. . .well, I'm just at the end of my rope!"

In a more accusing tone, Steve said, "I'm not going to take this any longer! All I ever think about is how to get back at her. . .and I will get back at her! I'm so mad I could kill her! She said she was being fair to me by breaking things off! Who did she think she was kidding? Nobody treats me like that and gets away with it! She's going to be sorry!"

As the session neared an end, Steve continued to appear quite anxious, "Things have reached a point where I have to draw the line and say, 'No more!' Maybe some people can let themselves be pushed

around this way, but not me! Believe me, I expect more out of life than this and I'll do whatever I have to to get it, even if it means stepping on a few people. . .like Karen. I've just had it!" When asked whether he would like further help, Steve said, in a somewhat hostile tone, that he would think about it.

NOW TURN TO THE NEXT PAGE. . .

FEMALE/AGGRESSIVE/PERSONAL

Diane, a 28-year-old woman, appeared anxious and somewhat hostile as the session began. She reported that her decision to see a counselor came after several friends suggested it might be helpful. Diane said she had been somewhat "put off" by their suggestion, but, after thinking about it, decided to "give it a try". Diane said this was the first time she had ever come to see a counselor.

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As Diane stated during the session, "I'll never forget what Alan (my fiancée) has done to me! Every time I see him I get so mad! I want to strike out and knock him to the ground! It makes me angry just thinking about him!" Diane said these feelings have been affecting "just about everything I do, including my job. Lately I've been flying off the handle at everyone. . .my friends, people I work with. . .even people I don't know."

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When asked to talk more about how she has been feeling, Diane appeared quite distressed, "I don't have much patience with anybody now! Before Alan broke off our engagement, I felt really happy about life, but now I feel mad all the time! Alan has pulled out of my life, but I'm not going to sit back and get dumped on like this! I've just had enough!"

Asked whether she had ever before experienced such feelings, Diane said she could not recall a time when she had felt "this way." When asked how she had reacted in the days immediately following the breakup, Diane said she had been shocked and upset. "I couldn't believe it was happening! We had been so close and had planned so many things together. Suddenly it was over. . .and now. . .well, I'm just at the end of my rope!"

In a more accusing tone, Diane said, "I'm not going to take this any longer! All I ever think about is how to get back at him. . .and I will get back at him! I'm so mad I could kill him! He said he was being fair to me by breaking things off! Who did he think he was kidding? Nobody treats me like that and gets away with it! He's going to be sorry!"

As the session neared an end, Diane continued to appear quite anxious, "Things have reached a point where I have to draw the line and say, 'No more!' Maybe some people can let themselves be pushed

around this way, but not me! Believe me, I expect more out of life than this and I'll do whatever I have to to get it, even if it means stepping on a few people. . .like Alan. I've just had it!" When asked whether she would like further help, Diane said, in a somewhat hostile tone, that she would think about it.

NOW TURN TO THE NEXT PAGE. . .

MALE/PASSIVE/VOCATIONAL

Steve, a 32-year-old man, appeared tired and sad at the start of the session. He said that several family members had advised him to contact a counselor. Though he had hesitated at first, Steve eventually agreed to make an appointment. Steve said this was the first time he had ever been to see a counselor.

Steve stated that he has worked in the sales department of a local company for over two years. In a rather subdued voice, Steve said that he was assigned to a new supervisor approximately six months ago, after his previous supervisor left to take another job. At first the new supervisor said little about Steve's job performance, but several months later, the supervisor began telling Steve that his job performance was below standard. About a month ago, Steve was denied a big promotion he had been counting on. Steve was told the supervisor's negative evaluation of him was responsible for this.

Since losing out on the promotion, Steve has become depressed and withdrawn. He said that he has been going to work only occasionally during the past few weeks. On those days when he does go to work, Steve tries to avoid his supervisor and co-workers as much as possible. At home, Steve has been spending more and more time alone in the bedroom, lying on the bed or sleeping - avoiding family and friends. As Steve stated during the session, "Right now I don't feel like doing anything or being around anyone."

