Attributional Processes in Therapeutic Relationships: Attributions of Causality, Stability, and Maladjustment of Clients' Problems as Affected by Sex of Client and Therapist Sex Role Ideology

by


Mary-Jane Robinson

A thesis
presented to the University of Manitoba
in partial fulfillment of the
requirements for the degree of
Doctor of Philosophy
in
Department of Psychology

University of Manitoba

1981

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ABSTRACT

The main purpose of the present research was to empirically validate the occurrence of sex bias in psychological evaluation and psychotherapy. Based on the now classic study by Broverman et al (1970), researchers have argued that there is a relationship between sex roles and ascriptions of pathology. It has been suggested that the negatively valued feminine role prompts therapists to view women's personalities as being the source of female clients' psychological distress. This attitude is assumed to be prejudicial because males' problems are not so characterized by attributions to dispositional factors. Because the stereotypic masculine personality is viewed more positively and as healthier than the feminine stereotype, therapists are thought to ascribe male pathology to factors external to the personality, or to more situational factors. In the present research the effect of therapist sex role attitude (measured by the Attitudes Toward Women Scale and the Sex Role Ideology Scale) and client gender on attributions of causality (location) and stability for presenting psychological problems and treatment goals was examined. The effect of client gender on therapists' perceptions of degree of client maladjustment was also examined. Two judges performed a content analysis

of verbatim responses of adult male and female clients and psychotherapists to an open-ended questionnaire concerning reasons for which clients seek psychological help. Attributions of location and stability were quantified using a 7 and 5 point scale respectively. Degree of client maladjustment was indicated by therapists using a 9 point scale. Results indicated that gender did not have a very powerful effect in determing client and therapist perceptions of how to explain and treat psychological problems. Both male and female clients perceived their problems as due to dispositional factors; although not significant, males tended to make higher stability ratings. Therapists did not make differential attributions of location and stability for clients' presenting problems or treatment goals on the basis of client gender, nor were gender effects found on therapist maladjustment ratings. Presenting problems for male and female clients were seen by clinicians as moderately internal and stable, and both males and females were perceived as moderately adjusted. Traditional therapists made significantly higher internal and stable attributions for clients' presenting problems than liberal therapists, and they also made significantly more internal attributions for treatment goals. Traditional therapists also saw males' problems as significantly more internal. In general, male clients were shown to conform more to the attributional pattern predicted for females, and this was interpreted to indicate a selec-

tion bias in the type of male client who seeks psychological help. Claims of widespread bias against female patients were not supported in this research. Therapists tended to show a diagnostic bias which conforms more to a traditional professional orientation of viewing psychological problems as dispositional and chronic in nature, and this bias in perception generally applied to both males and females. Theoretical implications of these findings for attributional research were discussed. Recommendations for future investigation included replication of analogue research using naturalistic studies, and the implementation of studies using higher-order interactions given the general research findings in this area of few main effects of client sex.

ACKNOWLEDGEMENTS

The completion of my PhD was a very rewarding experience for me, and at the most personal level, it was also one of self-discovery and personal growth. As with most such experiences, it was shared by others who nutured that growth with their advice and care. I first wish to acknowledge John Schallow who guided me through my graduate program, not only as my advisor, but also as my friend. Thank you John ---for being there along the way, and for getting me to the end.

To my committee, John McIntyre, Dan Perlman, and Nina Chappell, I wish to extend my gratitude for your invaluable assistance in helping me prepare this dissertation. My personal contacts with all of you were very rewarding to me, and if I were to do it all again, I would want you there.

To my close friends at Graduate school, Erma, Mike, Wenda, Linda, Laurel Lee, and Heather, I never could have finished without your help and most importantly, your unfailing friendship. Lastly, I wish to acknowledge my husband, Doug, who added the meaning and love to it all.

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INTRODUCTION

It has recently been suggested that traditional psychotherapy deals with the problems of women in a prejudicial fashion (Chesler, 1971, 1972; Report of the Task Force on Sex Bias and Sex-Role Stereotyping in Psychotherapeutic Practice, American Psychological Association, 1974; Brodsky, 1977; Rawlings & Carter, 1977). The fact that there are rapidly increasing proportions of women seeking psychiatric help (Frieze, Parsons, Johnson, Ruble, & Zellman, 1978) underscores the importance of empirically validating such speculations.

Claims of "biased" treatment of female psychotherapy clients are largely based on evidence from two areas of research. One such area has focused on the sex role expectations of mental health professionals: The classic reference is a study by Broverman, Broverman, Clarkson, Rosenkrantz, and Vogel (1970) which suggests a negative bias by practicing clinicians against women (clinicians were shown to attribute traits which characterized mentally healthy adults significantly more often to men than they were to women). Several other studies, using similar formats, reached similar conclusions (Burns, 1977; Maslin & Davis, 1975; Nowacki & Poe, 1973; Fabrikant, Landeau, & Rollenhagen, 1973). The

finding that therapists hold negative stereotypes of women is, however, by no means a universal conclusion: Some studies do not corroborate the notion of a double standard of mental health for men and women (Kravetz, 1976; Harris & Lucas, 1976; Billingsley, 1977).

Other evidence for bias against female psychiatric patients comes from epidemiological research which attempts to show, through statistical data on mental illness, that the culturally negative stereotype of women (Rosenkrantz, Vogel, Bee, Broverman, & Broverman, 1968) is reflected in the proportionately greater number of females showing up for psychiatric treatment in various mental health care facilities (Gove & Tudor, 1973; Luce & Wand, 1976; Radloff, 1975; Dohrenwend & Dohrenwend, 1969; Statistics Canada, 1970). These demographic studies also point to a greater liklihood of certain diagnostic categories for females, namely those characterized as predominantly emotional in nature, such as neurosis (Statistics Canada, 1970).

Both areas of research, demographic and role expectancy, share in the attempt to relate characteristics of adult female sex roles to aspects of mental illness. Phillip's and Segal's (1969) interpretation, for example, suggests that the feminine role allows women greater expression of emotionality and hence greater ease in displaying psychic distress. Chesler (1972), on the other hand, relies upon a role-deviancy analysis (adjustment model of mental health).

She reasons that women who express dissatisfaction with the feminine role, or who adopt alternative life styles, are labeled as "sick". The role-deviancy interpretation has received much attention in the literature (Kagan, 1964; Carter, 1974; Levine, Kamin, & Levine, 1974; Brodsky, 1977), but it has not been immune from criticism (Zeldow & Greenberg, 1975): Sex-role deviant males have been shown to receive more negative evaluations than their female counterparts (Tilby & Kalin, 1980), and typical female clients have been shown to elicit more bias in counselors than atypical females (Shapiro, 1977).

One of the most promising approaches toward clarifying the relationship between mental illness and sex role expectations comes from the literature on feminist and non-sexist psychotherapy (Rawlings & Carter, 1977). The feminist position is that therapists have mistakenly viewed the social problems of women as idiosyncratic symptoms of disease entities, such as neurosis, hysteria, and depression. The mechanism through which therapists are thought to convey their biases against women is by their conscious (or even unconscious) acceptance of the cultural values and roles for women, i.e., the view that women are inferior, not motivated to succeed, manipulative, rigid, tense, and unrealistic (Heilbrun & Sullivan, 1962; Carter, 1974) - essentially a composite of unhealthy and undesirable trait attributes (Rosenkrantz et al., 1968; Broverman et al., 1970).

Several aspects of this interpretation are significant and warrant further investigation. Of central importance is the hypothesis that therapists personalize women's problems, or, in other words, that for women they seek the cause of pathology within the person rather than looking for causes which reside within a larger social context. This implies that therapists do not personalize the problems of men, or at least not to the same extent that they do for women. If this is the case, we should predict that therapists would be more likely to seek the causes of male unhappiness outside the personality, or to look for causes external to the male client and within the socio/environmental context. To date, there are few direct tests of this hypothesis, especially within a naturalistic clinical setting. Some supportive evidence is offered by Peterson and Peterson (1973) from a survey of sex roles as portrayed in sex and marriage manuals. Results showed that the female was almost unanimously regarded as responsible (i.e., to blame) for the cause and cure of sexual problems when they arose. Prather and Fidell (1975), who surveyed drug advertisements in American medical journals, showed that the reasons for prescribing psychoactive drugs for men and women differed along the dimensions of cultural stereotypes: Men were protrayed as needing drugs for work-related reasons (such as work-induced stress), and women for less specific symptoms reflecting personality disorder - diffuse anxiety, tension, or depression.

Another critical assumption in the feminist argument is that bias in therapists (where bias is defined as misattributing the cause of womens' pathology to individual factors when this is not the procedure for men) is related to their adherence to cultural sex role attitudes and expectations. Due to the nature of the stereotypic femine role (Rosenkrantz et al., 1968), women are seen as unhealthy, or at least not as healthy as men, thus creating a greater liklihood that women, more so than men, will be seen as having something wrong with them. Since the stereotypic male is seen as healthier, there is not the same impetus to seek for the cause of male distress within their personalities. This leads to the speculation that psychotherapists who subscribe to the cultural stereotypes of sex roles would be more likely than their less traditional colleques to interpret women's distress as representative of internally caused emotional illness.

As a final point, the feminist position on how women are treated in psychotherapy readily lends itself to analysis from the perspective of attribution theory. This concerns the processes by which individuals attempt to explain their world, and as such, deals with the causes people assign for their own behavior and for the behavioral effects of other people around them. This analysis includes an assessment of the relative importance of personal dispositions as well as the social/environmental context. The distinction between

causal acription in terms of locus of control originates with Heider's (1958) "naive analysis of action". In simple terms this reflects the idea that the result of action is dependent on one of two sets of conditions , factors that reside within the person (personal attribution) or factors residing within the environment (situational attribution). Causal attributions that differ along a personal versus situational dimension are of considerable importance within a psychodiagnostic paradigm: Whether a therapist places the source of a problem within the individual's personality or locates the cause within contexts external to the individual may have a significant bearing, not only on the resultant diagnostic label, but also on the proposed solution to a client's problems (Shenkle, Synder, Batson & Clark, in press). To date there has been no systematic evaluation of how sex role expectation may affect causality attributions of practicing psychotherapists, or whether differential attributions, based on client sex, correspondingly affect diagnosis or treatment goals. However, results from several experiments on the attribution of both locus of causality and degree of maladjustment are relevant to the issue of perceived causality in therapy, and they provide a directional framework for continuing research.

Ickes and Layden (1978) in a success/failure experimental paradigm, demonstrated that the tendency to explain behavioral outcomes as internally or externally caused was sig-

nificantly related to the two variables of sex and self-esteem. Four main findings emerged from this research: (1)internalizing a task failure was a critical factor underlying performance deficits, (2)female performance was significantly more affected by failure than male performance, (3)the disruption of performance after failure was most evident for females internalizing failure and least evident for males externalizing it, and (4)low self-esteem subjects tended to make more internal attributions for failure and high self-esteem subjects tended to make more external attributions for failure; both high and low self-esteem subjects internalized success, but the effect was significantly attenuated for low self-esteem subjects. Feather and Simon (1973) had earlier shown that women demonstrate a self-derogatory tendency by internalizing failure. Other research (Feather, 1969; Stephan, Rosenfield, & Stephan, 1976; Feather &Simon, 1973; McMahan, 1973) had also indicated that subjects who have a lowered expectancy for success, typically females, generally make an internal attribution for failure. On the other hand, subjects who have higher expectations for success, typically males, attribute failure more externally. In this type of comparison, men function in a manner similar to Ickes' and Layden's high self-esteem subjects, and women to low self-esteem subjects. It is interesting to note the similarity between the attributional tendency of women to internalize negative-outcome experience and the attribution-

al style of low self-esteem subjects. The stereotypic portrayal of women has been associated with high anxiety, poor adjustment, and, most importantly, low self-esteem (Sears, 1970; Cosentino & Heilbrun, 1964; Gump, 1972; McKee & Sherriffs, 1957). Future investigation may demonstrate that the attributional style of females entering psychotherapy, where it is not unreasonable to assume that factors of self-esteem are involved, may be represented by a tendency to internalize causality for negative outcome experiences. Some supportive evidence in that direction has recently been reported by Frieze (1978): 50% of a sample of battered women located the cause of their battering as internal to themselves and blamed themselves for their husbands' violence. Sherman, Koufacos, and Kenworthy (1978) directly asked psychotherapists their opinion about the reasons why more females than males were in therapy. Only 1% of the sample felt that women themselves were to blame for their problems; yet, a disturbing 18% agreed that female victims of rape had been seductive and 'invited' their assault, a finding which we may interpret as an internal attribution of causality. Surprisingly, the 18% figure is included among the responses to an Information Scale and is not considered as part of the direct assessment of attributional processes. Snyder, Shenkel, and Schmidt (1976) demonstrated the predicted bias for therapists to make internal attributions of causality in a less direct, analogue situation. In their research, a bogus

female client clearly attributed the cause of her problems to situational factors, yet counselor-observers regarded the problem as personality based. Thus, subjects demonstrated the expected actor-observer differences on perceptions of the causes of behaviors (Jones & Nisbett, 1971), and the authors conclude that role-perspective affected therapists attributions of a client's problems. Unfortunately, there is no check for sex of client effect in this research, and there is no evidence to test the hypothesis that these results do, in fact, indicate effects of role-perspective rather than client sex effects.

The relationship between the locus of causality and perceived degree of maladjustment has also been explored in attributional research. Here again, results have relevance to the psychotherapy issues raised in this research. Shenkle et al. (in press) recently demonstrated that client problems diagnosed as 'personality oriented' were considered significantly more severe than problems receiving a situational diagnosis. Other researchers have similarly demonstrated that the greater the estimated maladjustment, the more likely an observer is to make a person-based attribution and vice-versa (Calhoun, Johnson, & Boardman, 1975; Snyder, 1977; Calhoun, Pierce, & Dawes, 1973). Unfortunately, client sex has not been analyzed for its effect as an independent variable in this research, again pointing for to a direction for research to take. Given the demonstrated

correlation between causality and maladjustment, it should follow that if therapists tend to make more internal attributions for female clients, they would then also attribute greater maladjustment to these same women. Conversely, if female clients are perceived as more maladjusted than male clients, their problems should also then be seen as more personality-based.

Attributions to personality factors or environmental factors may also be related to duration of symptoms, or whether the client has experienced similar problems in the past (i.e., a stability dimension; Weiner, Frieze, Kukla, Reed, Rest & Rosenbaum, 1971). In general, research has shown that there is a positive relationship between the attribution of a problem to internal causes, length of symptom duration (Calhoun, Pierce, & Dawes, 1973), and severity (Johnson, Calhoun, & Boardman, 1975). In accounting for a person's actions by appealing to basic and invariant personality dispositions (i.e., trait-orientation), it is logical that environmental factors will be given less weight in determining the behaviors in question. Whether women's psychiatric problems are directly viewed as more or less stable than men's is yet to be empirically established. Some research which shows that women stay in treatment significantly longer than men (Fabrikant, 1974) suggests that women's problems may be seen by therapists as more chronic in nature, and by implication, more personality based.

It is apparent from a review of the attribution literature, that many aspects of the attribution process may serve as channels through which bias in therapists' perceptions may be conveyed. This research is primarily interested in the manner in which sex, as a major contributing variable, may moderate specific attributions which therapists make and which have been shown to bear directly on ascriptions of mental illness --- namely attributions of causality and stability.

This research addressed itself to two additional concerns: Firstly, it is important for research on therapist bias to be conducted in a naturalistic therapeutic environment. It has been assumed that the implicit value systems which therapists maintain regarding women are, in fact, translated into explicit treatment decisions. Most of the research findings on this issue have been derived from experimental analogues, thus making conclusions about what happens in a genuine therapeutic relationship by definition, largely inferential. Secondly, it is also important to investigate the attributions of causality which clients make in their own estimates of their mental health. Therapy is an interactive process, reflecting not only the attributional perspective of the therapist-observer, but the patient-actor as well. Although attributional analyses of behavior have been previously studied from the perspective of the actor and observer, they have not been systematically assessed

in a clinical context. The existing research has generally demonstrated consistent differences between self-attributions of the actor and other attributions of observers, with actors attributing more causality to situational factors for their behavior and observers attributing more causality to dispositional aspects of the person (Jones & Nisbitt, 1971). Valins and Nisbett (1971) have extended the analysis of causal attributions for one's own behavior to include the specific case where the behavior is an 'emotional disorder'. They contend that emotional problems arise essentially from seeing one's own behavior as personally determined, versus viewing one's behavior as a consequence of the situation. Some research is consistent with this interpretation (Calhoun, Dawes, & Lewis, 1972), yet other studies disconfirm this hypothesis (Karlsruher, Fennson, & Nelson, 1976; Weinstein & Brill, 1971). Effects for sex of client are not analyzed in that research, yet since clients as individuals are affected by the same cultural sex role expectations as therapists, attributional biases relating to role perspective may moderate their behavior as well.

In summary, it seems likely that the problem of sex discrimination by therapists, if it indeed exists, will not manifest itself in overt biases, but will involve more subtle processes in the evaluation of abilities, performances, and other attributes of men and women. How men and women, both as clients and therapists, evaluate the source of psy-

chological problems, as well as severity and prognosis, may serve as an indicator of more subtle stereotypic evaluation. The specific variables with which this study is concerned are sex of client, therapist and client attributions for location and stability of presenting problems and therapy goals, therapists' perceived degree of client maladjustment, and therapist sex role ideology. A statement of the specific hypotheses are outlined in the following section. For a more complete historical review of the literature, the reader is referred to Appendix A,Historical Review of the Literature.

Hypotheses

1. It is hypothesized that female clients will make more internal and stable attributions for their presenting psychological problems than male clients.
2. It is hypothesized that therapists will make more internal and stable attributions for female clients than male clients.
3. It is hypothesized that more traditional therapists will make more internal and stable attributions for female clients than more liberal therapists.
4. It is hypothesized that female clients with high internality and stability ratings will be more maladjusted than: (a) female clients with low internality

and stability scores, and (b) male clients with high internality and stability scores.

5. It is hypothesized that attributions to internal causal factors will be positively correlated with attributions of stability. It is also predicted that client and therapist attributions of internality and stability will be positively correlated.
6. It is hypothesized that therapists will make more internal and stable treatment goals for female than male clients.
7. It is hypothesized that maladjustment will be positively correlated with internality and stability.
8. It is hypothesized that more traditional therapists will make more internal and stable treatment goals than liberal therapists.

METHOD

This research project consisted of two phases: the first phase was the preparation of a procedural manual which served as an instructional guide for the training of raters to code free response attributional data. The second phase consisted of the content analysis and rating of verbatim attributions of clients and therapists concerning perceived causality and stability of presenting psychological problems.

Development of a Coding Scheme of Attributed Causality

The coding scheme of attributed causality was developed as an instructional manual intended to be used by raters for the coding of free-response data generated by asking individuals what they believed to be the reason for their own and others' psychological problems. The coding scheme employed a two-dimensional analysis of causal attributions, namely internality (internal, mutual, and external) and stability (stable and unstable) after the fashion of Weiner et al. (1971). Although similar coding systems have been developed previously (see Elig & Frieze, 1975), they have been specifically intended for classifying causal attributions in achievement and social situations with positive or negative

outcomes (i.e., success/failure paradigm) and they have no direct a priori relevance to open-ended attributions generated in a clinical setting.

The analysis of free response (or open-ended) data is not without problems, but the advantages of this approach, especially in exploratory research with new populations, are thought to outweigh some of the more obvious disadvantages. For instance, most structured formats rely upon limited categories of causal attributions which are presented to subjects in the form of rating scales. This technique inevitably cues subjects by suggesting to them possible causes for their behavior. However, the attributions which subjects make in their everyday lives may bear no relationship to the categories selected by the experimenter. Attributional research deals with the phenomenal (perceptual) experience of the perceiver. As such, it assumes that individuals spontaneously initiate causal attributional processing in their private experience that corresponds to the public attributional assessments which they make in response to experimentally imposed requests for causal analysis (Elig & Frieze, 1975). As Heider (1958) and Kelley (1967) assume, naive and scientific epistomology are similar. Yet if research is to establish meaningful categories which are commonly used by people in variously designated situations, people must be questioned about causality for events without such cueing. Furthermore, rating scales im-

ply that the specified (and finite) causal judgements are the appropriate explanations for behavior, forcing subjects to rate causal categories higher than they ordinarily might in everyday, private attributional formation. Thus, in a new experimental situation, such as a diagnostic intake interview between a client and psychotherapist, categories of causal attribution are expected to differ from those which have a proven applicability to achievement and social situations, (such as luck, effort, or ability) even though attributional dimensions, such as internality and stability, are thought to be consistently relevant across situations (Elig & Frieze, 1975). It was proposed that the dimensions of internality and stability could be used to classify new attributional categories generated through free response techniques by subjects (clients and therapists) in a clinical intake interview situation. The dimension of internality (whether a cause of a psychological problem is due to factors within the person and is thus internal, or outside the person and is thus external, or to an interaction of the person with other persons or with the environment) is felt to be a variable which may have utility and relevance in analyzing therapists' choices of treatment goals and in their assessments of client maladjustment. Likewise, prognostic judgements by therapists or clients or problem perception may be fruitfully explored through an analysis of the dimension of stability (a stable causal factor being relatively

fixed and unchanging, connoting both temporal and spatial extension, and an unstable one having temporal and/or spatial variability).

Subjects

Clients and Therapists

The sample of subjects used in this research included adult (18 years and over) male and female clients who made an initial intake appointment for psychological treatment at the Grace General Hospital Day Patient Unit, Department of Psychiatry and at the Psychological Service Centre (PSC), which is a training facility primarily for clinical psychology graduate students and secondarily for BSW and MSW Social Work students at the University of Manitoba. Clients were undifferentiated on variables such as marital status, educational level, occupation, socioeconomic status, and type of presenting problems, although this data was collected for future reference and analysis.

The subject sample also included adult male and female psychotherapists, both at the graduate student level and at the faculty or professional level at the PSC and Grace Hospital. Therapists were not differentiated according to orientation of therapeutic technique or professional orientation (e.g., psychologist, social worker, or psychiatrist) although, as with clients, this information was referenced for subsequent analysis. Therapist inclusion in the sample

was contingent upon the therapist's active involvement in psychotherapeutic treatment, defined as the therapist carrying at least two current adult cases.

Raters

Four raters, two male and two female, were selected on a volunteer basis from the psychology honors program in the Department of Psychology. Raters were informed that they were to judge the responses of subjects of unspecified sex according to two attributional dimensions, but they were naive as to the purpose of the experiment that related to sex role ideology and sex differences. All four raters participated in the coding and rating of attributional data that was collected for developing the Procedural Manual. Selection of raters was made on the basis of the highest obtained interrater agreement, and only two raters, one male and one female were retained for the analysis of experimental data.

Procedure

Client and Therapist Recruitment and Instructions to Subjects

Each client that was scheduled for an initial interview at the PSC and Grace Hospital was asked to fill out an intake form as standard procedure prior to an interview with a therapist. Clients were informed that their questionnaire responses were to be used for experimental purposes and that

participation in the experiment was on a voluntary basis (see Appendix B for instructions to clients and attributional questionnaire).

Initially, clients were recruited when they presented at the PSC or Day Patient Unit for their intake appointment. Clients were given standard intake forms together with the experimental assessments as a total package by secretarial staff and they were requested to complete all forms before their session with the intake therapists. Completed forms were left with the secretary or mailed to the experimenter. Because response rates from clients at the PSC were low using this procedure, two alternative recruitment methods were adopted halfway through data collection. Forms were mailed to clients who had previously made appointments for intake and clients were requested to mail the forms in provided stamped and addressed envelopes. Since the response rates were equally low with this alternative, clients were again recruited when they presented for intake. This time, the experimental questionnaire from this present research was given to clients independently of the standard intake form, along with the questionnaires used by other researchers also collecting data on clients. It was hoped that this procedure would convey to clients the importance and acceptability of serving in therapy research. The latter procedure remained in effect until termination of the research.

Therapists were approached by the exprimenter and asked to participate on a voluntary basis in a research project concerning therapists' initial perceptions of clients. They were kept naive to the aspect of the experiment dealing with sex role ideology and sex differences. Each therapist was asked to engage in the same type of attributional assessment as the clients themselves. Each therapist received a coded form similar to that used with clients, and was instructed to complete the questionnaire according to instructions (see Appendix B, Instructions to Subjects and Attributional Questionnaires). All assessment forms were coded in order to provide anonymity for the subject and to ensure matching of client and therapist forms. Codes for client subjects contained information about client sex, whereas codes for therapists contained information concerning sex, number of years of experience and professional orientation.

Content Analysis of Attributions for Presenting Problems

All verbatim responses generated through open-ended questioning of clients and therapists was subjected to a content analysis procedure to establish the categories represented by the two attributional dimensions of internality and stability. The questions submitted to subjects provided a minimal cue function which served to focus the client's and therapist's attention on the nature of presenting problems. This type of assessment is similar to that employed in other

attributional research on causality and maladjustment (Snyder, 1977; Langer & Abelson, 1974; Snyder, Shenkil, & Schmidt, 1976).

Content analysis is a research tool that is basically limited to the analysis of manifest content, and it is broadly agreed to be a quantitative procedure characterized by meeting the requirements of objectivity, system, and generality (Holsti, 1969). Objectivity stipulates that each step in the process is to be carried out on the basis of rules and procedures. This requires that the experimenter use his or her judgement in making decisions about the data. The initial judgement in this research involved what categories to use, and how categories were to be distinguished from one another.

Approximately 20% of the data collected from subjects was used to develop the procedural rules for determining the categories. This required that the experimenter familiarize herself with all of the data to look for commonalities in subject communications, and to determine how to categorize the presence of shared attributes within the experimental documents.

Content attributes of the data appeared to be differentiated by two qualitative types of categories, targets and the elaborations of targets. A target was characterized as a single theme or assertion about the reason for the presenting psychological problem, or the major goal of a treatment

plan, whereby an elaboration was characterized as any material which further expanded the definition of the target (targets themselves were not further categorized as this was not relevant to the hypotheses of the research. See Appendix D, Procedural Manual for Content Analysis for a more comprehensive definition of targets and elaborations). Thus, working from the basic descriptive categorization, rules and procedures were developed in conjunction with the raters for specifying targets and elaborations. The continuing process of refining the decision-making rules and monitoring changes in inter-rater reliability was one test of objectivity, i.e., could the raters, following the identical procedures with the same data arrive at similar conclusions. Reliability checks were conducted on the raters after all four raters had analysed 10 subject forms. If inter-rater agreement was low (see Method, Reliability), rules were further clarified and the process was then repeated. Inter-coder agreement is described in detail in Results, and the reader is referred to this section.

The content analysis procedure was also systematic, which simply means that inclusion or exclusion of content or categories was done according to consistently applied rules. In other words, categories (again targets and elaborations) had to conform to specific rules of category construction with application to increasing amounts of new data. All of the rules and procedures for categorizing data are contained

in full detail in Appendix B, Procedural Manual for Content Analysis, and this manual is the end-product of the training process for analysing manifest content of subjects attributions for presenting problems.

Prior to the experimental rating of the subjects' responses for location and stability, which was the primary content analysis task, the two final raters, together with the experimenter, unitized all of the verbatim responses according to the rules for unitizing outlined in the manual; these units formed the core data for the attributional assessment. The procedure was to use consensus agreement among raters (2 out of 3 judges) to obtain the final thematic units. As a rule, the experimenter never cast the final vote. This technique which ultimately placed the weight for the ultimate decision on the judges. It was felt that this was a more realistic test of the reliability of the procedural rules, since the experimenter was primarily responsible for the manual development and was more skilled in its use. In some sense, this technique functioned as an additional measure of the objectivity of the categorization rules.

Along with the general opinion that objectivity and system are two of the defining characteristics of content analysis, another requirement for the definition of the content analysis was that it also be quantitative: Thus, once attributional themes were systematically categorized and agreed upon by raters, and category reliability was estab-

lished, the raters quantified the attributions using two bi-polar scales (a 7-point scale for location and a 5-point scale for stability) which indicated the extent to which each thematic unit represented both an internal and stable dimension. The scales are represented as follows: (a) Location.

+3	+2	+1	0	-1	-2	-3
highly internal	moderately internal	slightly internal	mutual	slightly external	moderately external	highly external

(b) Stability

+2	+1	0	-1	-2
highly stable	moderately stable	ambiguous	moderately unstable	highly unstable

The sum of the ratings indicates which pole is represented. For the location scale, a positive rating indicates internality and a negative rating indicates externality with the numerical value representing degree or intensity. If the sum of the ratings is zero, this indicates that the factor is mutual or intermediate, representing an interaction between internal and external factors. For the stability scale, a positive rating indicates stability and a negative one that the factor is perceived as unstable with numerical value again representing intensity. With this scale it should be noted that if the sum of the ratings is zero, the factor will not be taken into consideration since ambiguous responses are essentially non-representative of stability.

Raters were allowed to use scale half points (for example, +2.5, +1.5) if they were unable to make a decision

about an intensity rating and they felt this choice best characterized an attribution. However they were not encouraged to use this procedure. The rules for defining these dimensions are also outlined in detail in Appendix D.

The procedure followed for the quantification of the content analysis consisted of having the four raters apply the procedural rules to the unitized (or categorized) data to establish direction and intensity of both location and stability. Inter-rater agreements were calculated following the analysis of every ten or so data forms, and if inter-rater reliability was low, the rules were revised until satisfactory agreement was obtained (see Reliability and Results).

Reliability

Two measures of reliability were obtained: Inter-rater agreement was computed using Scott's pi as an index of reliability which corrects for inter-rater agreement by chance alone (Holsti, 1969). The average inter-judge reliability was expected to be .65 or above (Eliq & Frieze, 1975; Holsti, 1969). What would consistute an acceptable level of category reliability is a difficult question for which there is no simple solution. Although high levels of reliability can be achieved, with more complex categorical tasks results may be less reliable but more useful.

Scott's pi is computed as follows: pi = % observed, agreement - % expected agreement/1 - % expected agreement. Percentage observed agreement is represented as a ratio of coding agreements to the number of coding decisions. The coefficient of reliability is computed as follows:

C.R. =2M/N1 +N2

where M = the number of coding decisions on which two judges are in agreement with N1, N2 refer to the number of coding decisions made by judges 1 and 2 respectively. Percentage expected agreement is computed by finding the proportion of items falling into each category of a set, and summing the square of those proportions.

A composite reliability coefficient was also computed using the following formula (Holsti, 1969): composite reliability = N (Average inter-judge agreement)/1 + [(N-1) (average inter-judge agreement)].

Of the three coding tasks, location (internality/externality) is probably the easiest to master, and the inter-rater reliability was expected to be substantially higher than that for categories. Raters were expected to demonstrate a reliability of .80 or higher for location, and for stability as well, although greater ambiguity was anticipated in the coding of the stability dimension. Elig and Frieze(1976), report an average reliability agreement of .94 for location and .82 for stability.

Therapist Assessment: Maladjustment and Sex-Role Attitude

In addition to completing the attributional assessments, the therapists were also required to answer another question on the experimental form relating to perceived degree of client maladjustment. This question was presented in the following fashion:

> 1. We would like you to evaluate the client in terms of psychological well-being. How adjusted would you estimate the client to be? Please circle tha appropriate scale value.

1 2 3 4 5 6 7 8 9

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very disturbed — very well adjusted

When all of the data on the therapists' attributional evaluations of clients was collected, the therapists were asked to complete the Attitudes toward Women Scale (AWS) (Spence & Helmreich, 1972) and the Sex Role Ideology Scale (SRIS) (Kalin & Tilby, 1978) (see Appendix C, Measures of Sex Role Ideology). The AWS is a scale of 55 declarative statements for which there are 4 response alternatives ranging from Agree Strongly to Disagree Strongly. Items vary in terms of whether they reflect a conservative or liberal attitude toward the roles of women. Each item is scored from 0-3, with 0 representing the most traditional or conservative attitude and 3 representing the most liberal or profeminist attitude. The score is obtained by summing the val-

ues of the individual items and the scores can range from 0-165. According to content, the scale is grouped into 6 divisions: (i) vocational, educational, and intellectual, (ii) freedom, independence, (iii) dating, courtship, and etiquette, (iv) drinking, swearing, and dirty jokes, (v) sexual behavior, and (vi) marital relationships and obligations.

Normative data for the AWS was collected on introductory psychology students at the University of Texas at Austin in 1972 and 1973. Grouped frequency distributions for males and females indicate a positive skew toward the liberal end of the scale. The mean score for males is significantly lower ($p<.001$) (i.e., more traditional) than that for women. The scale was validated at the level of individual items, that is, means for men and women were compared on individual items with t-tests; significant differences ($p<.05$) were found between men and women on 47 items. A "known groups" procedure was not employed in item selection and in the original validation of the total score. The scale has been subsequently validated by showing its construct validity.

The SRIS is a 30 item scale designed to measure sex role beliefs about the behaviors considered appropriate for men and women. The items are presented as declarative statements to which subjects indicate agreement or disagreement on a 7-point scale. Items are varied in terms of traditional or liberal content, and total scores are obtained by rev-

ersing ratings on items specified as traditional and summing the scores. Scores range from 0-210 with higher scores representing more liberal beliefs. Items cover 5 content areas: (i) work roles of men and women, (ii) parental responsibilities, (iii) relationships between the sexes, (iv) special roles of women, and (v) motherhood, abortion, and homosexuality.

The criterion group for the SRIS was a female sample of profeminists from a Canadian Women's centre, a student sample of males and females, and a traditional sample from various women's organizations. Concurrent validity was established with a known groups procedure at the level of item selection. The split-half reliability of the test ranges from .57-.91, and test-retest reliability is .87.

Both the AWS and SRIS were presented to therapists as part of another experimenter's research on sex role attitudes. This procedure was adopted to prevent the therapists from becoming aware of the true purpose of the present research and possibly biasing their responses as a result.

The generality of the content analysis was assessed by establishing the theoretical relevance of the procedure. In essence, this is a judgemental process as well and consists of the analysis and interpretation of experimental findings. The following sections of Results and Discussion deal with the theoretical importance of the content analysis of attributional data.

RESULTS

This chapter will begin with a review of data relevant to the content analysis, including a discussion of the computational procedures for determining inter-rater agreement. This will be followed by a description of the sample, and will cover statistics related to a breakdown of subjects by sex, a review of subjects' response rates to the attributional questionnaire and sex role attitude scales, and frequency distributions of location and stability scores made by the two raters. A statistical summary of therapist responses to the AWS and SRIS will also be presented. The concluding section of this chapter contains the statistical analyses of the main hypotheses. Results from two additional analyses, a canonical correlation and a step-wise multiple regression will also be reported.

Content Analysis

Computation of inter-rater agreement

The measure of agreement between raters was calculated using an index of reliability (pi) developed by Scott (1955). Scott's pi was originally devised for coding content analysis data into nominal categories, but it's applicability with ordinal, interval, and ratio scales subesquently has

been demonstrated (Holsti, 1969). Scott's pi is computed as follows: pi = (% observed agreement - % expected agreement)/1-% expected agreement The percent observed agreement was calculated using the coefficient of reliability (CR) (Holsti, 1969) which is expressed as

Cr = 2M/N1+N2

where M=the number of coding decisions on which two judges are in agreement and N1 and N2 are the number of coding decisions made by judges 1 and 2 respectively.[1]

Inter-rater reliability for unitizing open-ended responses

The first content analysis task performed by the two judges consisted of unitizing the open-ended attributional responses from clients and therapists. Five separate coefficients of reliability plus an average CR for all data was computed. This analysis provided an assessment of the reliability of the Procedural Manual for the unitizing of open-ended data. The average CR for unitizing was .80, which is similar to the degree of association reported by Elig and Frieze (1975). This is an acceptable level of reliability given the complexity of categories and the units of analysis in this coding task. The average CR of .80 suggests that

---

[1] The coefficient of reliability, although widely used as a computational index of inter-rater reliability, does not take into account the extent of agreement between raters which may result simply from chance(Bennett, Alpert, and Goldstein, 1954). Scott's pi is a more preferable index since it both corrects for the number of categories and adjusts for the probable frequency with which each category is used.

procedural rules are both reliable and useful.

Inter-rater reliability for scoring Location and Stability

Measures of agreement (CR and Scott's pi) for location and stability were calculated five separate times over a total number of 484 coding decisions made by each judge for each of the attributional dimensions; an average index of agreement was also computed for each attributional dimension. According to this procedure Scott's pi for location and stability ratings was .67 and .70 respectively. The average coefficient of reliability for location was .72 and .84 for stability. These results are again similar to those reported by Elig and Frieze (1975). Moreover, since Scott's pi is such a conservative measure, the Scott's pi measures of inter-rater agreement indicate a more than satisfactory reliability of the Procedural Manual for the scoring of clinical attributional data.

Description of the Sample

A total of 47 clinicians from the Psychological Service Centre, University of Manitoba, Department of Psychology, Grace General Hospital, Department of Psychology, and Health Sciences Centre, Department of Psychiatry, were originally recruited as subjects. From this sample, a total of 20 subjects (42.6%), 13 males and 7 females, returned completed attribution questionnaires. Since several therapists com-

pleted assessments on more than one client, the final sample of data collected from therapist subjects consisted of 30 attribution questionnaires. Thirty-four client questionnaires were collected , 17 from female clients, 7 from male clients, and 10 from clients whose sex was not obtainable from the assessment forms. Thus, the client sample consisted of 24 usable questionnaires. Whether the low frequency of male subjects in this study represents a true sex difference in response rate is ambiguous, but the proportion of male to female clients in this study is comparable to proportions reported in other investigations (Chesler, 1971; Gove & Tudor, 1973, 1977; Gove, 1980).

Responses to open-ended questionnaires

The attributional ratings for location and stability from each subject's form were summed over thematic units and averaged across judges;each response questionnaire was thus represented by two numerical values, an average location score and an average stability score. For therapist responses an average location and stability score was independently computed for presenting problems (causality data) and treatment goal responses. Table 1 indicates the mean location and stability values for client and therapist subjects, together with standard deviations.

Figures 1 and 2 illustrate the frequency distributions of location and stability scores respectively for combined

TABLE 1

Location and Stability Mean Scores for Clients & Therapists

		Presenting Problem			Treatment Goals	
Group	n	Location	Stability	n	Location	Stability
Clients						
Males	7	1.09(1.74)	.77(0.87)			
Females	17	0.39(1.76)	.17(0.64)			
Therapists						
Males	13	1.10(1.47)	.44(1.00)	13	1.65(.99)	.14(.29)
Females	17	0.81(1.28)	.50(0.81)	16	1.63(.61)	.09(.43)

a) Numbers in parentheses indicate standard deviations

client and therapist data, undifferentiated by sex of subject. These distributions represent the number of times both judges placed a thematic unit into a specific subcategory along both location and stability scales.

The Location ratings indicate that internal attributions (categories ranging from +3 to +.5) accounted for 56.4% of all ratings. A much lower proportion (25.28%) of clients' and therapists' attributions were judged as external (categories ranging from -.5 to -3), whereas only 9.29% of attributions were seen as mutual in nature. As with the stability ratings, 9.1% of the responses were judged uncodable by the raters.

Looking next at the stability dimension, stable attributions (including categories that range from +2 to +.5) accounted for 32.43% of all ratings (N=484), and 14.27% of stability ratings were accounted for by unstable attributions (categories ranging from -.5 to -2). By far the majority of ratings on this dimension were made using the uncertain category, which alone accounted for 44.21% of the judges' ratings. About 9% (9.1%) of the ratings fell into the uncodable category.

Therapist Responses to AWS and SRIS

Attitudes Toward Women Scale.

The AWS is a 55 item scale with possible scores ranging from 0 to 165, with a higher score representing a more lib-

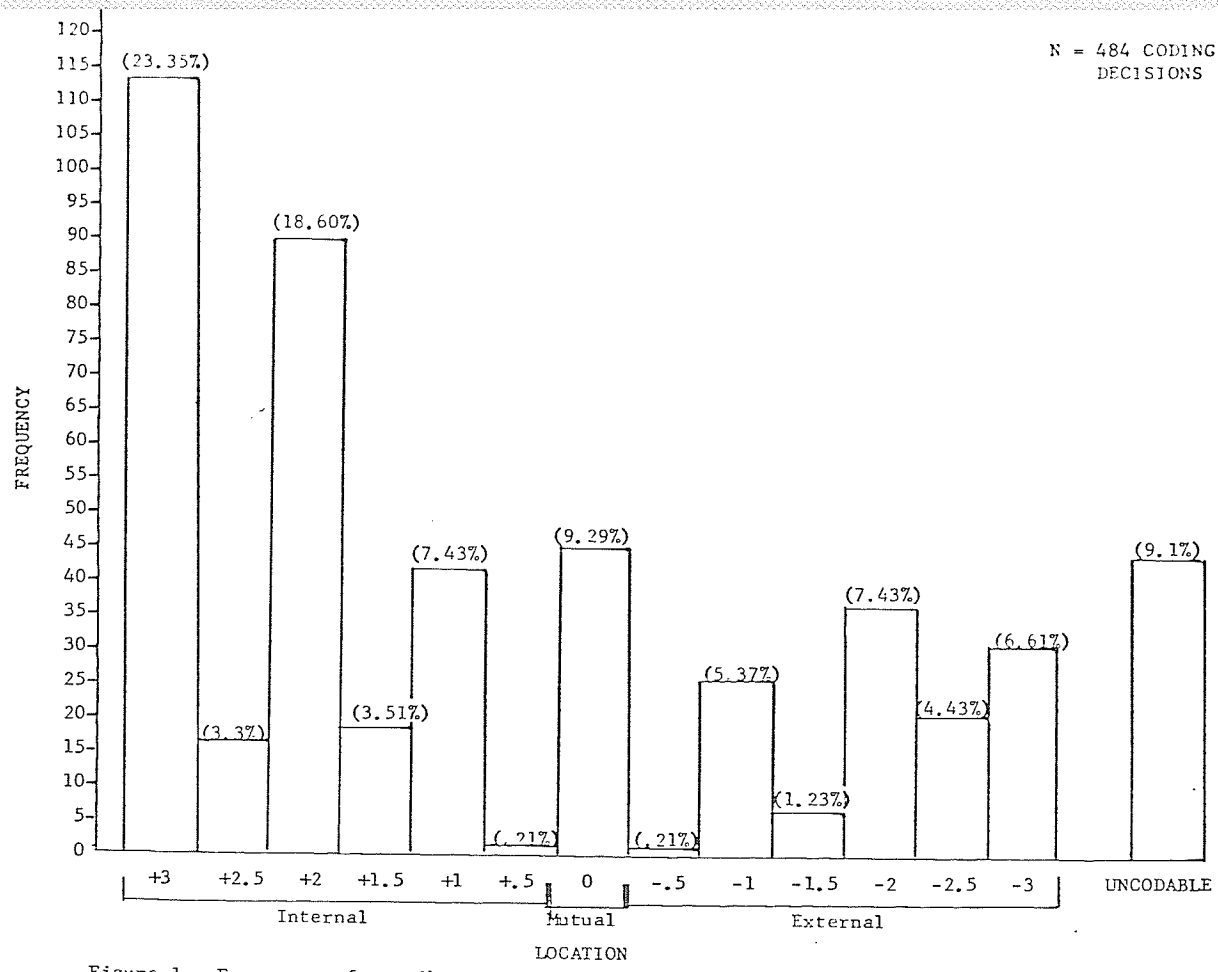

Figure 1. Frequency of attributional ratings for subcategories of the Location scale made by judges for client and therapist responses to open-ended questionnaires.