When asked to talk more about how he has been feeling, Steve spoke haltingly, "Well, I just feel disappointed. . .and really discouraged . . .I should have known the supervisor would keep me from getting the promotion. . .Though a few other people sometimes get criticized by this supervisor, it seems that no one gets hassled as much as I do. I try to do a good job. . .but I don't know. . .not getting that promotion has really done me in. . .I'm beginning to think that maybe I'm just not cut out for this job. Right now everything looks pretty hopeless, and at this point. . .well, I don't much care what happens anymore. . .with the job. . . or with anything else. I guess maybe good things just aren't meant to happen to me."

Asked whether he had ever felt this way in the past, about a job, or about anything else, Steve replied that he had not. As he spoke more about his job, Steve seemed very sad, "It's hit me hard. I was really counting on that promotion, but I guess the supervisor thinks I'm just not good enough. . .and maybe the supervisor's right. But it doesn't really matter now. . .nothing seems to matter right now. Some of the people I work with have told me to at least try to pull myself together and begin to look ahead - or maybe look for another job that might work out better. But I just don't have the energy. . .some days I feel like I just can't go on."

At the end of the session, Steve appeared very drained, "Life has become too difficult for me to deal with. . .I can't cope with things. . . with the supervisor, with the fact that I lost the promotion. Right now I wish someone would just take care of my problems for me,

so I wouldn't have to deal with anything. I don't know what's going to happen with the job, but it doesn't much matter to me now. . .I'd just like to go off by myself and not have to worry about anything." Asked whether he would like further help, Steve replied, "I don't know. . .I really don't know. . . what do you think I should do?"

NOW TURN TO THE NEXT PAGE. . .

FEMALE/PASSIVE/VOCATIONAL

Diane, a 32-year-old woman, appeared tired and sad at the start of the session. She said that several family members had advised her to contact a counselor. Though she had hesitated at first, Diane eventually agreed to make an appointment. Diane said this was the first time she had ever been to see a counselor.

Diane stated that she has worked in the sales department of a local company for over two years. In a rather subdued voice, Diane said that she was assigned to a new supervisor approximately six months ago, after her previous supervisor left to take another job. At first the new supervisor said little about Diane's job performance, but several months later, the supervisor began telling Diane that her job performance was below standard. About a month ago, Diane was denied a big promotion she had been counting on. Diane was told the supervisor's negative evaluation of her was responsible for this.

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NOW TURN TO THE NEXT PAGE. . .

MALE/AGGRESSIVE/VOCATIONAL

Steve, a 32-year-old man, appeared anxious and somewhat hostile as the session began. He reported that his decision to see a counselor came after several family members suggested it might be helpful. Steve said he had been somewhat "put off" by their suggestion, but, after thinking about it, decided to "give it a try". Steve said this was the first time he had ever come to see a counselor.

Steve stated that he has worked in the sales department of a local company for over two years. In a somewhat angry tone, Steve said he was assigned to a new supervisor approximately six months ago, after his previous supervisor left to take another job. At first the new supervisor said little about Steve's job performance, but several months later, the supervisor began telling Steve that his job performance was below standard. About a month ago, Steve was denied a big promotion he had been counting on. Steve was told that the supervisor's negative evaluation of him was responsible for this.

Since losing out on the promotion, Steve has become agitated and verbally abusive to those around him - especially toward his supervisor. As Steve stated during the session, "I'll never forget what the supervisor has done to me! I deserved that promotion, and I'm really mad that I didn't get it!" He said these feelings been affecting "just about everything I do. Lately I've been flying off the handle at everyone. . . my family, friends, people I work with. . .even people I don't know."

Asked whether he had ever felt this way in the past, about a job, or about anything else, Steve replied that he had not.