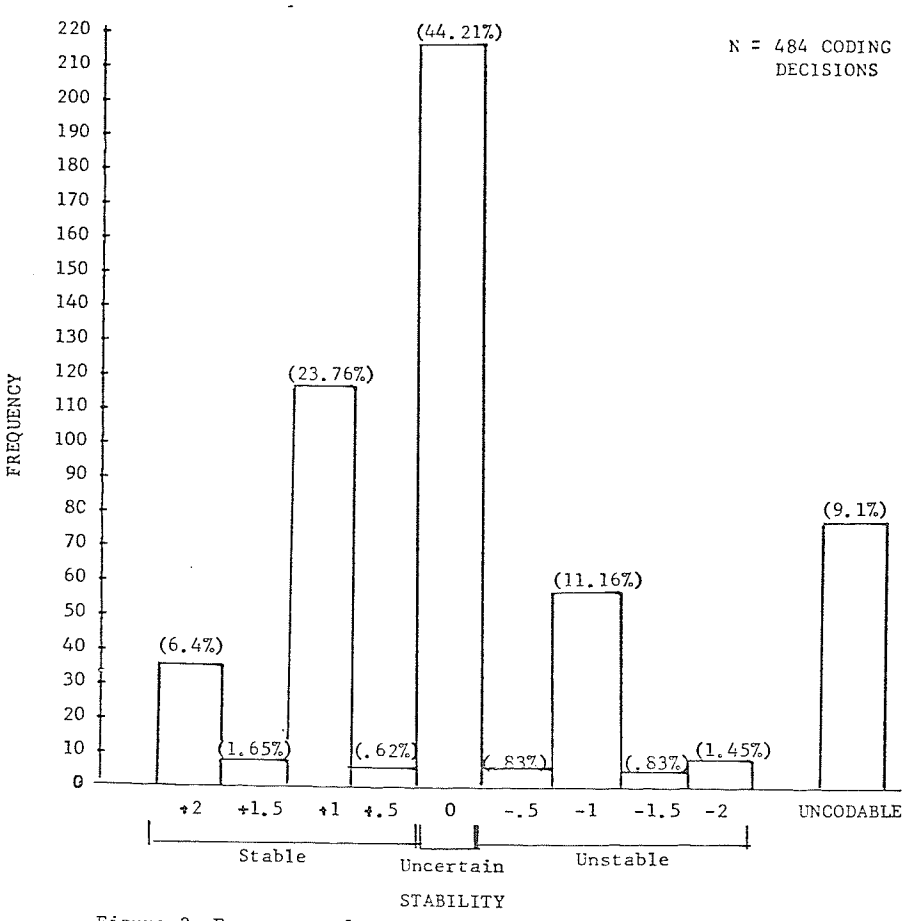

Figure 2. Frequency of attributional ratings for sub-categories of the stability scale made by judges for client and therapist responses to open-ended questionnaires.

eral or profeminist attitude. The AWS was sent to all recruited therapist subjects and the return rate was 31.9% (15 respondents out of 47 recruited). Based on therapists who actually served as subjects, the return rate was 83.3% (15 completed questionnaires from a total of 18 therapist subjects). The actual obtained scores for males and females ranged from 159-133, which suggested that this sample of therapists were highly liberal in their attitudes towards women.

The normative sample for the AWS consisted of Introductory Psychology students at the University of Texas at Austin (1971 and 1972) and their parents. The grouped frequency distributions for the combined sample of men and women students exhibited a slight positive skew towards the liberal end of the scale. The combined mean for males was 89.26 and the range was 37-155; for females the combined mean was 98.21, with a range of 35-161. Fathers and mothers tended to be more conservative in their attitudes, with fathers having a mean score of 81.36 (range =38-140), and mothers having a mean score of 86.50 (range = 28-143). In comparison to the normative sample, therapists in this study are more liberal in their attitudes, and display both a higher mean score and a higher and more restricted range. This may reflect a change in attitude towards women over the last decade, or a response bias in the current sample.

For purposes of statistical analysis, the sample was divided into two groups of therapists using a median-split technique (median=144.667; mean=144.043; standard deviation=9.651). On this basis, therapists were considered to be either Liberal or Traditional, although it is important to recognize that the Traditional group consisted of therapists who were only somewhat less profeminist relative to therapists in the Liberal group.

Sex Role Ideology Scale.

The SRIS is a 30 item questionnaire having a range of possible scores from 30 to 210 with higher scores representing more liberal sex role beliefs. The normative sample for the SRIS consisted of feminist women (drawn from Canadian womwn's liberation organizations), male and female university students, and traditional women from various church and recreational organizations. Although therapists in the present sample have a lower mean and greater range than the feminist criterion group (mean = 197.72; range = 169-210), they are more liberal than both the student sample (mean = 138.08; range = 78-195) and the traditional group (mean = 89.79; range = 62-119).

Again using a median-split technique, male and female therapists were divided into 2 groups of Liberal or Traditional subjects (median=160.250; mean=169.48; standard deviation=20.248). Actual obtained scores ranged from 144 to 205, again confirming that this sample of therapists was liberal in its attitude about woman's sex roles.

The Pearsons correlation between the AWS and SRIS was .81, indicating a strong degree of association between these two measures.

Statistical analysis

Analysis of Client Attributes.

Hypothesis 1 (female clients will make more internal and stable attributions for presenting problems than male clients) was tested using a t-test to analyze mean location and stability scores for client subjects; no significant differences were found between males and females on attributions of location ($t(24) = .89$, df=22, 1-tailed probability) and both sexes perceived their problems to be caused by internal factors; although not significant, male clients tended to see their problems as somewhat more internal than female clients. A test of the directional hypothesis on stability scores with a one-tailed alpha level was non-significant; means were in the opposite direction to prediction. There was, however, a tendency with a non-directional t-test for males to have higher stability scores than females ($t(24)=1.87$, df=22, 2- tailed probability=.075).

It had also been predicted (Hypoyhesis 5) that location and stability attributions would be positively associated with one another; thus we would expect a high degree of concordance between location and stability attributions for both direction and intensity.This prediction was not con-

firmed. The Pearson correlation of .12 (p=.285) (N=30) indicated that basically no relationship existed between these two measures of attribution. Thus a client who perceived a problem as being caused by highly internal factors was just as likely to see the problem as stable or unstable in nature.

Analysis of Therapist Attributions.

It was also predicted that both male and female therapists would make more internal and stable attributions for female versus male clients (Hypothesis 2). Contrary to prediction the t-test analysis indicated that therapists did not make significantly different attributions on either dimension for males and females (for Location, $t(30)=.58, df=28, p=.284$, one-tailed; for stability, $t(30)=-.17, df=28, p=.433$, one-tailed). Therapists were no more likely to perceive female clients' problems as caused by internal factors than male clients' problems, nor were they any more likely to perceive women's problems as being more stable than men's problems. Both male and female clients' problems were seen by therapists as internally located, and as being somewhat stable in nature.

When therapists made attributions about causality, regardless of client sex, results showed that their judgements of location and stability were significantly correlated; a Pearsons correlation coefficient (N=30) of .32 (p=.041) indicated a moderate and positive degree of association be-

tween location and stability. In other words, therapists who judged clients' presenting problems as being caused by internal factors also tended to judge those problems as being more stable in nature. A test for differences between independent correlations (Bruning & Kintz, 1977) indicated that the correlations between location and stability for clients and therapists were not significantly different ($z=-.723, SE=.292, ns$). Although each independent correlation seems to indicate that clients and therapists have differing perceptions of the relationship between location and stability, the r to z transformation indicated that both groups make similar correlated attributions. There was no significant correlation between location and stability for treatment goals ($r(29)=.12$, $p=.267$).

It was also predicted (Hypothesis 5) that therapist and client attributions for locus of causality and perceived stability of presenting problem would be positively correlated with each other. This prediction was only partially confirmed. Results indicated that client and therapist locus of causality attributions for the same presenting problem were significantly correlated ($r(8)=.65, p=.041$). Thus, both clients and therapists showed a moderately high degree of concordance on the dimension of location;for those cases where client and therapist data could be matched, it appeared that if a client made a high internal attribution, then the therapist who interviewed that client also saw that client's problems as caused by highly internal factors.

The relationship between therapist and client perceptions of stability showed a similar, but not significant, degree of association. The Pearsons correlation coefficient between client and therapist stability scores on the same presenting problem was .55 (p=.080) (N=8).

Therapist Attributions and Sex Role Ideology.

When we look at how therapists' sex role attitude interacts with their attributions for male and female clients' problems, a different picture from the therapist attribution data only emerges. It was originally hypothesized that therapists defined as traditional, using the AWS and SRIS, would be more extreme (i.e. high internal and high stable) in their attributional ratings of location and stability for female clients than their more liberal counterparts (Hypothesis 3). Four 2 (therapist sex role ideology) by 2 (client sex) analyses of variance (AWS and SRIS scores are analyzed separately) were conducted on location and stability to test the above hypothesis. Summary tables of these analyses are presented in Tables 2 and 3.

Using the AWS scores, the ANOVA indicated a main effect for therapist sex role attitude on location attributions. traditional therapists made more highly internal attributions than more liberal therapists (est w2 =.33) (See Table 4 for means and standard deviations for Location scores on the basis of therapist attitude and client sex.)

TABLE 2

Sex Role Attitude(AWS) by Client Sex ANOVA on Location & Stability

Source	SS	df	MS	F	p
Location Scores					
Therapist Sex Role Attitude (SR)	10.37	1	10.37	15.30	.001
Client Sex (CS)	3.77	1	3.77	5.54	.030
SR x CS	.00	1	.00	.00	.967
Error	12.91	19	.68		
Stability Scores					
Therapist Sex Role Attitude (SR)	2.81	1	2.81	3.54	.075
Client Sex (CS)	.02	1	.02	.03	.875
SR x CS	.28	1	.28	.35	.563
Error	15.05	19	.80		

a) N=23.

TABLE 3

Sex Role Attitude(SRIS) x Client Sex ANOVA on Location & Stability

Source	SS	df	MS	F	p
Location Scores					
Therapist Sex Role Attitude (SR)	6.46	1	6.46	7.42	.013
Client Sex (CS)	2.58	1	2.58	2.96	.102
SR x CS	.31	1	.31	.36	.558
Error	16.54	19	.87		
Stability Scores					
Therapist Sex Role Attitude (SR)	2.70	1	2.70	3.40	.081
Client Sex (CS)	.01	1	.01	.01	.923
SR x CS	.30	1	.30	.38	.547
Error	15.13	19	.80		

a) N=23.

TABLE 4

Location & Stability Means by Sex Role Attitude and Client Sex

Group	Therapist Sex Role Attitude: AWS Traditional	Liberal
Male Clients		
Location	2.08(0.69)	0.67(1.02)
Stability	0.99(0.88)	-0.03(1.06)
Female Clients		
Location	1.23(0.95)	-.14(0.66)
Stability	0.75(0.64)	0.21(1.10)

Group	Therapist Sex Role Attitude: SRIS Traditional	Liberal
Male Clients		
Location	2.08(0.69)	0.67(1.02)
Stability	0.99(0.88)	-0.03(1.06)
Female Clients		
Location	1.16(1.10)	0.26(0.94)
Stability	0.82(0.72)	0.29(0.96)

a) Numbers in parentheses indicate standard deviations

There was also a main effect for client sex, indicating that liberal and traditional therapists combined (N=23) made significantly different location attributions for male and female clients (est w2=.11) with males receiving more highly internal attributions than females. Once again, this finding was opposite in direction to the hypothesized outcome. No significant interaction effects were found. The analysis of variance on stability scores yielded no significant results (see Table 4 for means and standard deviations) although the effect of therapist sex role attitude on stability approached significance. A more powerful one-tailed t-test (t(23)=1.98,df=21,p=.03) indicated that more traditional therapists saw clients problems as significantly more stable in nature than liberal therapists.

A second analysis of variance on location and stability, this time using the SRIS scores to define sex role attitude, indicated only one significant effect, which was that traditional and liberal therapists (N=27) made significantly different location attributions. Results showed that traditional therapists judged clients' problems to be significantly more internal in nature than liberal therapists (est w2=.2926) (see Table 4 for means and standard deviations of location and stability scores for the SRIS). The main effect for client sex, and the the interaction effect on location scores were non-significant. The analysis of variance on stability scores showed that the main effect for client sex

and the interaction effect of client sex and therapist attitude to be non-significant. The effect of therapist sex role attitude is marginal.

Client Maladjustment and Therapist Attributions.

Several hypotheses were also formulated concerning the relationship between therapist ratings of the degree of client maladjustment and their corresponding attributions of location and stability. It was specifically predicted (Hypothesis 4) that female clients whose problems were seen as highly internal and stable would also be rated as more maladjusted than (a) female clients with low internality and stability scores, and (b) male clients with high internality and stability scores. These hypotheses were tested using a Pearson correlation coefficient analysis and a t-test analysis.

For the within-females analysis, Pearsons correlations were computed on causality data and on treatment goal data. Results indicated that there is a significant correlation between maladjustment scores and stability ratings ($r=-.57, p=.009, N=16$) for presenting problems. Thus therapists who judge female clients to be high on maladjustment also judge those same clients' problems to be low, that is, as more unstable, on the stability dimension. When r2 is computed, we find that 32% of the variance of maladjustment was accounted for by the stability ratings. All other correlations are non-significant ($r=-.12$ between maladjustment

and location on presenting problems; r=-.04 between maladjustment and location on treatment goals; r=.04 between maladjustment and stability for treatment goals).

In order to test the between group means on maladjustment scores, female and male clients were divided into high and low location and stability groups using a median-split technique. (i.e. the median score for internality and stability was computed and both males and females were divided into high and low groups on the basis of the same median score). Thus for treatment goals and presenting problem (causality) data, t-tests were conducted to compare maladjustment ratings for females high on internality and stability and males high on internality and stability. For both treatment goals and causality data there were no significant differences between ratings of maladjustment which therapists assigned to male and female clients who were high on internality and stability (t(10) =.83,df=8,p=.2165, one-tailed test and t(10) =1.39,df =8,p=.101, one-tailed test respectively). This was not an unexpected finding, since a t-test analysis on the maladjustment scores for all male and female clients also showed no significant differences between groups (t(30) =.24,df=28,p=.407, one-tailed

With a larger sample size, it is possible that significant differences may have been obtained for therapists' ratings of maladjustment for male and female clients high on internality. Since results showed no difference between

males and females on maladjustment scores, however, this may be unlikely.

Analysis of Treatment Goal Attributions.

Several predictions from this study were specifically related to how treatment goal attributions were affected by such variables as therapist sex role ideology, perception of maladjustment, and client sex. It was hypothesized that therapists would make more internal and more stable treatment goals for female clients than for male clients (Hypothesis 6). This hypothesis was analyzed using a t-test and was not supported on the basis of these results. No significant differences were found between therapists' attributions of location ($t(29) = .01, df, 27, p = .4725$, one-tailed test) for males and females, or stability ($t(29) = .37, df = 27, p = .358$). Treatment goals for both males and females were directed at changing factors seen as moderately internal in location and as slightly stable on the stability dimension. The means for males and females on both dimensions were essentially identical (see Table 5) which indicates that therapists did not make differential attributions for location and stability on the basis of client sex.

It was also hypothesized that maladjustment would be positively correlated with internality and stability for treatment goals (Hypothesis 7). On the basis of an analysis using the Pearsons correlation coefficient this hypothesis failed to be supported ($r(29) = .23, p = .114$ for internality and $r(29) = -.07, p = .358$ for stability).

TABLE 5

Mean location and stability scores for treatment goals

Group	n	Location	Stability
Clients			
Males	13	1.65(1.00)	0.14(.029)
Females	13	1.63(0.61)	0.09(0.43)

a) Numbers in parentheses indicate standard deviations

Thus judgement of degree of client maladjustment was not significantly related to therapists attributions of internality and stability of treatment goals.

The effect of therapist sex role attitude on treatment goal attributions was analyzed using a t-test with separate analyses conducted on the AWS and SRIS. With both measures of sex role ideology the only significant difference between traditional and liberal therapists concerned the location attributions. Therapists defined as traditional on either measure made significantly more internal attributions for treatment goals than the more liberal therapists ($t(22) = 2.22, df=20, p=.019$, one-tailed test for the AWS, and $t(22)=1.94, df=20, p=.033$, one-tailed test for the SRIS). According to both attitudinal measures, traditional and liberal therapists did not make significantly different stability attributions for treatment goals ($t(22) = .24, df=20, p=.408$, one-tailed test for AWS, and $t(22).56$, $df=20, p=.291$, one-tailed test for SRIS) (see Table 6).

Canonical Correlation and Step-wise Multiple Regression.

A final data analyses consisted of a canonical correlation and a multiple regression. The purpose of this analysis was to include all variables under consideration (location, stability, AWS, SRIS, and client sex) into a single correlation equation and to determine the importance or weight of each variable.

TABLE 6

Mean location and stability scores for AWS and SRIS

Group	n	Location	Stability
AWS			
Traditional	13	1.97(.59)**	0.17(.38)
Liberal	9	1.40(.62)**	0.13(.44)
SRIS			
Traditional	11	1.99(.62)*	0.20(.40)
Liberal	11	1.49(.61)	0.11(.40)

a) Numbers in parentheses indicate standard deviations
b) * p=.05; ** p=.025

The CANCOR was used to determine the degree of relationship between attributional dimensions (location and stability) with AWS scores, SRIS scores, and sex of client (N=23).. Table 7 presents the results of this analysis.

Inspection of this table shows that the canonical correlation was .76 (df=6, p<.01 between location and stability and AWS, SRIS, and client sex. This statistically significant result indicates a moderately high degree of relationship between the two sets of variables; thus AWS, SRIS, and location accounted for approximately 58% of the variance found in attributional rating results.

Inspection of the coefficients for canonical variates of set 1 also indicates that location was given the highest weight (.947) and stability the lowest (.164). The highest weight given a Canonical variable of set 2 was the AWS score (-.527), followed by client sex(.464), and SRIS (-.357).

In order to determine whether all of the 3 variables, AWS, SRIS, and client sex were necessary in terms of providing information about location and stability, 2 Step-wise multiple regression analyses were performed. These explored the relationship between each attributional dimension (first location and then stability) and the AWS, SRIS, and client sex. The Step-wise regression refers to the fact that a multivariate analysis relates all variables by entering into the analysis the set 2 variables (AWS, SRIS, and client sex) one step at a time in single steps from the most to the

TABLE 7

Results of the Canonical Correlation

Number	Eigenvalue	Canonical Correlation	Wilk's Lambda	Chi-Square	df	p
1	.57670	.75941	.3627	19.269	6	.004
2	.14314	.37834	.8569	2.935	2	.230

Coefficient for Canonical Variables of Attributional Dimensions(Set1)

Location	.94737
Stability	.16422

Coefficient for Canonical Variables AWS, SRIS,and Client Sex(Set 2)

AWS	-.52669
SRIS	-.35689
Client Sex	.46468

least important variable according to whether these variables meet certain statistical criteria. Results of the Step-wise multiple regression analysis for location are presented in Table 8 .

Table 8 presents the 3 variables in order of their relationship to the dependent variable, location. Because the step-wise multiple regression explains only unique variance contributed by each independent variable, it appears as though the SRIS contributes relatively little as a predictor variable, given the AWS scores and client sex. Within this context, it should be recalled that the SRIS and AWS are highly multicollinear, and because of the shared variance, the SRIS was entered last. It is likely, however, that the SRIS and AWS are both good predictors of location, but because of the high degree of correlation between these two measures, only one need be used as a predictor variable. Because of the relatively small number of subjects, there may be some question concerning the robustness of the F-test. Although the F will be more robust with larger Ns, the degrees of freedom approach 30, indicating that the F-test is relatively robust, and that it is likely conservative. Based on the results indicated in this table, it can be seen that when all variables were considered, the degree of relationship was .75 which indicated that the regression was statistically significant. An inspection of the increase in Multiple R suggests that all 3 variables may add signifi-

TABLE 8

Multiple Regression (R) Summary Table for Location

Variable Entered	Multiple R	R2	R2 Change	F	df
AWS	.64546	.41662	.41662	14.997	1,21
Client Sex	.74581	.55623	.13962	12.534	2,20
SRIS	.75213	.56570	.00946	8.250	3.19

cantly to the relationship. In order to confirm this another F was calculated using the procedure described by Kerlinger and Pedhazur (1973, p.71). This additional analysis was conducted to test the statistical significance of the variables entered into the regression equation.

Whether the addition of client sex added significantly to the regression was tested using the above procedure. Results indicated that the addition of variable 2, client sex, significantly increased the accuracy of prediction ($F=6.98$, $df=1$ and 20, $p<.01$). However, the addition of variable 3, SRIS, did not add anything significant to the regression ($F=.39249$, $df= 1$ and 18).

Table 9 presents the results of the step-wise multiple regression analysis for stability. The 3 variables were entered in order of importance beginning with SRIS, followed by AWS, and ending with client sex. Because SRIS was entered as the first step in the analysis, the results from Table 9 indicate that SRIS was a significant variable ($F=4.37$, $df=1$ and 21, $p=.05$). However, results of this analysis indicated that when all of the variables were considered, the degree of relationship was .46 ($F=1.68867$, $df=3$ and 19) which was not significant. (see Table 9).

TABLE 9

Multiple Regression(R) Summary Table for Stability

Variable Entered	Multiple R	R2	Change in R2	F	df
SRIS	.41491	.17215	.17215	4.367	1,21
AWS	.45809	.20984	.03770	2.656	2,20
Client Sex	.45881	.21050	.00066	1.689	3,19

Summary

This chapter reviewed the computation of inter-rater agreement, descriptive statistics of the sample, the distribution of location and stability scores, and therapist responses to the AWS and SRIS. Statistical analyes and results of the main hypotheses were reported. The main findings of this study were as follows:

Client Attributions of Presenting Problems. There were no significant differences between male and female clients on self attributions of location. However, males made significantly higher attributions of stability than females.

Attributions of location and stability were not significantly correlated for client subjects.

Therapist Attributions for Presenting Problems. Therapists did not make significantly different attributions on either location or stability for male and female clients.

Correlations Between Client and Therapist Attributions. Therapist judgements of location and stability of presenting problems were significantly and positively correlated. There was no significant correlation between these two measures for treatment goals.

Client and therapist attributions of location for presenting problems were significantly and positively correlated; a similar trend was shown for stability attributions, but results were not significant.

Effects of Therapist Sex Role Attitude on Attributions. Therapists who scored as traditional on the AWS made significantly more internal attributions than liberal therapists (ANOVA), and significantly more stable attributions (t-test).

Both liberal and traditional therapists (AWS) made significantly different attributions on the basis of client sex, with males receiving more highly internal attributions than females. Traditional therapists, as measured by the SRIS, also made significantly more internal attributions than liberal therapists.

Therapist Maladjustment Ratings.

Therapists who judged female clients as highly maladjusted also judged those clients' problems as significantly more unstable.

There were no client sex effects on therapists' ratings of maladjustment.

Treatment Goals.

No significant differences were found between therapists attributions of location and stability for males and females in the planning of treatment goals.

Perception of client maladjustment was not significantly related to therapists attributions of internality and stability of treatment goals.

Traditional therapists (AWS and SRIS) made significantly more internal attributions for treatment goals than more liberal therapists.

Multivariate Analyses.

The canonical correlation between location and stability and the AWS, SRIS, and client sex was significant.

The step-wise multiple regression analysis for location was significant, indicating that the AWS, client sex, and SRIS all added significantly to the relationship. The step-wise multiple regression for stability was non-significant.

DISCUSSION

The main purpose of the present research was to empirically validate the occurrence of sex bias in psychological evaluation and psychotherapy using naturalistic data. The dominant research paradigm in this field has been the analoque methodology, and few direct naturalistic assessments are available for comparison. Both the naturalistic data and the analoque research have failed to find strong support for claims of widespread sex bias, with which the findings from the current investigation are consistent. In general, the present findings do not confirm the hypothesis that women are differentially treated in psychotherapy evaluations, although speculations that gender and sex role attitude do affect some circumscribed clinical decisions were affirmed.

This chapter will begin with a discussion of the effects of client sex on the two attributional measures of location and stability. The perceived source of presenting problems together with attributions of chronicity or stability were both selected as variables which had potential for serving as more subtle and thus perhaps more sensitive indicators of discriminatory clinical judgements than the use of stereotypy questionnaires. Measures of subjects' attributions are considered to be more unobtrusive as they impose few parame-

ters on how subjects are to respond. Such data is relatively free from explanatory schemas imposed by the researcher, who otherwise structures response units, and by so doing, shapes the subjects' perceptions. The effectiveness of these measures as predictor variables of therapist bias will be discussed. The effect of therapist sex role attitude will also be examined and this will include a critique of the two widely used measures of sex role attitudes, the AWS and SRIS. An overview of the feasibility of measuring bias via attributional and attitudinal scales will follow. The relationship between naturalistic and analogue research will be explored, followed by conclusions and recommendations for future research.

Effect of Client Sex on Attributions of Location and Stability

The present study was designed to investigate the effect of client gender primarily on the functional context, or the environment prior to therapy. According to Orlinsky and Howard's (1980) conceptualization of this phase of psychotherapy, the functional context includes patients with their presenting problems, as well as their beliefs and values; included as well are the therapists with their particular skills and orientations and their own ideological or value systems. As such, the manner in which a client perceives his or her presenting problems, both in terms of location and stability attributes, would be one of many salient factors of the functional context.

Client Perceptions of Presenting Problems

It was initially postulated that women would be seen as presenting with issues formulated in terms of an internal locus of causality and high on the stability dimension. This formulation of attributional style has been mirrored in feminist arguments that women's psychological problems are characterized as being unique to them, or idiosyncratic in nature, largely emotional in a diagnostic sense, and reflective of underlying personality disorder (Johnson, 1976; Brodsky, 1973). In other words, the source of the problem is seen as residing within the female personality, and by implication, as being more stable given our understanding of personality development and dysfunction.

In the present study, no significant difference was found between male and female clients on attribution of location. Both sexes tended to generally perceive their problems to be caused by internal factors. Contrary to expectation, males showed a nonsignificant trend to perceive their problems as more internal than female clients. Failure to observe gender differences here may be explained in several ways. One interpretation may be that the nature of the problems which men and women bring to therapy is highly selective, and this speaks more to characteristics of the patient population than to individual characteristics, including gender related attributes. Prevailing models used to explain problematic behavior have largely focused on personality structure and

assumed underlying disease entities, thus placing the causal locus of disturbance within the individual. It has been suggested (Yaffe & Mancuso, 1977) that lay persons, in this case clients who act as judges of mental illness, make attributional categories on the basis of signals offered by mental health professionals. In the present research, client attributions were collected prior to evaluation by a clinician; thus clients' perceptions concerning the nature of their problems are free from the influence of therapists' explanations of psychological disturbance. This is not to say that clients' perceptions are totally naive, since the lay public have ready access to information about psychology and psychotherapy, be it through various media, or previous exposure to therapeutic intervention with other professionals. To the extent that the therapeutic milieu reinforces dispositional explanations to account for behavioral effects, explanations accepted by individuals for their experiences will reflect prevalent and popular conceptualizations of mental illness shared by mental health professionals. Other attributional research also confirms the traditional link between judgements of pathology and internal personal causality (Calhoun, Dawes, & Lewis, 1972; Calhoun, Pierce, Walters, and Dawes, 1974). Sarbin and Mancuso (1970), for example, suggest that there is a positive relationship between clients' help- seeking from professionals and the attribution of problems to an internal cause. Tes-

sler and Schwartz (1972) similarly report a greater degree of help-seeking behavior for subjects who attribute difficulties to internal sources.

Although no gender differences were observed for clients' causality attributions, this was not the case for attributions of stability. Significant differences were found between male and female clients' perceptions of the stability of a presenting problem; contrary to expectation, males saw their problems as more stable than females. From an attributional perspective, this is consistent with previously reported findings that psychological difficulties attributed to internal causes will be related positively to a stability dimension (i.e. as having lasted longer, or as recurring over time) (Calhoun,Pierce, & Dawes, 1973; Kelley, 1967). The exact nature of the relationship between these two attributional variables, however, is still unclear. Although research indicates a consistent positive correlation between internality and stability, the relative importance of each variable has not yet been determined. We may speculate that there is an implicit causal relationship between internality and stability such that causal attribution is the determining variable for stability. We have some evidence that causal attribution is highly salient for subjects in this research. If subjects use dispositional attributions as primary explanations for dysfunctional behavior they may then see the development of the dysfunction as being of

longer duration given common understandings of the development of personality and personality change. Since males in this sample tended to see their problems as more internal in location (although this was not significant) it is not all that surprising that they show the predicted relationship between location and stability. The converse of this argument may also be valid; if subjects perceive their problems as being chronic or as generalizing across situations, they may then infer that some stable aspect of thier personality is 'responsible' for their dysfunction. At this point, however, the relationship between perceptions of stability and causality is still speculative.

It is difficult to assess the generality of this finding to male clients seeking psychotherapy. The general picture would suggest that males are responding in a direction not unlike the pattern that was predicted for female clients. This may mean that only a particulaly select group of males see themselves in need of treatment, and that males who externalize the source of distress and/or who judge that distress as temporary do not present themselves for psychotherapeutic help. This hypothesis would need to be explored in further research. One possibility would be to evaluate the attributions of a non-client male population for psychological problems. In addition, if we could ask these subjects whether they would seek professional help for those problems, we may come up with an attribution profile of

males likely or unlikely to present for treatment and look at correspondence between the clinical and non-clinical populations. Such a study should also make comparisons with the non-client female population, for it is equally possible that a select group of females see themselves as not needing treatment.

A more important consideration for this data, however, lies in the relationship between the clients' attributions and the attributions made by the therapist sample. Sex differences in clients' perceptions (or lack of such differences), in and of themselves, tell us relatively little about the effect of gender on the therapeutic process, and almost nothing about the interface of patients and therapists where the issues of sexism would arise. Gender, as a variable affecting the process of therapy, can exert a modifying influence in one of several ways. Firstly, client sex may moderate therapists' expectations; a therapist who, for example, may ascribe to stereotypic notions about male/female behavior, may have differing reactions, expectations, or perceptions of men and women seen in treatment. Secondly, gender may serve as a moderating influence on the life experiences of men and women who come for treatment, and these historical differences in social roles may affect the contributions that man and women make to the therapy process.

Therapist Perceptions of Client Problems

We have already established the effects of client gender as one of a set of variables that can potentially exert a moderating influence on the input phase of the therapeutic process. A remaining factor to consider is the therapists' perceptions of clients and their problems. Looking at the same two variables used to assess clients' perceptions, attributions of location and stability, we see that therapists bring a slightly different perspective to the input context of therapy. As a group, therapists do not make any differential attributions for male and female clients on either the location or stability dimension. Clients' presenting problems are evaluated by therapists as being moderately internal, in other words as due more to dispositional than situational factors, and as being moderately stable, that is as recurring over time or across situations. Thus we find that client gender has no effect on therapists' perceptions of presenting problems. This is a major finding in this research, and has important clinical implications. In many discussions of biased treatment of women in relationship to mental disturbance, inferences of bias have been drawn on the basis of differences, or apparent differences in the treatment of women. This research does not support such inferences and offers clear evidence for the non-prejudicial treatment of women by clinicians.

As previously noted, several writers have criticised therapists' attitudes toward women on the basis that the impact of the social context in which womens' lives are embedded, has been ignored as a major contributor to womens' problems. Therapists in the present research are not, however, shown to discriminate against women in this fashion. If we are dealing with a bias here, it is a diagnostic bias that encompasses men as well as women, and sex of client does not have the saliency of a moderating variable that it was expected to have. If the causes of men's and women's problems are actually different, a failure to see this would be indicative of gender bias. However, it has been shown in this research that men and women show a fair amount of consensus in their perceptions of their presenting problems.

It is important to acknowledge the relationship that exists between clients' and therapists' perceptions of the same presenting problem, for it is here, at the interface of expectations, that the greatest opportunity arises for discriminatory attitudes. As a first step toward affirming or dispelling claims of prejudice against women, we can look for any discrepancies between therapist and client evaluations of the nature of the problem that will be the focus of therapeutic intervention. If men and women share a perspective of their psychological needs, any differences therapists generate in their evaluation of men and women may be a potential source of gender discrimination. Therapists and

clients studied in this research show some agreement in their perspectives of such evaluations. Both groups have incorporated an internal locus of causality into their evaluations of what determines psychological distress. Both male and female clients and male and female therapists see presenting problems as stable in nature, although male clients see their problems as significantly more stable than female clients, and this issue has been previously discussed.

This type of comparison is based on two partially independent samples of clients and therapists, and is not necessarily the best approach to adopt in making a comparison of attributes (the therapist and client samples are not completely independent since some client subjects from whom data were collected were assessed by therapists on whom data were also collected; other clients who contributed data have no therapist assessments and some therapists likewise submitted assessments for which there is no corresponding client data). The more stringent analysis would be to examine concordance of perception using matched therapist-client dyads which would allow one to assess different perceptions of the same problem. On the basis of an analysis where client-therapist data could be matched, it appears that the degree of concordance between therapists and clients on the measure of location is moderately high. In other words, when a client of either sex makes an internal, mutual, or external attribution, the therapist who interviewed that

client also sees the problem in corresponding fashion. Results for stability show a similar, but not significant degree of association. Unfortunately, sample size for this analysis was small, and too small to examine the degree of concordance between same sex and opposite sex pairs. To date, no other research has examined the extent of correspondence between client and therapist attributions and how this relates to prejudicial treatment of clients. This certainly should be a direction for future research to take.

If it can be established with replication that one reason why therapists persist in seeing females' problems as dispositional is because women in fact present themselves this way, we have gone a long way towards dispelling some myths surrounding the treatment of female patients. To illustrate this point, Fidell (1980), in a recent critique of published research on sex biases in the medical interview, concludes that stereotypic views of physicians that women present with disease of psychogenic origin can well be reinforced by the model of symptom presentation of women themselves, i.e. the presentation of symptoms that are psychologically not medically relevant.

There is one final consideration to explore concerning the congruence of perceptions between therapist and client samples. Attribution literature of causality has proposed that several variables are important in the attribution process; in particular, it has been shown that several of these

variables covary with an individual's perceived causal locus of psychological problems. Kelley (1967) and others (Calhoun Pierce, & Dawes,1973) have suggested that consistency over time is significantly related to whether the actions of persons are attributed to internal causes, with longer duration (one aspect of stability) tending to be associated with attribution to internal factors.

For the therapist sample in this research, attributions for location and stability are shown to be moderately and positively correlated. Thus it appears that both attributional dimensions are involved as a clinician forms impressions of a client. For therapists the strength of association between these variables may again represent a diagnostic bias. If clients demonstrate sufficient justification for seeking treatment, it may be that therapists have a specific inferential set to evaluate the joint effect of causal locus and stability as part of justifying the need for treatment.

Interestingly enough, this relationship between causal locus and stability does not hold as strongly for the client sample. It was shown that a client who perceives a problem as being caused by highly internal factors is also likely to see the problem as stable or unstable in nature. This may be due to at least two reasons: firstly, it may be that clients do not formulate impressions of their problems using a stability dimension because it bears no relevancy to their con-

ceptualizations. An inspection of Figure 2 indicates that a large percentage (44.2%) of clients' responses do not contain any information which would have allowed judges to rate for stability (see Appendix D for criterion for rating stability), suggesting that this type of attribution is not a prominent feature for the majority of clients. In other words, duration of the problem or consistency across situations may not be as salient as causal explanations. Secondly, it is important to recognize that many of our notions about the frames of reference people use to make judgements about causality are derived from analogue research. The implicit assumption in this area is that lay persons explain behavior in terms that correspond to the explanatory framework outlined by experimental attribution investigation (i.e. the use of causal attribution and stability ascriptions).

Recently, some authors have challenged these assumptions by questioning whether at the personal level, attributional processes are central to an individual's analysis of the structure and meaning of events (Brickman, 1978; Buss, 1978). We are now in a position , by replicating analogue research with naturalistic data, to supplement some of the conceptual distinctions arrived at by attributional theorists.

The Effect of Gender, Location, and Stability on Maladjustment

So far, we have focused on two variables that affect the initial perceptions of a client's presenting problem, location and stability. In deciding how to help a client, attributions concerning where the problem lies and how chronic(stable) it is, are important because therapists will presumably act in response to perceived needs of the client. Therapists also make other judgements about clients entering treatment, with one of the more important judgements being the degree of psychological maladjustment of the client.

Historically, both the feminist literature and the more experimental,academic literature have fostered the view that women have higher rates of mental illness than men (Gove & Tudor, 1973; Tudor, Tudor, & Gove, 1977; Gove, 1980; Chesler, 1971), although this point is still controversial (Johnson,1980; Kramer,1977). This position has been challanged on several grounds; for example, how should mental illness be defined, and what biases may be involved in determining incidence? One consistent theme in the research supporting findings of greater frequency of mental illness in women is the assumption that adult women are psychologically less healthy than adult men, a position that was popularized by Broverman a decade ago (Broverman et al. 1970).

The present research addressed the issue of gender differences on therapists' perceptions of client maladjustment using a 9-point rating scale ranging from very disturbed (1)

to very well adjusted (9). Although more women than men were seen in therapy (17 females and 7 males), female clients were not seen as more maladjusted than male clients. Both males and females were seen as moderately maladjusted, and there was virtually no difference between mean ratings for either sex. Essentially, findings from this study cannot support the view that therapists see women as less psychologically healthy than men. It is possible that this finding reflects more egalitarian beliefs of what constitutes healthy (or unhealthy) characteristics of men and women, and perhaps suggests that rigid stereotypic notions, such as those exposed by the Broverman et al. (1970) research on practicing clinicians is now being relaxed. It should also be noted that the present study used actual clients as stimuli, whereas Broverman required therapists to respond to hypothetical adult males and females. This is an important difference in procedures, and in part may account for the differences in results.

Several other predictions that were made concerning the relationship between internality and stability and maladjustment scores also were not confirmed. It was expected that females whose problems were seen as highly internal and stable would be rated as more maladjusted than (a) males who were high on both attributional dimensions and (b) females low on both attributional dimensions. Two sets of data were used in this analysis of maladjustment - presenting problem

data and therapy goal data. In only one case was a significant group difference found, and that was between females who were high or low on both location and stability. Therapists who judged female clients to be high on maladjustment also judged those same clients to be low on the stability dimension, that is as more unstable.

The relationship of perceived severity to other attributions, such as location and stability, has been inconsistent in the research. However, several studies indicate that behavior which is described as being caused by external factors results in the least amount of perceived psychological disturbance (Calhoun, Selby, & Wroten, 1977; Calhoun, Pierce, Walters & Dawes, 1974). Johnson, Calhoun, and Boardman (1975) also demonstrate a positive relationship between perceived severity and stability, with more stable problems being associated with estimates of greater severity. These relationships are not clearly established in the present study. For female clients only, maladjustment is significantly and moderately correlated with stability, but the association is negative and unpredicted. Female clients whose problems are viewed as unstable are seen as more highly maladjusted. (An inspection of the verbatim responses by therapists for those female clients who were seen as highly maladjusted and as having highly unstable problems, revealed certain commonalities in attributional themes. Many of the causal attributions were seen as external or mutual in na-

ture, and had themes dealing with role conflict or role deviancy. Examples include problems centering around breakdown in communication with spouses or boyfriends or in-laws. Several attributional themes had as targets dissatisfactions and conflicts with stereotypic roles, such as doubts about sex role identity, or doubts about adequacy as a parent). All other correlations (between maladjustment and location for presenting problems, maladjustment and location, and maladjustment and stability for treatment goals) are all negative and non-significant.

These unexpected relationships may be due to several reasons. One possible explanation is that if women present with a person-based problem, yet see that problem as temporary, the therapist may assess the profile as more atypical and hence as more pathological. A second, and perhaps more parsimonious explanation may be that some of the assumptions regarding attributions which have been validated in analogue research have no validity in naturalistic research. This point will be explained in more detail in the section comparing the two types of research.

It is encouraging to note that when male and female clients both high on internality and stability are compared for differences on maladjustment scores, no sex differences in ratings are observed. Again, both groups are seen as moderately adjusted by the therapist sample. No evaluative favoratism is shown toward males using a measure of diagnostic

severity. It should be noted, however, that because of the small N, there may be little power to detect differences on this variable. In a study with a larher sample size, it would be profitable to explore this relationship further. A finding of no sex difference here is relevant, since we would be assessing therapist perceptions of men and women with fairly similar patient profiles. of diagnostic severity.

The Effect of Therapist Sex Role Attitude

Results so far have suggested that attribution concepts may be of some value in the study of gender differences in psychotherapy by producing a frame of reference for understanding some cognitive processes that occur as clients and therapists attribute presenting problems to internal or external causes or to stable or unstable factors. However, results also indicate that attribution theory may not account for all of the variance in individuals' conceptualizations of psychological difficulties, and supplementation by other concepts and data may be necessary for increased understanding of the therapeutic process.

A valuable source of such additional information may be the attitude of the therapist toward women. The majority of studies suggest that there is at least some evidence of stereotyping by clinicians (Sherman, Koufacos, & Kenworthy, 1978; Englehard, Jones, & Stiggins, 1976; Brown & Hellinger,

1975; Abramowitz, Abramowitz, Jackson & Gomes, 1973; Thomas & Stewart, 1971). There is also some evidence for the development of more liberal attitudes in therapists over time (Englehard et al., 1976), due perhaps to broad cultural changes or perhaps to increasing sensitivity on the part of therapists to the negative implications of responding in a now socially undesirable (i.e. stereotypic) fashion. Therapists who participated in this study are best described as having highly liberal attitudes towards women as measured by the AWS and SRIS, both measures being highly and positively correlated. Thus, the present sample of therapists also reflects a growing trend toward the development of a less conservative ideology regarding the roles and behaviors of women.

One very legitimate criticism that can be leveled toward many studies that have evaluated therapist attitude and sex role stereotyping is that the effects of such measures are not judged in relation to other therapeutic variables. What ultimately needs to be established, in most cases, is the way that prior context, such as therapist attitude, determines either therapeutic process (either quantity, quality, or content of patient-therapist communication) or outcome (symptom relief, change in patient life style, or change in patient self-evaluation).

This study attempted to relate therapist sex role attitude toward other input variables, such as therapist percep-

tion of locus of causality and attributed stability of the presenting problem, and another variable thought to have direct bearing on the therapeutic process, namely the planning of treatment goals.

Since the therapist sample was biased toward the high liberal ends of both the AWS and SRIS, this presented a problem in terms of how to make comparisons between therapists who were more conservative or liberal in attitude. A median-split technique was utilized to divide the sample into two groups. Although this statistical manipulation allowed for the dichotomizing of the sample, it should be noted that ideologically, the traditional group is only slightly less more conservative in attitude than the group referred to as liberal. An item scan revealed that the particular items which would have discriminated between the two groups are namely those items dealing with sexual behavior and morals of females. Thus, while traditional therapists have generally nonstereotypic views of women in the economic and political spheres, they have highly conservative attitudes regarding women's sexual behavior.

When results were analyzed for sex of client effects on therapists' perceptions of location and stability, it will be recalled that the clinician sample made no differential attributions on the basis of client sex, with presenting problems for both male and female clients being attributed to internal and stable factors. When the variable of

therapist sex role attitude is taken into account, a different attributional pattern is produced.

First, using the AWS scores an ANOVA main effect for therapist sex role attitude on attribution of location was found, with traditional therapists making significantly more internal attributions than their liberal counterparts. With a more powerful t-test it was also demonstrated that the more traditional therapists also saw clients' problems as significantly more stable in nature than liberal therapists. No interaction effects were found using the ANOVA for therapist attitude and client sex. A main effect for client sex was also found, indicating that for those therapists who provided information about their sex role attitude, liberal and traditional clinicians combined saw male clients as having more person-based problems than female clients.

The SRIS, another measure of sex role ideology, does not prove itself to be as sensitive a predictor of therapist attribution as the AWS. The ANOVA on the SRIS scores shows only one main effect, with traditional therapists again making significantly more internal attributions for clients' problems than liberal therapists. Again, no interaction effects were found for client sex and therapist sex role ideology. It is difficult to say why we do not get a more consistent replication of results with the SRIS without doing a factor analysis of both scales. However, it would appear that the items dealing explicitly with sexual behavior

on the AWS are powerful enough to make a more discriminating difference between what we call conservative or liberal attitudes, and this may have been sufficient to make the AWS just that more powerful as a predictor measure of attribution.

For several reasons the results suggest that we should pay careful attention to the contribution of therapist attitude as a variable which can modify the therapeutic process. Statistical differences between what determines conservative and liberal attitude, for example, are slight, given the composition and the sample, yet this slight difference allowed us to make some discriminations between therapists' treatment of men and women clients that were not otherwise apparent without the addition of this information. In addition, the information that we did obtain with the use of this variable was contrary to expectation--which further suggests that it may provide some critical insights.