When asked to talk more about how he has been feeling, Steve appeared quite distressed, "I'm at the end of my rope! I should have known the supervisor would stop me from getting the promotion! This supervisor really has it in for me! Though a few other people sometimes get criticized by this supervisor, no one gets hassled as much as I do!"

When asked to talk more about his job, Steve spoke of a recent incident. Steve said that his supervisor came into the office early one morning and asked him if he's completed several routine reports that weren't due until later the next day. Steve stated, "When I said the reports weren't finished, the supervisor told me I'd better get with it. Well, I just exploded and said, 'Get off my back! I'll get to the reports when I have time!' I was so mad! I wanted to strike out and knock the supervisor to the floor! I've just had enough! Nobody can treat me like this and get away with it!"

Steve continued, "I don't think I can take this much longer! All I ever think about now is how to get back at the supervisor for messing up my chance for the promotion. . .and believe me, I'll do it! The supervisor is going to be sorry! I was really counting on that promotion, and I should have gotten it!"

At the end of the session, Steve continued to appear quite anxious, "Things have reached a point where I have to draw the line and say, 'No more!' Maybe some people can let themselves be pushed around this

way. . .but not me! I expect more out of a job than this. . .and I'll do whatever I have to get it. . .even if it means stepping on a few people. . .like my supervisor. I've just had it!" Asked whether he would like further help, Steve said, in a somewhat hostile tone, that he would think about it.

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Diane continued, "I don't think I can take this much longer! All I ever think about now is how to get back at the supervisor for messing up my chance for the promotion. . .and believe me, I'll do it! The supervisor is going to be sorry! I was really counting on that promotion, and I should have gotten it!"

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way. . .but not me! I expect more out of a job than this. . .and I'll do whatever I have to get it. . .even if it means stepping on a few people. . .like my supervisor. I've just had it!" Asked whether she would like further help, Diane said, in a somewhat hostile tone, that she would think about it.

NOW TURN TO THE NEXT PAGE. . .

APPENDIX B

DEPENDENT MEASURES

Included in this section are the dependent variables as they applied in the study.

PLEASE ANSWER THE FOLLOWING QUESTIONS:

1. Briefly, what do you think is the source of this person's problem?

2. What short-term advice would you offer this person?

EACH OF THE FOLLOWING QUESTIONS IS FOLLOWED BY A SCALE WITH NUMBERS RANGING FROM 1 TO 8. PLEASE INDICATE YOUR ANSWER TO EACH QUESTION BY CIRCLING A NUMBER ON THE SCALE.

3. Difficulties sometimes arise because of a problem with the individual or because of the individual's social situation. Where, in your opinion, does the problem lie in this case?

1 : 2 : 3 : 4 : 5 : 6 : 7 : 8

Exclusively With the Individual — Exclusively With the Individual's Social Situation

4. Where do you feel change is needed?

1 : 2 : 3 : 4 : 5 : 6 : 7 : 8

Exclusively With the Individual's Social Situation — Exclusively With the Individual

5. The source of a person's problem can sometimes be described as stable or due to an unchangeable part of his/her character. To what extent would you describe the source of this person's problem as "characterological?"

1 : 2 : 3 : 4 : 5 : 6 : 7 : 8

Completely Characterological — Not At All Characterological

6. The source of a person's problem can sometimes be described as changeable or due to behavior which the individual has or has not engaged in. To what extent would you describe the source of this person's problem as "behavioral"?

1 : 2 : 3 : 4 : 5 : 6 : 7 : 8

Completely Behavioral — Not At All Behavioral

7. In your opinion, how serious is this person's problem?

1 : 2 : 3 : 4 : 5 : 6 : 7 : 8
Very Serious — Not At All Serious

8. In your opinion, how healthy is this person's approach to the problem?

1 : 2 : 3 : 4 : 5 : 6 : 7 : 8
Very Healthy — Not At All Healthy

9. In your opinion, how much help does this person need?

1 : 2 : 3 : 4 : 5 : 6 : 7 : 8
A Great Deal Of Help — Very Little Help

10. If you had conducted an intake session with this person, how do you think you might have been feeling during the session?