We now have some idea that sex role attitude may be important in determining a therapists' initial perception both of what causes a clients' problem and how stable that problem is likely to be assessed. More traditional therapists adhere more firmly to what we have already described as a diagnostic bias which many other clinicians in the therapeutic community seem to share; that is, an emphasis on intrapsychic factors and a belief that disorders which are person-based are not as transient as the more situational

problems. We would have expected, on the basis of previous research however, to find females more likely to be characterized by this attributional pattern than males. In fact the presence of this very pattern in therapuetic evaluation has been targeted as a major indication of stereotypic or prejudicial treatment of women. Yet, on the basis of the present research, we find that males are seen by therapists to fit the pattern more closely than females. Chesler (1970) for example has defined the problem for women patients in the following way "most (but not all) clinicians... implicitly encourage them (women) to blame themselves or to take responsibility for their unhappiness in order to be 'cured'" (p. 363). Thus female pathology becomes a matter of individual pathology. Often feminist writers who endorse cultural determinism or the environmental model of psychopathology, have similarily attacked the therapeutic establishment for locating the source of women's problems to be within the feminine personality.

The present sample of therapists do not attribute the source of women's problems to external (i.e. social or situational) factors, as feminist writers suggest. But the important point here is that therapists were shown to treat problems as idiosyncratic to individuals in general, and to do so for men more so than for women.

It has also been argued that women are discriminated against in the fashion we have just been discussing both be-

cause they act out of role, where this deviance is seen a personal rejection of the culturally accepted behavioral model, or because they so closely adhere to a stereotypic role which clinicians regard as unhealthy. It may be possible that males who present for therapy are seen as relatively more out-of-role by therapists than females, and perhaps even more deviant than males who are functioning closer to cultural prescriptions. Recent analogue research, however, does indicate that role deviancy is not a particularly salient factor in a clinician's treatment of either men or women; the majority of research in this area does not confirm claims that therapists show favoritism to the sex role conforming male or female (Abramowitz & Dokecki, 1977; Billingsly, 1977; Fischer et al., 1976; Johnson, 1978). If the initial emphasis is on deviancy, then perhaps the attribution of internal locus is a closely associated diagnostic assumption. Certainly the attributional research would support this interpretation; however since no data were gathered on role attributes for clients, this is still speculative, and further research would be necessary to examine this hypothesis.

Therapist Sex Role Attitude and Treatment Goals

One final issue to be addressed in this section involves the relationship of therapist sex role attitude and attributions to type of treatment planning which the clinician en-

qaqes in as part of the therapeutic procedures. The therapeutic formula for alleviating a person's disturbance is invariably linked to the initial understandings the therapist has of the client's problem. It has been suggested that, depending upon the initial perceptions the therapist forms, he or she may use procedures either to change aspects of the patient's environment reflective of the basic social structure, or to change the person, and to accomodate to roles and behaviors to existing social structures (Gove, 1980). It has been anticipated that diaqnoses focusing on dispositional attributes would be more closely associated with therapy qoals aimed at producing some change in the patient's person, usually involving a more complex and at times lenqthy process. On the other hand, if emotional disturbance is primarily seen as a reaction to particular aspects of societal conditions it would be more congruent for the therapist to alleviate distress by using procedures that would lead to change in the person's environment. Because the emphasis here is more situation-specific, treatment qoals may correspondinqly reflect a shorter duration of therapy.

On the basis of the present research, therapists show a general trend toward formulating therapy goals directed primarily at person change and using modalities or techniques which we would consider to be of moderate duration, such as insight therapy or family therapy. Interestingly, this

treatment formula is applied across the board for all clients, regardless of sex or perceived degree of maladjustment. Once again, therapist sex role attitude is shown to be a significant factor, with the more traditional therapists prescribing more person-based goals than liberal therapists.

In conclusion, it is clearly demonstrated that client sex is not a significant factor in a therapist's formulation of treatment goals. It has previously been suggested that therapists keep women in therapy longer than male clients (Chesler, 1971; Fabrikant, 1974); reports on studies of duration of treatment are inconsistent however; although many studies show that there is no difference between men and women on length of stay in therapy (Garfield & Affleck, 1959; Kirshner, Hauser & Genack, 1979; Mendelsohn, 1966), a fair number of studies found women to be in therapy longer than men (Abramowitz, Abramowitz,Roth,Roback,Corney, & McKee, 1976; Lowinger & Dobie; 1968). The present research is not an outcome study, and we cannot make any statements about actual length of treatment. However, we can say that therapists do not plan for women to be in treatment longer than men, and at this initial phase of therapy, no discriminatory treatment of female clients is evident. One would hope that treatment plans have some relationship to therapy outcome, or in other words, that some cause and effect relationships between process and outcome occurs. Because client gender

seems not to have a consistent effect on actual duration of therapy, it is difficult to speculate about what factors do intervene to change plans for treatment goals. Maracek and Johnson (1980) and Safer (1973) suggest that other factors intervene to affect this outcome variable, such as therapist gender and frequency of sessions. Maracek and Johnson (1980) also point out, that the therapist does not have complete control over the duration of a treatment program, since the client can also choose to terminate early, or to stay in treatment longer.

The present research also shows that with respect to projected treatment goals women are not discriminated against in terms of perceived severity of illness. The accusations laid against therapists regarding the nature of the treatment women receive while in therapy have been particularly severe. Psychotherapy has been described as a service that works against their (women's) best interests (Rawlings & Carter, 1979). On the assumption that therapists' personalities and attitudes toward women affect the adequacy of therapy, male therapists in particular, who are seen as serving the status quo (probably because of their preponderance in the field) have been under microscopic examination. Therapists, in particular the more conservative ones, and female therapists who role-identify with the male establishment have been judged as mislabelling (or misdiagnising) women's problems, as encouraging women to accept subordinate

roles, and as perceiving women as inferior and unmotivated. This attitude is assumed to translate into therapeutic practice such that models of mental health (i.e., goals of treatment) reflect psychotherapists' values about women. For example, archival research using samples of males and females showing equal amounts of distress compared the two groups of clients regarding duration of treatment and medical prescriptions. Female neurotic depressives were seen for more therapy sessions and were given more medications than male neurotics (Stein, Del Gaudio & Ansley, 1976). In the present research, however, women are not seen as more disturbed than men, and therapists' treatment planning reflects their initial perceptions of both men and women on this variable of severity of illness. Both sexes are seen as moderately adjusted and the nature of the treatment goals specified by clinicians does not suggest that women need any special type of treatment because of greater emotional illness.

As a summary statement of this section it can be said that the variable of client sex seems to be a much less salient factor in determining therapists' perceptions of clients' problems than expected. On the other hand a therapist's attitude toward the roles of women assumed much greater importance as predictor variable for the two attributional dimensions of location and stability. The majority of the conclusions reached concerning client and therapist

variables were drawn from univariate statistical analyses, which at a conceptual level implies that in the natural setting these variables operate in isolation of one another. In reality, this of course is not the case. All of the variables that we isolated for statistical analysis, operate in a complex, interrelated fashion in the natural dialogue that occurs between a client and a therapist.

It is thus important to consider the interrelationships between variables and how they operate together as predictor variables. For this reason it is worth mentioning the results of the canonical correlation and multiple regression analyses.

The CANCOR analysis determined the degree of relationship between the attributional dimensions, location and stability as one set of variables and the therapist attitude (AWS & SRIS) and client sex as the second set of variables. Results show a moderately high degree of relationship between the two sets, with AWS, SRIS and location accounting for 58% of the variance. In other words, if we have some information concerning a therapist's attitude towards the role of women, using both attitudinal scales, we can predict with a reasonable degree of confidence where that therapist is likely to locate the source of a presenting problem. It is also evident that accuracy in predicting location is much better than in predicting stability, given the same information about therapist attitude. This same analysis also sug-

gests, that by adding information about client gender we are not likely to significantly increase our accuracy in predicting the attributional biases of therapists.

Since location and stability were considered to be two very useful measures by which we could assess the discriminatory treatment of women, it was also considered important to determine how much information was actually needed about the relationships of the remaining variables in order to make predictions about therapists' attributional processes. In other words, if we wished to predict how a therapist would perceive the source and the stability of a problem, do we need information about all three independent variables? It was demonstrated that the AWS is a sensitive predictor of location attribution, but that information of how a therapist scores on the SRIS and knowledge of client sex also significantly contribute to predictions we make about therapists' perceptions of clients, particularly attribution of location for the presenting problem. This analysis indicated that the regression was significant. Thus, each time we add information to our equation, we do increase the accuracy of predicting where the source of a problem is likely to be located. It should also be reiterated that because the AWS and SRIS are highly correlated, the use of both scales to predict attributions is redundant. In other words, given information about a therapist sex role attitude, using the AWS or SRIS as indicators, together with information about

client sex, we have a reasonably good idea of knowing where a therapist is likely to locate the source of a clients' problem. However, if we wish to make some predictions about attributions of stability, it appears that measures of therapist sex role attitude contribute significant information as predictor variables, with client sex adding little to our prediction.

In conclusion, we can see that gender is not the only input variable that modifies therapeutic process. Knowledge of gender, in the absence of other qualifying information about the individual, such as attitude or an individual's definition of what constitues a reason for seeking treatment, tells us relatively little. The method with which we choose to investigate how these modifying variables affect therapueutic process is also significant, and the following section will address itself to relevant methodological issues.

A Comparison of Analogue and Naturalistic Research

A review of research on sex bias in psychological evaluation and pyschotherapy indicates that the experimental analogue is yet the most preferred methodology. The analogue study strives to replicate, or create an analogy of, a real-life situation, and is a preferred methodology by many researchers as it allows for greater control of variables otherwise thought uncontrollable in the naturalistic set-

ting. In brief, the analogue methodology translates into using analogue subjects to serve as therapists (e.g. use of Introductory Psychology students), stimulus materials to represent clients' verbatim reports or therapists summaries, or video and audio tapes of supposed therapeutic dialogues.

On the whole, evidence of bias derived from analogue research is equivocal. Of 16 clinical analogue studies reviewed by Sherman (1980), nine studies support the claim of sex bias or show evidence of stereotyping; the remaining research either shows no support of the hypothesis or is too unclear to draw firm conclusions. According to an equally extensive review of analogue and archival research by Davidson and Abramowitz (1980), the findings are interpreted by the reviewers as "overwhelmingly negative" regarding charges of sexism in clinical practice.

One of the major criticisms of the analogue is its generalizability, and one cannot overlook the obvious differences between the analogue study of psychotherapy and the real life situation. Cases where replication of analogue studies have been attempted in the naturalistic setting show rather poor agreement in results (Marecek & Johnson, 1980; Kushner, 1978). There are several reasons why this may occur. Because of the popularity of the analogue method, it has been suggested (Sherman, 1980) that clinicians are sensitized to the purpose of the investigation. Participants in analogue research, aside from being aware of the experimen-

ter's intent, may also respond differently in the experimental analogue, not being subject to the same pressures that shape their behavior in real life. From the perspective of Rawlings and Carter (1979), for example, therapists would be under no obligation to maintain the status quo when responding as subjects rather than as clinicians.

Analogue studies are also very diversified in the methodological approaches to the study of sexism. The most popular, but not the most ecologically advantageous format, has been the written case summary, with diagnostic, prognostic, and treatment recommendations being the most common dependent variables. More sophisticated advances include the use of video and audio tape presentation, and this enhances the realism of the situation, while extending generalizability of results (Johnson, 1978). Yet despite methodological continuities that do exist among analogue studies, the question of generalizability is still problematic. Generalization is always, in fact, problematic because of its inductive nature, and systematic extension and replication are the most tenable means of increasing generalizability.

Analogues also vary along conceptual as well as methodological lines, and a serious problem with many of the analogue studies is the lack of cogency to the question of therapists' attitude toward women and therapists' sex role stereotyping of women. Many writers mistake stereotyping for mysogyny, and conclusions which they draw concerning

sexism bear no validity to external criteria. This point is well made by Orlinsky and Howard (1980) who underscore the importance of establishing causal relationships between modifying variables and the outcome of therapy. Perhaps the greatest benefit of analogue research lies in the fact that results suggest relationships that can be explored or replicated in the naturalistic environment.

The naturalistic methodology provides an alternative procedure for answering those questions concerning what specific factors may determine or predict therapeutic process or outcome. To date, few naturalistic studies of sex bias have been conducted, likely because of difficulties accessing therapy session material, difficulty in controlling all relevant variables, and the lengthy analysis of the data.

The present research was an attempt to investigate sex bias in a naturalistic setting, and makes a contribution to the field by carrying the investigative process beyond the analogue stage. This type of investigation is considered far less obtrusive than the analogue procedure for it can be presented to subjects in a format which is not unlike the procedures normally followed for intake psychological evaluations. No deceptions need be employed, other than not drawing the subjects' attention to the purpose of the study, since the basic experimental question is the question clients and therapists typically ask on a first therapeutic encounter - - - what is the nature of the problem which

will become the focus of therapy? There are two distinct advantages to this procedure: we can assess not only the therapists' perceptions, but the clients' as well, an often overlooked factor in the evaluation of discrimination; we can also relate input factors to actual therapy process variables, and thus increase the validity and generalizability of our results. Another important methodological consideration is the fact that we can relate therapist attitude to actual decision making processes of the clinician (i.e. to other behavioral correlates) without having to rely on measures of therapist sex role attitude as the sole indicator of discriminatory treatment. Thus we can assess whether attitude translates itself into observable and measurable behaviors crucial to the therapeutic process.

This is not to say that naturalistic research is without flaw. This choice of procedure has its own inherent weaknesses, as does the analogue method. The next section will be devoted to an analysis of the naturalistic procedure, including a critique of the measures and procedures employed in the present research.

Methodological Issues: A Critique

In 1974, the Society for Psychotherapy Research (Waskow, 1976) set as a research priority the study of manifest content of therapist interventions; however, empirical work in this area is scant, and only one relevant study has dealt

with the prevalence of sex biased content (Shapiro, 1977). The present research utilized a content analysis procedure in which raters evaluated open-ended responses of both clients and therapists. Their primary analytic task consisted of categorizing data along two attributional dimensions of location and stability. Attributional ratings were considered more useful as potential indicators of bias than other available content categories used in research of therapeutic process. In the first place, the field of attribution research is the study of the rules employed by the average person in making causal judgements concerning either his own or another person's behavior. The significance of any event that is brought about by an individual is determined, at least in part, by the perceived cause of an event. A study of attributions made by the lay public, in this case, clients, and a professional group of therapists to explain significant life events, makes an important contribution to our understanding of person perception. Secondly, the attributional assessments of the raters was simply a way of quantifying verbatim perceptions and explanations offered by a therapeutic population of clients and therapists. The two attributional measures that were ultimately selected for experimentation were thought to be the most relevant to the issue of sexism in therapy. From the author's perspective, the crux of the issue is whether therapists perceive the problems of female clients in a way that is not only differ-

ent from their perceptions of males, but whether this perception results in differential treatment procedures on the basis of sex. To explain behavior in this causal fashion is an integral part of psychological evaluation. Content analysis thus becomes a means of imposing a conceptual framework on unstructured, qualitative data.

Whether the choice of location and stability were ultimately useful dimensions to study is a complex question to answer. The stability dimension was particularly problematic to evaluate. If the reader refers to Fig. 2, it is immediately apparent that close to half of the raters' responses fell in the Uncertain category. After lengthy examination of the open-ended responses, it can be concluded that the primary difficulty encountered was in the nature of the responses themselves, and not in the scale construction or with the procedural manual which was a directive for categorizing the subjects' responses. In the final analysis, it was felt that in a semi-structured context, clients and therapists do not readily use stability concepts in describing how they see a psychological problem. Without explicit instructions about how to characterize psychological complaints along dimensions of temporal and spatial extent, stability has little saliency to the subject. If we wish to gather information on this variable, it is recommended that a more structured questionning procedure be employed.

On the other hand, location was an extremely salient factor for subjects; thus, given the opportunity to explain why treatment is needed, both therapists and clients make numerous causal ascriptions. The present research demonstrates the significance to individuals of making distinctions between personal and impersonal causality. We believe that continuing investigation of causal attribution in particular, can further our understanding of the conceptual structure which person-perceivers (both clients and therapists) utilize in their analysis of phenomenal causality.

By examining Figures 1 and 2 it is also apparent that raters tend to use the broader descriptive categories without difficulty, and inter-rater agreement with this procedure is good. Thus, a 5 point scale, as with stability, and a 7 point scale, as with location, provide fine enough categorical distinctions to give us useful information. This is considered to be a definite improvement over the more dichotomized approach used in most attributional research, where the typical experimental task is to place a response in either an internal or external category or a stable or unstable one. However, to expand the scale by including half steps does not provide any additional content information, and from a statistical perspective, could contribute to an inflated measure of inter- rater agreement.

The use of attitudinal scales to assess another aspect of perception was also a useful procedure, for therapist atti-

tude was shown to be a significant modifying variable. However, exclusive use of an attitudinal scale to measure sexism is not a recommended procedure. In a study by Shapiro(1977), for example, male and female counselors made differential use of stereotypic cues of stimulus-clients, yet a measure of counselors' sex role attitude failed to predict responses of the therapists to the stereotypic cues. This serves as a reminder that stereotypic attitude may bear no relationship to other behaviors of therapists. In the present study, attitude of the therapist did affect other therapist behaviors and thus showed itself to be an important predictor variable.

It is important to recall that therapist sex role attitude was useful primarily as a predictor of liberal and traditional therapists global attributions and not necessarily of therapists differing perceptions of location and stability between male and female clients. We may speculate that sex role stereotypes were not translated into negative judgements and evaluations of female clients in part because of the nature or definition of stereotypy itself. Basically, a stereotypic attitude is said to exist to the extent that different subjects agree in the choice of trait adjectives or perscriptive beliefs; the more the agreement, the more definite the stereotype. Thus, at one level, this type of stereotype is a social stereotype, because it is a group measure defined by consensus agreement. The weakness in this

conceptualization is that we have a measure of social stereotypy that may not represent individual attribution, with little possibility of identifying ideosyncratic personal stereotypes. Perhaps therapists may have individual stereotypes about clients (independent of client sex) that have been learned through professional training, and discipline effects may then assume a mediating role on attributional and attitudinal processes. Such discipline effects may relate to underlying theoretical assumptions of therapy models that stress, for instance, the importance of intrapsychic factors in personality evaluation. When we measure effects of sex role stereotypy on attribution and on psychological evaluations of male and female clients, we may be assessing not only social attitude, but a confound contributed by an unquantified individual attribution. In the present study, therapists stereotypic attitudes were measured and documented. What was not documented, primarily because of sampling problems in ensuring adequate representation across the spectrum, was the mediating role of discipline biases and effects, and other correlated variables, such as level of experience of the therapist. Both of these fcators may have influenced attributions and perceptions of clients along with sex role attitude. It remains for future research to explore the relationship between personal stereotypes and social stereotypes.

Some of the difficulties using a naturalistic research paradigm and a content analysis procedure should not be overlooked. Naturalistic research introduces more error, and it is difficult to control variables that can otherwise be more easily manipulated in analogue research. Response rates in this research were low, which has been shown to be a problem with other types of field investigation. In such a case, the researcher must consider the possibility that those subjects who chose to participate in the research are introducing an uncontrollable source of selection bias. Client data is particularly difficult to access since participation must be on a voluntary basis, and clients cannot be coerced into serving as experimental subjects without violation of their ethical right to receive treatment. The content analysis is also extremely time consuming and subject to its own difficulties. No reliable categories for use with attributional data on therapy material were available, so a procedural manual had to be devised specifically for use in this research, and its usefulness is yet to be replicated with other therapy subjects and raters.

One final consideration with the naturalistic method also involves the issue of generalizability. This research was conducted at two institutions providing therapeutic service, and other therapists in other settings may have very different attributional biases. Therapists perceptions are intimately tied to their background training and current pro-

fessional orientation. A sample of therapists having a large behavioral contingency, for example, might not show the same diagnostic predilections as the therapists in this sample who characterize themselves as largely eclectic. Different institutions also service and draw very different client populations. Replication in other settings is necessary before we can begin to make confident conclusions about therapeutic practice and the issue of sexism in the local population. However, the present research is a beginning in this direction, and it provides ample guidelines for further study.

Summary and Recommendations

The main purpose of the present research was to empirically validate the occurrence of sex bias in psychological evaluation and psychotherapy. The effect of client sex and therapist sex role attitude on client and therapist attributions of location and stability were examined. The effect of client sex on therapist ratings of degree of maladjustment was also evaluated. One male and one female judge performed a content analysis on verbatim responses of adult male and female clients and therapists to an open-ended questionnaire concerning the nature of the problems presented at a diagnostic intake interview. Attributions of location and stability were quantified using a 7 and 5 point scale respectively. Thus, presenting problems were given

location ratings ranging from +3 (high internal) through 0 (mutual) to -3 (high external); presenting problems were also rated on stability with intensity ranging from +2 (high stable) through 0 (uncertain) to -2 (high unstable). Therapist sex role attitude was measured using the Attitude Toward Women Scale and the Sex Role Ideology Scale. Degree of client maladjustment was indicated by therapists on a 9 point scale. In addition, therapists also specified at least two treatment goals for each client, and these responses were also rated by the judges for location and stability.

Results indicated the following:

1. Both male and female clients perceived the source of their problems as due to internal or person-based factors, and the hypothesis of gender effects on attributions was not supported. However, an unexpected finding was that males made significantly higher stability ratings than females. Location and stability ratings were not correlated, indicating that a client who perceived a problem as internal was just as likely to see the problem as stable or unstable in nature.

2. Therapists did not make differential attributions of location and stability for clients on the basis of client gender. The presenting problems of both male and female clients were seen by clinicians as moderately internal and stable, and these attributional

ratings were significantly correlated showing a moderate and positive degree of association.

3. Traditional therapists were shown to make more highly internal attributions than liberal therapists using both the AWS and SRIS. Traditional therapists also saw problems as more stable according to the AWS, but this was not confirmed using the SRIS. Again using the AWS, a client gender effect was demonstrated, with male clients receiving more highly internal attributions than female clients.

4. No gender effects were found for therapists' maladjustment ratings. Clients of both sexes were seen by therapists as moderately adjusted.

5. For therapists' formulations of treatment goals, it was demonstrated that therapists who judge female clients as highly maladjusted also planned treatment goals low on the stability dimension. Thus, maladjustment and stability were moderately and negatively correlated for therapists' evaluations of female clients.

6. For male and female clients rated as high on internality and stability, therapists made no significantly different maladjustment ratings on the basis of client sex. Thus, gender had no effects on perceptions of maladjustment in this analysis.

7. No gender effects were found for therapists' formulations of treatment goals. For clients of both sexes, treatment goals were directed at changing person-based problems, and treatment was seen as being of moderate duration. Therapist maladjustment ratings were not correlated with their ratings of internality and stability for treatment goals on a combined sample of male and female clients.

8. Results on the effects of therapist sex role attitude on treatment goal attributions indicated that therapists defined as traditional on the AWS and SRIS made significantly more internal attributions for treatment goals than liberal therapists, but no difference was found for therapists' perceptions of stability.

9. The results of the CANCOR and Step-wise multiple regression indicated that knowledge of therapist attitude, particularly if the AWS is used as the attitudinal measure, significantly increases the ability to predict the attributional biases of therapists. While knowledge of client sex adds to our predictive ability about therapists' perceptions of clients problems, it is not all that powerful a predictor in the absence of other qualifying information, such as therapist attitude.

It can be concluded on the basis of these results that gender did not have a very powerful effect in determining client and therapist perceptions of how individuals explain psychological problems. This finding is fairly consistent with other recent research which shows essentially no main effects for sex as a modifying variable in therapeutic evaluations. Results of the present study do not support claims of widespread bias against the treatment of women in psychotherapy. Therapists tend to show a diagnostic bias which conforms to a rather traditional professional orientation of seeing psychological problems as dispositional in nature and somewhat chronic (i.e.stable) in nature, and this perception applies to both males and females seen in therapy. If anything, male clients conform more to the attributional pattern that was predicted therapists would form for their female clients. It has been suggested that this may represent a selection factor in the type of male who presents for treatment.

On the basis of the findings of the present research, the following recommendations are made for further study: 1. It is important to continue to replicate analogue research using naturalistic studies and move beyond the simple sex bias analogues that have so heavily contributed to this field. This will hopefully increase the generalizability of findings so that we have a more realistic understanding of the impact of gender in a genuine therapy context. 2. It is

recommended that further research be conducted using attributional measures as indicators of discriminatory treatment of clients, particularly in naturalistic research. The use of more unobtrusive measures circumvents the problems encountered when more obvious measures of stereotypy are utilized. Sexism in therapy is both a sensitive and popular research issue, and with increasing attention to the issue, more blatant measures are prone to rater bias. In addition, we need to confirm whether clients and therapists make use of attrubutional concepts in their attempts to understand the nature of psychological distress. Attributional research from social psychology has provided us with promising leads about the mechanisms by which individuals explain significant life events, and we must validate this beyond the analoque paradigm. 3. Since very few main effects for client sex have been found in the literature, we suggest the use of research using higher- order interactions. Research designs of this type show that client sex interacts with several significant variables, such as level of experience of the therapist, and client socio-economic and marital status. 4. Lastly, it is recommended that researchers pay careful attention to the design of research so that cause-and-effect relationships can be clarified in the therapeutic process. Factors such as client sex, which exert a modifying effect at the prior environmental context of therapy, must be demonstrated to directly alter therapeutic process and ulti-

mately, outcome of therapy. Experimental manipulations which demonstrate functional relationships rather than simple correlational effects would make a major contribution to this field of research.

Appendix A

HISTORICAL REVIEW OF THE LITERATURE

Sex Role Stereotyping in the Mental Health Profession

Sex Role Stereotypy: Definition and Values

Sex role stereotypes are highly consensual norms and assumptions about the differing qualities, traits, or behaviors of men and women (Broverman et al., 1970; Deaux, 1976; Kagan, 1964). These "folk models" presume dichotomized aspects of sex roles based upon gender association: In other words, when we employ sex role stereotypes we ascribe characteristics to individuals based solely on the fact that they are male or female. Societal expectations are directly related to stereotyping by definition. Thus, not only does the term 'sex role stereotyping' apply to what males and females are and do, but to the normative and generalized expectations for men and women (Weisstein, 1971; Rosenthal & Jacobson, 1968; Maslin & Davis, 1975).

The masculine stereotype has been characterized by a cluster of traits representing competency, rationality and assertiveness (Rosenkrantz et al., 1968). For example, men are seen as independent, objective, competitive, adventurous, self-confident and ambitious. Females are characterized as possessing the polar opposite of each of these

traits, so that they are seen as dependent, subjective, passive, not competitive, not adventurous, not self confident and not ambitious (Rosenkrantz et al., 1968; Broverman et al., 1970).

The most significant net effect of the research on masculine and feminine traits has been to rationalize the inferior status of women by ostensibly demonstrating the superiority of men. Although a small cluster of female traits are considered desirable (such as tactfulness, awareness of feelings of others, and ability to express tender feelings easily), both men and women as a whole see male traits as more desirable, and they are valued positively more often than those characteristics ascribed to women (Broverman et al., 1970; Broverman, Vogel, Broverman, Clarkson, & Rosenkrantz, 1972; MacBrayer, 1960; McKee & Sherriffs, 1957). Thus, while the research on sex differences has shown men to be superior on those variables which society values and rewards, like competitiveness, strength, and aggression, (Bernard, 1976), women, however, are indicated as retaining an inferior status and are seen to possess those variables which are negatively valued and at times punished by the same society, like help-seeking behavior, display of emotionality, timidity, and lack of self confidence (Chesler, 1972).

The continuing interest, both professional and public, in the area of sex differences attests to the notion that con-

cepts of masculinity and femininity encapsulate some aspect of reality which is important to a number of people. Stereotypic notions of masculinity and femininity have been preserved for decades with a marked invariance in conceptual formulation. A recent survey (Burns, 1977) of stereotypic attitudes among university students manifested the conventional stereotypes despite presumed changes due to current social pressures toward greater equality between the sexes. Perhaps this stability reflects the fact that it is easier to make decisions based on consensual beliefs rather than on knowledge of the individual case. Reverting to the stereotype saves both the time and the attention that would be necessary to judge the individual person. Within the folk model, masculinity and femininity are also seen, to some extent, as biologically determined and, as such, are immune to modification through environmental influence. Times may change, but "boys will be boys".

Although many concerned individuals ask that such stereotyping be eliminated and that men and women be judged according to their individual achievements, research on sex differences has done little to challenge the utility of sex role stereotypy. Masculinity and femininity, as hypothetical constructs, would have a utility only if they were shown to increase our prediction, control, or understanding of behavior. Given that sex stereotypes have largely been descriptive in nature and have been based upon a process of

trait attribution with numerous referents, it is not surprising that the predictive value of these norms is questionable. Despite the fact that sex differences have been observed across a variety of behavioral measures and personality tests (Deaux, 1976; Maccoby & Jacklin, 1974; Maccoby, 1966), the exceptions to each case speak to the influence of specific situation variations and underscore the recurrent problem with normative beliefs - the reliance on stereotypic traits as fixed entities. As a proponent of social learning theory, Mischel (1966, 1968) cautions against assuming that there are norms or even general predictive personality traits.

Another problem in this research lies with the psychometric definition of masculinity and femininity. Researchers vary in their opinion as to whether masculinity-femininity is a single, bi-polar dimension, ranging from extreme masculinity at one end to extreme femininity at the other (Rosenkrantz et al., 1968; Broverman et al., 1970, 1972), or whether there are two separate and orthogonal dimensions of masculinity and femininity (Bem, 1975). Whether end-points of a single dimension or separate dimensions, a related issue is whether masculinity and femininity involve multidimensional or unitary traits. Neither of the two assumptions of unidimensionality and bi-polarity has been tested for the validity of its application to the masculinity-femininity concept. For example, in test construction most measures of

masculinity-femininity incorporate bi-polarity from the start although the appropriateness of this notion of duality is of questionable validity since very little work has been done which bears directly on the assumption of inherent bi-polarity in masculinity-femininity. With respect to multim-dimensionality, if either masculinity or femininity reflects a number of subtraits, we must have evidence which points to the fact that we have more to gain by combining these meas-ures in ways most characteristic of men and women rather than dealing with each individual trait as a predictor vari-able. Again, there is no convergence of data which clearly justifies the assumption that there is, in fact, a regular configuration of traits which we categorize as masculine or feminine and which predictably distinguishes men from women or masculine from feminine individuals.

In summary, the concepts of masculinity and femininity presumably represent enduring traits which serve to distin-guish males from females in attitude and behavior. The traits ascribed to women are, in general, more negative than those ascribed to men. Given both the empirical and concep-tual problems which are related to definitions of masculini-ty and femininity, however, it is unclear as to what the stereotypes really do represent. As hypothetical con-structs, masculinity and femininity are ill-defined and seem to have questionable utility in terms of increasing our un-derstanding and prediction of human behavior. Whether this

reflects a measurement problem or whether the referents of the terms themselves vary so widely, nonetheless there is no existing body of data which indicates that masculinity or femininity are consistently related to other variables in predictable ways, such as sex role adaptation, sex role identity, or sex role preference.

Assessment of Stereotypes by Mental Health Professionals

The pervasive cultural view of sex-linked traits is also reflected in the behavior of mental health professionals. The widely cited works of Broverman and her colleagues (Broverman et al., 1970, 1972; Rosenkrantz, Vogel, Bee, Broverman, & Broverman, 1968), now classics in the area of sex role stereotyping, indicated that clinicians hold different concepts of mental health for men and women which closely parallel the prevalent sex role stereotypes held by society in general (Nowacki & Poe, 1973). Based on an initial study by Rosenkrantz et al. (1968), Broverman et al. (1970) analysed the sex stereotype questionnaire using therapists as subjects and found a positive relationship between the social desirabiltiy of behavior and clinical ratings of mental health: Both male and female therapists considered the more socially desirable masculine characteristics as healthy more often for men than for women. The clinicians' concept of a healthy, mature adult also reflected their concepts of a healthy male but not a healthy female, who was viewed as

differing significantly from the standards for healthy adults and healthy males. "Clinicians were more likely to suggest that healthy women differed from healthy men by being more submissive, less independent, less adventurous, more easily influenced, less aggressive, less competitive, more excitable in minor crises, having their feelings more easily hurt, being more emotional, more conceited about their appearance, less objective and disliking math and science" (Broverman et al, 1970, p. 5). This double standard of mental health is interpreted by the authors as an indication of the clinicians' acceptance of an "adjustment" notion of mental health. The ramifications of this could be serious for women, since the Broverman data implies that for a woman to be considered healthy she must conform to behavioral expectations for her sex, where such behaviors are regarded as less desirable and less healthy than those of a "general adult" and/or a mature male. On the other hand, if she adjusts to the norm for healthy adults she runs the risk of being considered "unfeminine". This would seem to be a logical assumption for Brovermran et al. (1970) to make, since the use for their bi-polar scale implies, by definition, that non-feminine is masculine. This is not, in fact, a well tested proposition. Only a few studies approach the problems of ideological change that may arise with shifts in sex role definitions, and results of these studies are divergent. Horner (1972) for example, demonstrated that col-

lege females in competition with males (where competitiveness is a masculine-typed personality attribute) displayed a "fear of success". This was interpreted to mean that successful competition would result in social rejection or lack of femininity. Bem (1975) on the other hand, suggests that women with sex role differentiation can maintain an image not necessarily defined as masculine. Such women, who incorporate aspects of both masculinity and femininity are referred to by Bem as "androgynous", and they do not carry the negative connotation for 'masculine' women that Broverman et al. would lead us to anticipate.

The conclusions drawn by Broverman et al. (1970) can be questioned on several important points: (1) Broverman et al. perpetuated an error in description initially made by Rosenkrantz et al. (1968) in the construction of the Stereotype Questionnaire. If both men and women fell on the same side of the midpoint in a bipolar scale, for example, if both sexes receive scores toward the "logical" end of an item, but men fell closer to the "logical" pole, women were described as "illogical", and this then became the feminine polar opposite. Women were so stereotyped throughout the scale on 27 of the so-called male-valued items. Qualitatively we must concede that to call a woman "less logical" than a man is quite different than referring to her as "illogical". The latter case has a more perjorative connotation, and this labeling error would contribute greatly to a

continuing negative stereotype of women with further use of this scale; (2) This qualitative aspect is related to a second and quantitative criticism of the scale. There are no indications that the actual differences between the ratings of men and women are statistically significant. It is only an assumption that such significance has been established, yet published data do not indicate whether an analysis of individual items has been conducted. Whereas an overall t-test does suggest that health scores for males are higher, this can be interpreted as a scale artifact since both men and women are rated on the same set of items which contain a disproportionate number of male-valued stereotypic items. To illustrate this point, a recent study (Maxfield, 1976) analyzed responses to the Rosenkrantz Stereotype Questionnaire on an item-by-item basis. Male and female therapists completed the questionnaire for a healthy male or female and for male and female therapy patients. Maxfield found that when the socially desirable pole and the masculine pole corresponded, males fell closer than females to that particular pole on only 30 of 53 items, and this was not significant. On the other hand, when the feminine and socially desirable pole corresponded, females were closer to the more desirable pole on 23 of 25 items, constituting a significant finding. Less than half of the means on individual items differentiated healthy men and women, and of those individual means which did, about half favored women. Also, on 90% of the items, men and women fell on the same side

of the mid- (or neutral) point, with no critical or quantitative differences between the sexes; (3) One of the conclusions drawn by Broverman et al. (1970) is that a double standard of mental health exists for men and women. This judgement was based on the finding that therapists rated healthy women significantly different from a healthy adult; no such differences appeared in the ratings between men and adults. A more parsimonious explanation may be that "adult" was assumed by subjects to refer to "man", this being the more commonly accepted generic referent, at least in the time when the scale was constructed. This may reflect a bias in language, and not necessarily a sexist standard of mental health.

Other investigators using a Broverman-type scale (Kravetz, 1976; Harris & Lucas, 1976) do not find evidence supporting a double standard of mental health for men and women. Harris and Lucas (1976) and Kravetz (1976) found no significant difference among ratings of healthy adult females and males. In addition, Kravetz found that it was the social desirability of an item which determined the pole that was most frequently chosen by subjects who were rating healthy men and women. Consequently, on male-valued items most subjects used the masculine - and more desirable - pole to describe women as well as men. The same trend was observed on female-valued items, with the more desirable female pole being used to describe both sexes.

Several other investigators have also examined stereotypy among practicing psychotherapists with mixed results. Fabrikant, Landau, and Rollenhagen (1973), in what was essentially a replication of the earlier Broverman research (1970, 1972), showed therapists as having a more "liberal" view of women (i.e., women were accorded more of the positive behaviors and roles which were previously considered exclusive to men). For example, both male and female therapists endorsed the view that women should exercise the freedom to choose roles other than those of marriage and family. In a 1974 study, Fabrikant found, however, that therapists' perceptions of sex role characteristics more closely paralleled findings in other studies (Chesler, 1971, 1972; Broverman, 1970, 1972; Nowacki & Poe, 1973) which, to reiterate, generally show a less positive evaluation of the female role. In this second study Fabrikant (1974) used an adjective check list describing sex role characteristics as applied to either a male or female. Therapists of both sexes were asked to choose those works which were most descriptive of men and women respectively and to rate their selection according to its positive or negative value. It was demonstrated that male therapists rated 70% of the female words as negative in constrast to 71% of the male words which rated as positive. Female therapists were similar in their ratings; 68% of female words were rated as negative and 67% of male words were rated as positive.

One of the more intriguing lines of development to arise from the differential valuation of male and female stereotypes is the notion that sex role itself may be differentially related to psychiatric symptomatology. Although the relationship is rarely made specific, it is assumed that the inferior portrayal of women, as it emerges in the stereotypy research, is connected to female neuroses, which are seen as resulting from societal demands and discriminations rather than as representing a supposed mental illness of the person. It is also assumed that women "go crazy" more often than men, probably as a result of biased diagnostic labeling. Lastly, it is assumed that the therapeutic process, by representing the traditional/cultural norms, reinforces a system of beliefs and attitudes which are psychologically damaging to women (Brodsky, 1977; Chesler, 1971, 1972b; Rawlings & Carter, 1977; Broverman et al., 1970; Bem & Bem, 1970). Because these assumptions constituted serious criticism of the treatment of women in the realm of mental health services, the evidence bearing on the relationship between client sex and therapist stereotypy will be reviewed in detail.

Research on Sex Bias in Clinical Diagnosis and Treatment

Before reviewing the research on sex bias in clinical diagnostic assessment and therapeutic treatment, a brief discussion on methodology and definition of sex bias is in order.

Methodology

The most common approach in investigating the problem of how women are dealt with in therapy has been to use an analogue in which therapists are required to describe women in general, or women patients in particular, and whose responses are then taken to be indicative of how they would treat women in therapy. Analogue studies vary considerably in the extent to which they achieve some ecological validity. Some studies attempt to show that therapists have stereotyped views of women, but these studies fail to show how or if such an orientation translates into the therapy situation (e.g., Broverman et al., 1978). Other studies come closer to the clinical situation by having therapists make judgements based on materials concerning real or simulated cases (Abramowitz, 1977). In this instance, however, the affective context of therapy is absent and the therapist's judgement may constitute an intellectual response that otherwise might be moderated by the emotional aspects of the client-therapist relationship. Therapists may also demonstrate differences in attitude toward males and females in the experimen-

tal situation that may never be reflected in the therapeutic situation. This is not particularly surprising: When called upon to produce a stereotypic response, men and women, even those who are therapists, repeatedly produce clearly defined stereotypes with very little variation across studies. In ambiguous situations, which are generalized and unclear, for example, when asked one's opinion about women "in general", the tendency to stereotype is increased: However, as information increases the specificity of the situation or more clearly defines the individual under consideration, this tendency vastly diminishes (Rotter, 1967).

On the other hand, therapists can produce socially desirable responses to the same extent as any other group of subjects, and they may produce judgements free of sex bias in the experimental situation while behaving in a sexist fashion when confronted with a client. In conclusion we must employ caution when interpreting the results of analogue research on sex bias in therapy. The data from such studies allows us to draw inferences, but we cannot generalize from these inferences to the therapeutic situation. Unfortunately, all to many generalizations about therapists' attitudes toward their female clients have been drawn from analogue research without any demonstration of the generalizability of results. The question yet remains as to whether stereotypes are incorporated by mental health professionals in

their work with clients; well designed field research would contribute greatly to completing this complex and still unanswered question.

Research on Sex Bias in Psychotherapy

The issue of how sex stereotyping by therapists affects their treatment of women clients is clouded by confusing definitions of sexist therapy. To demonstrated that female patients are being treated differently than male patients is not sufficient evidence in and of itself. More to the point is whether in treating women differently therapists are offering women a service which is inferior in quality to that available for men. This would represent a legitimate and irrefutable example of sexist therapy. Sexism could also be identified if it could be demonstrated that even if the treatment of men and women was equal, that the treatment was more appropriate for men. Equal treatment does not always lead to equal outcomes, and if different goals are appropriate, equal outcomes may not be desirable.

By way of an introduction to a review of research on sex bias in clinical treatment, two studies will be considered first in order to illusrate the problems with ambiguity in our definitions of sexist therapy.

Abramowitz (1977) conducted an investigation of prejudicial opinions among family-oriented clinicians by assessing the relative degree of blame ascribed to mothers and fathers

of maladjusted children. Based upon cultural traditions and various psychological theories which stress the mother's involvement in personality development, she anticipated that therapists would over-attribute blame to mothers. Both therapist sex and sex role attitude (traditional versus non-traditional) were proposed as variables which might moderate stereotypic blame attribution. Each therapist was presented with bogus clinical descriptions of two child-stimulus configurations: Two examples typifying masculine and feminine maladjustment were described (athletic incompetence and obesity-unattractiveness respectively), and child sex was role matched or unmatched within each description (an athletically incompetent male and obese-unattractive female constitutes a sex-role matched, whereas the reverse sex-inadequacy pairing is unmatched). Mother versus father proportion of parental blame for the child's pathology and mother versus father treatment need were assessed. The mother was generally held more responsible for faulty child rearing than the father, although this effect was not as strong as anticipated. In addition, mothers of maladjusted girls were blamed more and were seen as more in need of treatment than mothers of disturbed boys. Therapists with a more traditional sex role attitude assigned greater treatment need to mothers of obese-unattractive children, and tended to blame mothers of maladjusted daughters slightly more than did their less traditional colleagues. In conclu-

sion, one can only say that the Abramowitz study lends only partial support to the notion of sex-role related clinical bias. This study does not demonstrate whether the traditional therapists' perscription of greater treatment focus for mothers of daughters truly reflects sex bias or, on the other hand, a realistic assessment based on societal expectation that mothers are responsible for feminine socialization. Abramowitz herself is not quick to fly the banner for sexism in therapy. To quote the author, "if the mother is, in fact, more involved in feminine than masculine socialization, the traditional therapists' allocation of treatment focus according to patient sex-role inadequacy domain might not be regarded as more justifiable than that of their untraditional colleagues" (Abramowitz, 1977, p. 32). This sort of interpretation goes a long way towards neutralizing the association between womanhood (in this case motherhood) and mental illness. Thus mothers may be more "blame worthy", but keeping in mind the tentative character of the results, while interpreting these findings within the context of prevailing sociological ideologies, it is not easy to claim biased treatment against women in this one instance.

In other instances strong claims of widespread bias by therapists are made, yet evident methodological flaws in the research would caution against such definitive interpretations. The 1974 APA task force (Task Force on Sex Bias and Sex-Role Stereotyping in Psychotherapeutic Practice, 1974)

which examined the extent of sex bias in psychotherapeutic practice serves as a good example. As a result of this survey (an open-ended questionnaire designed to elicit descriptions of circumstances indicative of sexism) four main areas of sex role stereotyping and perceived sex bias emerged. First, therapists were seen to foster traditional sex roles for female clients: This involved their emphasizing marriage and family as primary sources of gratification. Role diversity was not encouraged and therapists were seen to scapegoat women in family therapy by deferring to the husband's wishes. This finding corresponds to an early study of dual career families by Holmstrom (1972). Although this is not a clinical study, it nonetheless demonstrates that when problems arose it was generally the wife's interests that were sacrificed. Although the wife's time, interests, and career were highly valued, the husband's were considered still more important. Another study (Poloma, 1972) of role conflict in married professional women describes similar results. Even among modern, egalitarian couples, remnants of traditionalism affect behavior: Similar sex role ideology emerges as a predictor in areas of psychotherapy and contributes to the pattern of perceived stereotypic male superiority. Secondly, therapists were observed to show bias in their expectations of women. The related theme of female devaluation was reflected by the therapists condoning of violence toward women and their acceptance of the victimiza-

tion of women (e.g., the notion that women "ask" for rape). Devaluation of women was fostered by the use of demeaning labels to describe women, such as "histrionic", "hysterical", and "manipulative" (Brodsky, 1975 relates other examples from our speech that illusrate how much harsher we can be in our evaluation of one sex or another as a result of stereotyping: Men are "ambitious" or "exuberant" when exhibiting the same behavior which is referred to as "aggressive" when engaged in by a woman). Symonds 1971-72, similarly notes that a show of aggression in boys is referred to as "strength of character", while in girls this is labelled "unfeminine". Thirdly, psychoanalytic concepts were used by therapists in a sexist fashion. For example, assertiveness in women was interpreted as "penis envy". Fourth, women were treated as sex objects by their therapists, including seduction by the therapist. Double standards for males and females in the sphere of sexual activity were reinforced by therapists. In conclusion, the Task Force report identifies the concerns of female psychotherapists which relate their personal experiences of perceived sex bias in clinical practice. Aside from the fact that the recommendations of the Task Force are not based on any empirical data, several other problems are evident in this report. The questionnaire was mailed to 2000 women in appropriately selected divisions of APA, but only 320 recipients returned the completed questionnaire. It is almost certain that this sample is biased

in that only women who had concerns or experiences with the issue of sex stereotyping in psychotherapy responded to the form. As we know nothing about the remaining 1680 women who failed to reply, any truer estimates of the extent or manner of perceived stereotyping by clinicians is inexact. Also, the questionnaire was mailed only to females, again creating a biased sample, and the male viewpoint is noticeably absent.