1 : 2 : 3 : 4 : 5 : 6 : 7 : 8
Very Comfortable — Very Uncomfortable

11. Included below is a list of some referral resources available in this area.

Please mark the <u>one</u> referral resource which, in your opinion, is most appropriate for the person whose case has just been described.

_____ Mental hospital

_____ Residential treatment center

_____ Mental health clinic

_____ Private practitioner

_____ Community follow-up and case management program

_____ Community self-help center (e.g., support groups, etc.)

_____ Citizens' advocacy group

_____ Other (Please specify:_____)

_____ No referral

12. Briefly, why did you choose this referral option?

13. How likely do you think it is that the person's problem can be alleviated by the resource you have chosen?

1 : 2 : 3 : 4 : 5 : 6 : 7 : 8
Extremely Likely — Not At All Likely

WHICH OF THE FOLLOWING CHOICES WOULD YOU RECOMMEND?
PLEASE CHOOSE ONLY ONE FROM EACH PAIR.

14. _____ Individual treatment

_____ Group treatment

15. _____ Male therapist

_____ Female therapist

16. _____ Short-term treatment

_____ Long-term treatment

17. _____ Medication

_____ No medication

NOW TURN TO THE NEXT PAGE. . .

PLEASE INDICATE YOUR IMPRESSION OF DIANE, THE PERSON DESCRIBED IN THE FIRST INTAKE SUMMARY, BY CIRCLING A NUMBER ON EACH OF THE SCALES GIVEN BELOW.

1 Extremely Passive	: 2	: 3	: 4	: 5	: 6	: 7	: 8	Not At All Passive
1 Extremely Aggressive	: 2	: 3	: 4	: 5	: 6	: 7	: 8	Not At All Aggressive
1 Extremely Depressed	: 2	: 3	: 4	: 5	: 6	: 7	: 8	Not At All Depressed
1 Extremely Angry	: 2	: 3	: 4	: 5	: 6	: 7	: 8	Not At All Angry

How would you describe Diane's problem?

1 Personal Problem	: 2	: 3	: 4	: 5	: 6	: 7	: 8	Vocational Problem

APPENDIX C

CLINICAL BACKGROUND QUESTIONS

Included in this section are the clinical background questions as they appeared in the study.

BACKGROUND INFORMATION

Please respond to the following questions. This background information is being sought, not out of interest in you as an individual, but as a means of providing an overall picture of the sample of respondents. All your responses are strictly confidential.

1. Sex:

   _____ Male

   _____ Female

2. Age: _____

3. What professional degree(s) do you hold?

4. From what college or university did you receive your degree, and when did you receive it?

5. What was the nature of your professional training? (e.g., psychoanalytic, humanistic, etc.)

6. How many years have you worked in the mental health field? _____
   (Note: Exclude any graduate internship, practicum, etc.)

7. What kind of mental health work are you currently doing - and in what setting?

8. Have you done any other kinds of mental health-related work during the past several years? If so, please briefly describe.

9. Are any areas within the mental health field of special interest to you? If so, please briefly describe.

THIS COMPLETES THE STUDY. . .THANK YOU FOR YOUR PARTICIPATION.

APPENDIX D

BRIEF DESCRIPTION OF STATISTICAL SYMBOLS

SYMBOL	DESCRIPTION
df	Degrees of Freedom
F	Ratio of two sample variances
N	Number of subject responses in the sample
p	Probability that statistical results are chance occur
r	Pearson correlation coefficient. The measure of linear relationship between two parallel sets of data.
t	The deviation of a sample means (average) from a population mean, divided by the standard deviation of the sampling distribution of means.
<	Less than