An interesting aspect of the Task Force Investigation was the attempt to have respondents convey their experiences with sexism from the perspective of both therapists and clients - as providers of psychotherapeutic services and as consumers. Generally very few studies have paid attention to the effect of the patients' perceptions of stereotypic attitudes held by the therapist. Since it has been demonsrrated that a therapist's expectancies about a client can influence the client to respond in the expected direction (Goldstein, 1962), the compliance issue may be a very important aspect in sex stereotypy research. A portion of a study by Fabrikant (1974) was concerned with the extent to which patients were attuned to the therapist's values and perceptions. Each therapist was required to ask a male and female patient to respond to the same form which they themselves completed (i.e., an Adjective Check List of sex role characteristics). In addition the patients were asked to provide their opinions as to how the therapist came across

to them. Unfortunately, the results of this aspect of Fabrikant's study are confusing and often contradictory. What emerges is a mixture of traditional viewpoints held by male and female patients, as well as a movement towards attitudes reflecting increasing equality between the sexes. Patients sometimes do and sometimes do not accurately perceive the therapist's attitudes: For example, male thearapists state that they neither limit nor encourage female patients to the traditional wife/mother passive female role, and both male and female patients concur that this attitude of the male therapist prevails. The feminist view that male therapists perpetuate male dominance is not substantiated in this instance. On the other hand, male and female therapists claim to hold a single sexual standard for married couples, yet patients of both sexes indicate that the therapists strongly convey a double standard.

Determining whether or not patients can pick up on therapists' values, and can be shown to either agree or disagree with these attitudes is perhaps a limited exercise, however, unless these correlations are also shown to have some measurable impact on the therapeutic process. This is not to suggest that a counselor's attitudes do not matter, since the weight of evidence regarding the pervasive effects toward conformity seems to counter such a disclaimer (Frank, 1973; Rosenthal, 1966). The only information in Fabrikant's (1974) study that relates the therapists' stereotypic atti-

tudes to some aspect of therapy is that female patients report that they have been in therapy over twice as long as male patients. In conjunction with the data that therapists still view male characteristics as positive and female characteristics as negative, one might consider that differential stereotypic attitude is in some way related to length of stay in treatment. Fabrikant does exactly that, and states "the overall results most strongly support the feminist viewpoint that females in therapy are victimized by a social structre and therapeutic philosophy which keeps them dependent as long as possible" (p. 96). Fabrikant bases this hypothesis on the fact that female patients in his sample spent an average of 5.7 years in therapy compared to 2.3 years for males, a difference which is significant. Female therapists who have also been patients show a similar pattern: They have reported being in therapy significantly longer than their male colleagues (3.5 years vs. 1.8 years). The dependency interpretation is reminiscent of Bardwick's (1971) description of the dynamics of the therapeutic relationship, which includes a dependent, suffering individual - the patient (usually female) - who looks for help from a more powerful, independent individual who is not suffering - the therapist (usually male). The congruence between the client's expected role and expected (stereotypic) feminine behavior (i.e., dependent, interpersonally oriented, help-seeking) does not escape Bardwick or Fabrikant.

Returning to Fabrikant's findings of longer time in treatment for females, other interpretations of these results are as equally plausable as the stereotypic bias explanation, and they should be considered. For example, perhaps the type of presenting problem or the choice of therapeutic technique (which may be related to presenting problem) is the more critical factor in determining length of stay in treatment. Further investigation on stereotypic attitudes as they affect this variable is definitely called for before we can unequivocally accept as fact opinions such as Fabrikant's.

A more recent and better designed study (Billingsley, 1977) tested the hypothesis that if clinicians' stereotyped mental health attitudes carried over into treatment, therapists would choose more feminine goals for female patients and more masculine goals for male patients. On the other hand, if therapists were not responding to client sex in a stereotypic fashion, treatment plans should reflect an effect for more situation-specific factors, such as client pathology. The results confirmed that client sex did not influence the therapists' choice of treatment goals, but that client pathology in fact did: Therapists chose significantly more feminine treatment goals for an explosive pseudoclient than for a restricted pseudoclient. A main effect for therapist sex was also found, indicating that the female therapists chose more feminine goals, with no client sex or pathology interaction.

Contrary to Billingsley's findings, Maslin and Davis (1975) did find evidence of sex role stereotyping by counselors-in-training. In this study, a significant main effect for therapist sex was found. Male therapists were shown to hold more stereotypic attitudes of women than were the female therapists. Other research (Hill, 1975) has also confirmed that male and female counselors respond differently with male and female clients (counselors were more empathic with same versus opposite sex clients; clients of female counselors reported more satisfaction than clients with male therapists). Male therapists have also been shown to see a greater proportion of clients as improved (74%) as compared to female therapists (50%) (Strassberg and Anchor, 1977), and this is irrespective of client sex. Male and female therapists were also shown to differ in their judgements of degree of client disclosure, with male therapists seeing more of their clients as high disclosers. Female therapists rated female clients as low disclosers.

Delk and Ryan (1975) examined sex role stereotyping in therapists, not as a function of counselor sex, but as a function of A-B therapist distinction. They found that A-therapists (who endorse the more "feminine" stereotypes in their self descriptions, Goodwin, Geller, & Quinlan, 1973) sex stereotyped to a greater extent and B-therapists (who endorse the "masculine" stereotype in their self descriptions) in evaluating the mental health of others. Interest-

ingly enough, in this study female therapists did not cluster at the A-pole of the A-B continuum (Goodwin et al., 1973 indicated that they did).

Several other psychotherapy variables have also been tied to the therapist sex variable. Female therapists have been shown to keep troublesome clients in therapy longer than do male therapists (Hiler, 1958), to elicit greater expression of feeling (Fuller, 1963), to be more directive in psychotherapy (Heilbrun, 1961), and to be generally more positive toward clients (Fuller, 1963; Meltzoff & Kornreich, 1970), showing significantly more positive feeling than males and using significantly more positive comments (Persley, Johnson & Hornsby, 1975).

Many studies examining sex biases in therapy use both client sex and therapist sex as independent variables. Undoubtedly, studies using a therapist-client gender pairing design (at least a 2x2 factorial) are complex (see Tanney and Birk, 1976, for a comprehensive review), and inconsistencies in results should not be surprising given so many variations in research methodology. Other independent variables may also be introduced for investigation, further complicating procedures. Hill, Tanney, Leonard, and Reiss (1977) for example, suggest that the type of problem with which the client presents may be one of the variables, aside from client and/or therapist sex, affecting differential counselor resposnes. Different types of personal-emotional

problems may elicit different responses from therapists. For example, Thomas and Steward (1971) found that counselors responded differentially to females on the basis of career choice: Girls who chose traditional career goals were rated as more appropriate and received fewer recommendations for need of counseling than girls choosing "deviant" career goals (e.g., engineering). Hill and her colleagues (1977) also present some preliminary evidence that counselor's reactions to female clients varied as a function of both counselor sex (e.g., female counselors were more empathic than male counselors and they were also more optimistic about counseling outcomes than their male counterparts) and client problem (existential anxiety elicited significantly more empathy from counselors than vocational problems).

The emphasis on variables other than client sex (for example, presenting problem) leads one to speculate that perhaps sex stereotyping is the result of an interactive process between the client, other situational factors, and the therapist, where client gender is only one variable in the entire contextual situation. An article by Frieze and Ramsey (1976) is pertinent to this discussion, for it emphasizes the effect that additional variables, besides client gender, have upon the formulation of stereotypic orientations. These authors conclude that specific non-verbal behaviors (e.g., eye contact, posturing, and intonation) function as cues which reliably differentiate men and women.

One set of behaviors (occupying large personal space, more touching of others, lower voice pitch, and more talking) is commonly interpreted as signifying dominance, whereas another constellation is thought to communicate emotional warmth and lower status (such as, small zones of personal space, greater intrusion into personal space, higher voice pitch with more extreme pitch shifts, greater frequency of eye contact, and eye contact held for greater periods of time). These two sets of cues are often those where sex differences are maximized, so that men tend to display more high-status, dominance cues, and women create a greater impression of emotional closeness in their non-verbal behaviors. This trend is consistent with our prevailing sex role stereotypes, and is critical to attributions of femininity (and masculinity), and, as it has been demonstrated, to attributions of inferiority (or superiority in the case of men). Such non-verbal cues are regarded as particularly powerful in their effect on maintaining the stereotypes because they often function at an unconscious level, and are thus more resistant to active change. Research on the perceptual process also suggests that we tend to both focus on and recall what is familiar, thus relying on our habitual response sets (Sebald, 1962). Our selective attention, as it were, influences us to literally see men and women acting out their traditional sex roles. Thus, given men and women do act differently and in a manner which is congruent with sex

stereotypes, it is not unlikely that clinicians, attending to such behavior, accurately label it as typically masculine or feminine. We already have some idea of the consequences of such labeling when men and women conform to sex role expectation, and we will now review this in greater detail.

Adjustment and Feminine Identity

A large body of research demonstrates that a high level of sex typing is undesirable and that this is particularly true for women (for example, masculine males are seen as more adjusted than feminine females, Brown, 1958; Mussen, 1962). High femininity in females has been correlated with high anxiety, low social acceptance and poor adjustment (Sears, 1970; Cosentino & Heilbrun, 1964). Bem (1975) demonstrated that androgynous subjects were more adaptable than highly sex-typed individuals and that feminine females tended to show the greatest behavioral deficits. Ego strength has been shown to be inversely related to adoption of a female sex role (Gump, 1972), a finding which is supported by other research (McKee & Sherriffs, 1959) showing adult women, in general, as having lower self-esteem than men.

Sex role identification with parental models has also been related to female adjustment. Girls who strongly identified with feminine mothers were less well adjusted than girls whose mothers were characterized as masculine (Heilbrun & Fromme, 1965); identifying with a masculine father

was even more highly associated with psychological adjustment. The trend toward poorer adjustment for feminine females was also indicated in another study by Heilbrun (1968). The better adjusted masculine girls were more goal oriented and they demonstrated more assertive, self-assured interpersonal behaviors (high dominant, high exhibition, low succorance, low abasement).

While the results of studies seeking to establish a relationship between the sex role identity of females and their psychological health can be enigmatic (i.e., results often fail to reach statistical significance and estimates of the relative size of an effect are absent from the published reported findings), the trend is that femininity in females is associated with poorer adjustment. However, some research into psychological adjustment and it's relation to sex role identity in women provides what seems to be contradictory evidence. Women who identified more closely with the feminine stereotype were shown to be better adjusted and happier than women who had more masculine concerns (Wessman, Ricks & Tyl, 1960; Wessman & Ricks, 1966; Constantinople, 1965). Mood was assessed with an Elation-Depression Scale which consisted of 10 adjectival statements reflecting a range of feeling with the extremes represented by "Utter depression and gloom; completely down" to "Complete elation; rapturous joy and soaring ecstasy". Happiness and adjustment may be correlated positively with the feminine stereotypic role to

the extent that role-appropriate women experience less negative consequences from society, whereas fewer social reinforcements may be available for masculine-identifying women. This apparently is not only the case for adult women who, for example, have been shown to avoid success (i.e., a masculine concern) to prevent negative consequences (Horner, 1970), but also for young girls. Data suggest that bright, independent and creative girls (i.e., more "masculine" girls) receive less affection from their mothers and less attention from their teachers (Bardwick, 1971). We should also recognize that within-group variances may be large, and that different sub-populations of women may differ in the extent of their investment in sex role identification. For example, it may be more important for a housewife to consider herself as happy with her role than a career women who has, in her work, an alternative source of gratification. In general, strong identification with the female role tends to be correlated with poorer adjustment. What about women who reject the feminine role - how are they valued, and how are they affected by the prevailing double standard of mental health?

Mental Illness and Sex Role

The notion that women who express dissatisfaction with the feminine role, or who adopt alternative life styles are labeled as "sick" has been entertained by many researchers (Chesler, 1971, 1972; Brodsky, 1977; Levine, Kamin, & Levine, 1974; Stockburger & Davis, 1978; Rawlings & Carter, 1977; Gingras-Baker, 1976; Lerner, 1974; Barrett, Berg, Eaton, & Pomeroy, 1974). To quote Chesler, "Woman's inability to adjust or to be contented by feminine roles has been considered as a deviation from 'natural' female psychology rather than as a criticism of such roles" (Chesler, 1971, p. 363). The idea that women's unhappiness with the feminine role is considered a matter of pathology, or the idea that women's choosing of non-feminine roles is regarded as deviant, is thought to be reflected in the personality evaluations that mental health professionals make of women. Cowan (1976) for example, found that a sample of 30, mostly male therapists, rated their female clients "feminine" characteristics as problems. An accumulating body of research implies that the particular representation of males and females observed in mental health facilities can be attributed to biased expectations of disorders by sex. Demographic studies point to a greater population of females in mental hospitals, show that more women than men receive outpatient services, and reveal a greater likelihood of certain diagnostic categories for females, such as depression and hysteria (Gove & Tudor, 1973; Statistics Canada, 1970).

Although the analysis is still speculative, several investigators have attempted to relate characteristics of adult female sex roles to aspects of mental illness (Gover & Tudor, 1973). One of the most intriguing hypothesis is a variation on the theme that mental health professionals do not think of women's symptoms as reflections of an oppressive sex role, but as "problems of individual pathology" (Chesler, 1971). This is succinctly expressed by Barrett et al. (1974): "Rather than being viewed as manifestations of a slave psychology of the oppressed (Szasz, 1961) their [women's] symptoms depression, inferiority, and low self esteem are seen as signs of neurosis, hysteria or personality disorder, that is, as indicators that something is wrong with women themselves" (Barrett, Berg, Eaton & Pomeroy, 1974, p. 12). Perhaps because sex acts as a master status which channels individuals into such particular roles, most of the explanations for the preponderance of women served by mental health professionals has involved an analysis of sex roles. Without doubt, the research emphasis has been, and continues to be, on the female role as it is associated with mental illness. When we get on to how men have fared within the mental health system we find, as researchers, that we have committed the sin of omission: The relative absence of research on sexist bias against men by the same therapeutic community which stands accused of sexist judgement against women is significant. Although it is never made explicit,

there is an assumption that men are simply not victimized by the same biases that so affect women. Whether this assumption has any validity or not is impossible to say given the present state of the research. Intuitively one would suspect that men should have as many problems with role adjustment as women (this hypothesis receives some empirical support by Tilby and Kalin, in press, and Cowan, 1976), but there can be many reasons why men do not tax mental health facilities to the same extent as women do. For example, perhaps, because of role constraints unique to men, they are not allowed to express emotions as readily as women, and therefore never make the initial contact with therapeutic agents as frequently as do women. One study (Cowan, 1976) found that therapists did not feel that men had any fewer problems resulting from sex role expectation than women. Eighty-three percent of the sample agreed that sex role expectations did, in fact, cause problems for males in therapy.

Another explanation involves the form of the disturbance expressed by men. If men are as "disturbed" as women, perhaps the way this reveals itself prevents society from seeing the disturbance as primarily emotional or psychological in nature. In this vein Phillips (1968) has suggested that men express psychopathology in a manner that frequently involves destructive behavior toward others, such as rape and robbery (Zigler & Phillips, 1960). Because men often ex-

press themselves in socially deviant ways, we should then expect them to be more affected by the legal than by the health system. The ratio of males to females in correctional institutions in 1973 was approximately 25 to 1 (Williams, 1977), and these statistics tend to support this line of reasoning.

It is not an easy matter to finally decide whether women or men, for that matter, are victims of sexist bias within the larger social order and within the smaller therapeutic sphere as well. An initial step has been made in this direction by research endeavors which attempt to analyse the stereotypic negative assessment of women, and to relate this role characteristic with another value judgement - that being the presence or absence of mental illness. This research perspective represents an interchange between social context and psychiatric forms of social control. Various theories using a role-analsyis approach, which have been advanced to explain the differential sex distribution of mental illness, will be discussed in the following sections.

Demographic Research

The demographic research attempts to show, in the statistical data on mental illness, evidence of the effect of oppression and negative stereotpyic evaluation on women. If these effects have any validity, proportionately more women than men should be showing up for treatment in various

health care facilities and rates of mental illness among women ought to be higher than rates for men.

Various epidemiological studies (Leighton, 1971; U.S. Department of Health, Education and Welfare, 1970; Luce & Wand, 1976; Mayo, 1976; Radloff, 1975; Gove & Tudor, 1972; Dohrenwend & Dohrenwend, 1969) have shown that male and female admissions to psychiatric services are disproportionate to their representation in the general population. Although figures on mental health statistics are not entirely free of controversial interpretations,[2] by and large a higher incidence of psychiatric disorders and symptoms are indicated for the adult female population in comparison to same-age males (some studies do control for sex distribution in proportion to the numbers of men and women in the population at each of the age categories, Smith, 1975. In other studies this is not the case: Chesler, 1972, for example, uses

[2] Luce and Wand (1976), in reviewing the Canadian statistics on mental illness, found a reverse trend for sex distsribution in comparison to U.S. figures. They report that males in Canada require a disproportionate amount of care in institutions for the mentally ill. Smith (1975) also reports a similar picture for the Canadian data; compared to men, a consistently large female involvement is not shown. Some of these sorts of inconsistencies arise because the definitions of what constitutes 'mental illness' vary from study to study; statistics across studies are also put together very differently. In some cases, for example, raw data is reported, whereas in other surveys percentage data might be presented. Breakdown of data by age and marital status also varies considerably. These discrepancies make it difficult to compare reports and, at times, to draw conclusions from the data presented within the same report. Gove and Tudor (1973), for example, present a breakdown of data by sex and diagnostic category for outpaitents, but no comparable data is presented for individuals of inpatient status.

overall numbers instead of rates in the over 60's category although, since women end to live longer than men, there are likely more women than men in this category).

In general, an analysis of sex ratios based on a breakdown of psychiatric facilities shows that when we consider various levels and types of care situations, including first admission to psychiatric hospital, psychiatric care in a general hospital, hospital psychiatric outpatient, private psychiatric practice and general medical practice, more women than men are considered mentally ill (Gove & Tudor, 1972, report the female to male ratio as 4:1). Greater distress and symptoms are also reported by more women than men for all adjustment areas (Joint Commission on Mental Health, 1960) and in general medical practice, psychiatric disorders are ranked third among presenting conditions for women and seventh among men (Shepherd, Cooper, Brown & Kalton, 1964). Radloff (1975) points out that higher rates of mental illness for women occur among the married (Gove, 1972; Luce & Wand, 1976), but that in other marital categories results are less clear (e.g., in the never married/widowed category more males are depressed than females).

Demographic studies also point to a greater likelihood of certain diagnostic categories for females, for example, neurosis (48% of all women psychiatrically diagnosed on first admission are placed in this catch-all category (Statistics Canada, 1970). On the other hand, males are much more like-

ly to receive diagnoses of antisocial personality, drug addiction, neurological impairment and alcoholism (Brodsky, 1977). Statistics Canada (1970) indicates that the diagnostic categories of alcoholism and personality disorders alone account for 42% of the diagnoses for men on first admissions. For males there is no concentration in the "emotional" types of diagnoses; for women, psychiatry seems to organize their problems as predominantly emotional. The very idea of neurosis focuses on the emotional state as a problem for psychiatric intervention. Emotional states are thus given independent status as problems, particularly for women.

Interpretations of Demographic Research: True Rate Theory, Stress Models, Normative Models

The full range of implications of the reported sex differences in mental illness is as yet unknown and several interpretations may apply to this data. It is possible for example that the statistics reflect a "true" rate. In a sense, statistics will always represent something which is real about the problems that men and women have, but it must be kept in mind that what is real cannot be separated from professional operations which define and shape what is happening into recognizeable form. Given the variability among psychiatric institutions and among mental health professionals, even in terms of defining mental illness and its vari-

ous subcategories, as well as the vast differences in the approach of various epidemiological studies (for example, Gove and Tudor, 1973, exclude organic categories of psychiatric disturbance in compiling their statistics, whereas other studies do include organic disoders), it is unlikely that the research even begins to reflect a "true" rate.

The true rate theory might be seen as closely related to a biological determinism interpretation which suggests, for example, that men are less emotional than women because of hormonal (Gray, 1971) or neuronal (Gray & Buffery, 1971), or genetic (Slater & Cowie, 1970) differences. Thus we might find women naturally clustering within categories of neurotic disorders; the greater tendency toward expression of emotionality might make women more visible in the display of distress symptoms. Men, as less emotional, would not be so visible for target labeling. Several criticisms of this point of view exist (Archer, 1971; Marks, 1969) and at present many authors have adopted a cautious opinion which treats biological and genetic factors in a low-key fashion (Rosenthal, 1970).

Another interpretation of the unequal sex distribution across psychiatric categories is based on general stress theory. Gove and Tudor (1973) assume that women experience more frustration and less reward than men, and that this stress is primarily related to difficulties associated with the feminine role. Along the same lines, Phillips and Segal

(1969) suggest that women seek psychiatric help because the feminine role (and not genetic disposition) also allows them to display emotionality and stress more easily than men. Dohrenwend and Dohrenwend (1969) suggest that both men and women experience the same stress but react to it differently. Chesler (1972) essentially sympathizes with this point of view, but adds her own qualifications. While she agrees that men may be as equally disturbed as women, she hypothesizes that the form the male disturbance takes is much more tolerated within the social system and so is not seen as "neurotic" or "sick". Societal pressures related to role expectation may force men to express pathology in forms that escape labeling for greater periods of time. For example, it is more permissible for men to drink to the point of intoxication. In this respect, a man can "drown his sorrows" in drink, yet he may not be labeled as alcoholic as quickly as a woman, since the female role so strongly censures this sort of behavior to begin with. Thus, "true" rates of mental illness may be similar across the sexes, but because of certain aspects of stereotypic role definition, males may not enter the psychiatric statistics to the same extent as females. One possible interpretation is that role expectations for men may be better defined, providing both more guidelines for "masculine" behavior, as well as a clearer indication of when the guidelines are breached. Thus, if role deviancy is a criterion for mental illness, the chances

of labeling a man as 'sick' when he is not, according to this definition, would be substantially reduced. Whether women are as successful as men in executing their female role may be more ambiguous, since traits that comprise the role may be fuzzy themselves. It thus may be harder to judge when a woman is being interpersonally effective (a feminine trait) than it may be to judge academic success and achievement (a masculine expectation) in a man. Thus, for women, role deviancy, may be less clear cut, and just to be sure, we may take the risk of labeling her as "sick" when in fact she may not be.

Another possibility may be that the range of acceptable behavior is much greater for men. This line of reasoning implies that labeling is an indication of what society considers unacceptable behavior. The argument follows that women are more confined by their roles i.e., they are allowed fewer acceptable behaviors and therefore more of their behaviors would be considered unacceptable and subject to labeling bias. Thus we are led to expect that therapists will attribute mental illness to women who deviate from their stereotypic norms, but that different attributions which do not suggest mental illness are made for men who also deviate from role expectation. In a recent study Tilby and Kalin 1980) challenged the concept that role deviancy has more severe consequences for women. Their results showed that on the contrary, sex role deviance resulted in a much more neg-

ative evaluation by psychology students for male than female stimulus persons. These findings are interpreted by the authors as suggesting that society demands greater role adherance by males to the male role than by females to the female role. Interestingly enough, women who perceive themselves as deviating from stereotypic roles consider themselves to be in need of therapy. According to women's responses on the Adjective Check List (Gough & Heilbrun, 1965), women who see themselves as requiring counseling describe themselves as aggressive, assertive, discrete, independent, intelligent, self-centered, effeminate and noisy (Heilbrun & Sullivan, 1962). A woman thus described does not conform to the cultural sex role stereotype for women, and failing to fit expectations, these women apparently do not regard themselves as emotionally fit (Carter, 1974). Several studies confirm that deviations from culturally sanctioned sex role behavior were considered maladaptive and undesirable (Kagan, 1964; Kohlberg, 1966). Consistent with this interpretation is the finding that women who do not see themslves in need of therapy describe themselves in a manner more consistent with the feminine stereotype (Carter, 1974). However, a study by Cowan (1976) indicates that therapists' ratings strongly indicate that the typical female client is not described by sex role inappropriate masculine characteristics: The finding for female clients indicates clinical judgements of overinvestment in femininity. Degree of sex role devian-

cy may be a factor to consider in explaining what seems to be contradictary findings. The further a client is seen as deviating from her norm, the greater the severity of attributed disturbance may be (Shapiro, 1977). Sex based attributions may also be evident to the degree that the therapist accepts the stereotypic norms for men and women. Tilby and Kalin (1980) show the predicted relationship with evaluative bias and sex role ideology: The more traditional their subject-raters were, the more they reacted to sex role deviance with attributions of maladjustment. This lends empirical support to Chesler's arguments (1971, 1972, 1975) which she bases largely on informal impression. Thus, to the extent that individual therapists do not accept stereotypic views of man and women, attributions of psychological disturbance, predominantly to females, should be less frequent.

Although the normative model (which is based on an adjustment notion of mental health) has received much attention as a way of explaining differential attributions of mental illness for men and women, certain inconsistencies remain that are not so easily explained by this model. That it is role deviancy which elicits bias is challenged by the findings of a recent study (Shapiro, 1977) which showed that counselors were significantly more biased in their behavior (i.e., less verbally reinforcing) with a typical female client than with an atypical client. Female counselors tended to be more biased than males, but this difference was

not significant. Moreover, the ideal woman was described in masculine and instrumental terms, suggesting that the traditional woman was less valued. However, the study did show that when the atypical client was rated as maladjusted, the greater the degree of perceived maladjustment, the more biased was the counselors' behavior toward the client. Zeldow and Greenberg (1975) also disagree with the hypothesis that sex role deviancy is responsible for attributions of mental illness, and they formulate a theory that sex attribution (i.e., explaining behavior by specifying the sex of the actor as the causal agent) is most likely when males and females behave according to traditional role ascriptions: Thus, when behavior is sex appropriate, it more clearly differentiates men and women. Some empirical investigations by the authors lend support to this argument.

A more microscopic examination of "mental illness" reveals that the psychiatric sub-categories are themselves sex-typed: Women display 'female' psychiatric symptoms, such as depression, frigidity, neurosis, suicidal attempts and anxiety, whereas men display 'male' disorders - alcoholism, drug addiction and brain disease (Annual Statistical Report, 1971; Annual Statistical Summary, 1969, 1970, 1971; Annual Report, 1971; HEW, 1965-1968; Gove & Tudor, 1972; Levine, Kamin & Levine, 1974). Adult women's symptoms express self-criticalness, self-deprivation and often self-destructiveness. Male psychiatric symptomatology is more

likely to reflect pathological self-indulgence and hostility toward others.

The relationship between female psychiatric symptoms and the description of the feminine stereotype is clear (some studies show that female patients display more behavior independently rated as masculine (Angrist, 1968). However, once a woman is identified or labeled as a patient, certain assumptions may automatically follow - one of them being that the reason she is labeled as mentally ill is because she has deviated from her culturally prescribed norm and displays masculine behavior). The normative model, which suggests that deviancy from one's sex type is critical in mental illness attributions, would lead us to expect more masculine symptomatology for women patients, and we do not have much evidence for this.

Chesler (1972), as a major proponent of the normative model theory, handles the discrepancy or ambiguity in the following way, "what we consider 'madness', whether it appears in women or men, is either the acting out of the devalued female role or the total or partial rejection of one's sex-role stereotype. Women who act out the conditioned female role are clinically viewed as 'neurotic' or 'psychotic'. When and if they are hospitalized it is for predominantly female behaviors such as 'depression', 'suicide attempts', 'anxiety neuroses', 'paranoia', or 'promiscuity'. Women who reject or are ambivalent about the female role ...

are also assured of a psychiatric label ... and, if they are hospitalized it is for less 'female' behaviors, such as 'schizophrenia', 'lesbianism', or 'promiscuity'" (Chesler, 1972, p. 56).

One of the more significant oversights in Chesler's argument is her failure to account for the behavior of men within the psychiatric system. The normative model is intended to provide a definition of mental health for both men and women. Chesler has painstakenly constructed her case for the position that women are victims of biased psychiatric judgement. She presents evidence for a double standard of mental health which is shown to penalize women through the devaluative aspects attached to the feminine stereotype (women are labeled as 'ill' when they act feminine), and she documents findings which are interpreted to show that women receive equally harsh assessment when they behave in a masculine fashion. This does nothing to explain how men enter the psychiatric system, and statistics show that they definitely do. Are we to assume that there are no negative aspects attached to the acting out of the male role, or for that matter, that there are not equally harsh criticisms of men who deviate from masculinity? If the mental illness model is thought to personalize social problems for women, clear empirical evidence must be submitted before we are asked to believe that men too are not subjected to the same restrictive and stultifying roles that medical model adherents ascribe to women as patients.

One of the sentiments expressed by Chesler (1972) is a reiteration of a theme that surfaces repeatedly throughout the literature on the treatment of women by the therapeutic community - and that is that therapists label women's rebellion against their perscribed role as a projection of their personal inadequacies and as proof of their psychological disturbance for which they (women) themselves are to blame. This is the essence of the argument which states that females are victims of sexist therapy (Rawlings & Carter, 1977). Women, as the largest consumer group of psychotherapy, are the most influenced by a service whose net effect is seen as maintaining the "status quo" (Halleck, 1971). If we accept the evidence for a double standard of mental health for men and women, any therapeutic orientation which values conformity to cultural sex roles would be seen as working against the best interests of women. A key assumption in the sexism argument is that women's unhappiness, for which they seek professional salvation, is primarily and directly related to social factors - namely the oppressiveness and restrictiveness of the female role (Brown, 1973; Barrett, Berg, Eaton, & Pomeroy, 1974; Polk, 1974). Therapists have been accused of mistakenly viewing the social problems of women as idiosyncratic symptoms of disease entities - neurosis, depression and hysteria. Therapists who treat women are thought to convey their biases against them through their conscious (or even unconscious) acceptance of the cul-

tural values and roles for women - i.e., the view that women are inferior, not motivated to succeed, manipulative, rigid, tense and unrealistic (Heilbrun & Sullivan, 1962; Carter, 1974) - a composite of unhealthy trait attributes (Broverman et al., 1970). Seeing women as unhealthy (or as less healthy than men) is a perspective that bears some relation to conceptions which are tied in with the medical model. The medical model draws a parallel, which can be misleading, between individual unhappiness or socially deviant behavior, and physical disease. The very notion of "mental illness" forces one to think of behavior problems within the medical analogue, which seeks for the cause of pathology within the person (i.e., makes an internal attribution). It therefore seems that, due to the nature of the feminine role, women are seen as unhealthy and therefore are thought of as having something wrong with them. Psychotherapists who subscribe to the medical model are thought to encourage women to see their anger and unhappiness as emotional illness; thus women "bear the brunt of psychopathic classification - not only in terms of being more relatively diagnosed (and mistreated) as "mentally ill", but in terms of specific illnesses being invented just for them; e.g., puerperal (childbirth) and menopausal neurosis and psychosis" (Brown, 1973, p. 450).

The view of men, on the other hand, who are seen as dominant, forceful, intelligent, superior, thorough and enterprising, for example, does not immediately strike one as un-

healthy. Since the male profile is seen as so much healthier, relative to the female composite, there is not the same impetus to seek the cause of male unhappiness within the personality; the stereotype defines the male personality as having a "cleaner bill of health to begin with.

To follow through with the line of reasoning, this ought to mean that therapists should focus on environmental stress as a major source of the male client's pathology, rather than diagnosing his problem as residing within his personality. There are few direct tests of the hypothesis that psychotherapists encourage female clients to regard their psychological distress as internally caused, and male clients to see the identical symptoms as having their origin in external factors. Some corroborating support for this idea is offered by Peterson and Peterson (1973) who conducted a survey in which they undertook to examine sex roles as they are portrayed in popular sex and marriage manuals. The collection of publications reviewed were shown to credit the male partner for responsibility in a positive sexual relationship. However, when sexual problems arose, the female was almost unanimously regarded as responsible for the cause (and the cure).

Other, but more indirect support, is also evident in a survey analysis, but in this case of drug advertisements, from four American medical journals (Prather & Fidell, 1975). Content differences emerged which showed psychoac-

tive drugs to be preferred for women while non-psychoactive medications were the treatment of choice for men. The authors interpreted the findings to suggest that, in conformity with cultural stereotypes, women were diagnosed as having emotional illnesses, but that men had organic ones. Moreover, within the psychoactive drug category alone, the reasons given as to why women and men needed the drugs were very different: Men needed them for work-related reasons and women for less specific symptoms - diffuse anxiety, tension, or depression.

Essentially, both of these surveys are attempts to analyze the causes of different attributions of pathology made to men and women. Attributions of causality have been made to the dispositional qualities of women (personal dispositions) and to factors in the environment (environmental dispositions) in the case of men. Such dispositional attributions, either to the person or the environment, are thought to increase our understanding of the behaviors of therapists and possibly clients. The following section will be devoted to an examination of the aspects of attribution theory that relate specifically to sex biases and therapeutic judgements.

Attribution Theory and Sex Bias in the Diagnosis and Treatment of Mental Illness

Although the classic finding of clinicians' bias against healthy adult women (Broverman et al., 1970) has resulted in considerable research related to the stereotypic evaluations of women, the full implications of these findings on clinical judgement are as yet unexplored. The negative bias against women has been considered to be an important variable in the attribution of mental disorder. However, the exact role of sex in the attribution of mental illness has not been clarified or well integrated within existing theoretical models. Looking at attribution theories within a psychotherapeutic paradigm may be especially relevant to increasing our understanding of how client sex affects ascriptions of mental illness by therapists. Attribution theory in general is a study of the rules which the average person uses in making causal judgements concerning their own behavior or the behavior of another. Sex, as an object characteristic, (i.e., characteristic of the actor) in the attribution process is really a special case of a more general judgement process. When an observer (i.e., the therapist) is called upon to interpret (causally attribute) an actor's (i.e., the client's) behavior, two types of information are used to arrive at an explanation: (1) the actual, observed behavior - what the actor is doing, or (2) the expectancies the observer has for that behavior. The expectancies of in-

terest here are the categorical assumptions which the observer makes about the actor as a representative of a particular group. We have already reviewed some of the general literature which indicates that observers do have expectancies for the behavior of males and females which derive from the stereotypic assumptions of men and women as members of groups defined by gender. Consequently, the behavior of males and females is judged in connection with the set of stereotypic expectancies, and the resulting attributions will differ to the degree that stereotypic expectancies differ.

A concept which is central to theories of attribution is the distinction which is made between causal attributions in terms of the locus of control (Heider, 1958). The result of an action, according to a naive psychology analysis, depends upon two sets of conditions: factors that reside within the individual (internal dimension), and factors that reside within the environment (external dimension). Other works by Jones and Davis (1965) and Kelley (1972b) also attempt to account for the process whereby acts are attributed either to the person (internal) or to the environment (external).

It has already been noted that the prevalent medical model of mental illness predisposes therapists to place the causal locus of psychological disturbance within the patient (i.e., pathology is due to some trait or personal characteristic). Most studies in the area of bias have only indi-

rectly investigated the effect of sex role and/or gender on these attributions of pathology. Chesler's (1972) contention that deviation from traditional sex role stereotypes plays a critical part in clinical labeling and treatment, is an example of the indirect way that the relationship between sex and attribution of pathology is made. Chesler implies that mental illness is more often attributed to women who sex role deviate than to men and, more significantly, that therapists attribute pathology to internal factors more often in the case of women than in the case of men. Thus she implies that women are the victims of unfair or inappropriate attributions because of the overemphasis on personal causes in the case of women.

Various theoretical works (Jones & Davis, 1965; Kelley, 1972b) have attempted to account, in a general way, for the process whereby acts are attributed to the person or to the environment. Attributional processes have also been studied as they specifically relate to the development and ascription of pathology. Such studies bear the most relevance to the topic under discussion, and they will be reviewed in some detail. Pathology is assessed from an interpersonal perspective in the attribution research, as it is considered both from the point of view of the observer (in this case, the mental health professional) and the actor (the client).

Attribution of Causality by Actors

In a series of studies, Ickes and Layden (1978) demonstrated that one's tendency to explain behavioral outcomes as either internally or externally caused was significantly related to the two variables of self-esteem and sex. Previous research had already demonstrated that high self-esteem subjects tended to have an attributional style which emphasized the internalization of successful outcomes and the externalization of failure experiences. This style was not relied upon to the same extent by subjects low in self-esteem who were more likely to attribute failure to internal deficiencies (Solley & Stagner, 1956; Fitch, 1970). A correspondence in attributional style and sex has also been demonstrated by such researchers as Deaux and Emswiller, 1974, Deaux and Farris, 1974, and Feather and Simon, 1973. Attributional style refers to an individual's characteristic pattern of attribution that is based on a non-rational model (i.e., motivational/emotional) of explanatory processes (Ickes & Layden, 1978). The style of attributing impersonal task outcomes more internally following success and more externally following failure is referred to as a self-serving bias and is thought to reflect a person's motivation to maintain or enhance self-esteem. Sex differences in self-serving bias have been reported, although results are not always consistent (Simon & Feather, 1973; Feather, 1969; McMahan, 1973); in general however, results indicate the

self-serving bias to be more prominent for males (Feather & Simon, 1973; Levine et al., 1976; Stephan et al., 1976). Feather and Simon (1973) consider women to demonstrate a self-derogatory tendency or bias, as they internalize failure (at least following failure on anagram task solutions).

Self-enhancing and self-defeating biases have also been related to such factors as expectancy for success and ego-involvement. That females have less expectancy for success than males has been documented (Feather, 1969; Stephan et al., 1973; Feather & Simon, 1973). Not too surprisingly, studies also show that subjects with lower expectations for success (typically female) also tend to attribute success less internally and failure less externally than subjects with higher expectations (typically males) (Feather, 1969; McMahan, 1973; Simon & Feather, 1973). Ego-involvement, as a motivational factor, has also been demonstrated to affect attributions. When a task is defined by it's characteristics as reflecting one's self-esteem or self-image, then self-enhancing attributions on task performance may be exaggerated. We may expect to find sex differences in self-serving bias depending on whether tasks or situations are represented as stereotypically masculine or feminine in character. Such sex differences in attribution of causality occur to the extent that males and females show expected differences in expectation for success and ego-involvement

in the task (Rosenfield & Stephan, 1978; Deaux & Farris, 1974).

To summarize, results suggest that at least for skill and achievement tasks, men expect success, but that women expect failure. Thus, in their expectations and their attributions of causality for performance outcomes, men seem to function more similarly to high self-esteem subjects, whereas women appear more similar to low self-esteem subjects.

The research of Ickes and Layden (1978) demonstrates clear differences in attributional style in groups which differ in sex and in levels of self-esteem. In the first of a series of studies, the authors had male and female undergraduates make causal attributions (internal or external) for a wide range of hypothetical events having either a positive or negative outcome. It was shown that subjects who were low in self-esteem differed the most in their attributional style in response to negative outcomes: These subjects tended to make internal attributions for events with negative outcomes whereas high self-esteem subjects demonstrated the opposite tendency by externalizing the cause of the outcome. For positive outcomes, subjects both high and low in self-esteem made internal attributions, but the effect was significantly attenuated for low self-esteem subjects. The second study essentially replicated the findings of the previous research, but several methodological changes were incorporated in the second experiment. Rather than

have subjects make an internal or external attribution of causality, in Study Two, subjects rated the probability of each cause on a five-point scale. Again, with negative outcomes, the differences between high and low esteem subjects was most apparent: High self-esteem subjects externalized the probability of negative outcomes to a significantly greater extent than did low self-esteem subjects. The findings regarding sex differences in this study also parallel those in the previous research. For positive outcomes, males tend to find internal attributions more probable than do females, and external causes as less probable than females. For negative outcomes, males rate both internal and external causes as less probable than do females. Regarding the relationship between sex and self-esteem, males are clearly shown to resemble high self-esteem subjects, whereas females closely resemble those low in self-esteem; for positive outcome situations males at each level of self-esteem (high, moderate and low) rate internal causes as more probable. On the other hand, for negative outcomes, males rate all causes at each level as less probable than do the corresponding females. One other study in the series, in which a failure situation was experimentally induced, emphasized the critical effect of attributional style on performance. Three important findings emerged from this piece of research: (1) the most crucial element underlying performance deficits was recognized as the attributional style of inter-

nalizing failure, and not as low self-esteem per se, (2) females performance was definitely affected by failure, but the performance of males was unimpaired, and (3) the disruption of performance following failure was more evident for females who internalized failure and least evident for males who externalized it.

Ickes and Layden postulate two major theoretical interpretations of their data. First, either the findings represent the true cause-outcome experiences of subjects, or second, the data reflect attributional biases (or distortions) in subjects' perceptions of cause-outcome relationships which result from learning through socialization or from motivational differences that arise from the individual's need to maintain either a stable self-concept or the perception of control.

It is interesting to note the reported similarity between the attributional tendency of women to internalize negative experiences and the attributional bias of low self-esteem subjects. The stereotypic portrayal of women has previously been associated with high anxiety, poor adjustment, and most importantly, low self-esteem (Sears, 1970; Cosentino & Heilbrun, 1964; Gump, 1972; McKee & Sherriffs, 1959); perhaps the attributional style of women who identify with the feminine stereotype will also be characterized by the ascription of negative consequences to personal factors, and correspondingly, of positive outcome experiences to external fac-

tors (thus showing the same pattern as low self-esteem women in the Ickes and Layden, 1978, research). This tendency to make negative internal and positive external attributions is referred to as pathological by Ickes and Layden, and perhaps future investigations will demonstrate this style to be representative as an attributional style of female psychotherapy clients.

Some supportive evidence in this direction has been reported recently by Frieze (1978). Although her sample of battered women does not necessarily constitute a pathological group, these women nonetheless do form part of the psychiatric client population, and they are, of course, women. Working from an attributional model, Frieze outlined four sources that clients could use to locate the source of the wife-beating problem - it could be attributed to the husband, the wife, joint cause of husband and wife, and causes in society as a whole. Although the women sampled in this study had a variety of causal explanations for the wife-beating, the majority (50%) felt that it was because "they had failed to do something their husband wanted them to do". Thus the women generally located the cause as internal to themselves and blamed themselves for their husband's violence (it was something about them that justly provoked the husband). When the same battered women were asked to make locus of causality attributions about a hypothetical case of wife-beating, 56% of the women attributed causality to the

husband. A majority (65%) of non-battered women also attributed the locus of causality to the husband (external attribution) in a hypothetical battering case.

It is important that more investigations on client attributions be conducted in the same vein as the research of Frieze. Such data adds another dimension to the stereotypy literature which largely has been ignored to date - the relationship between client and therapist attributions. If it can be demonstrated, for example, that female clients in general demonstrate attributional biases toward the internalization of emotional difficulties, it may not be entirely accurate to lay the responsibility for the personalizing of women's problems solely on the therapists' shoulders. If, on the other hand, it can be demonstrated that therapists make internal attributions of causality independently of, or in contradiction to the client's own ascriptions, then we may be able to consider the possibility that therapists also have attributional biases, which may vary depending on the sex of the client, for example, therapists may reflect with more accuracy the attributional statements of causality made by their clients.

Attributions of Causality by Observers

Many observers in society make causal attributions for emotional disorder, including of course, mental health professionals who are trained and sanctioned by society to do so. A number of research studies have attempted to specify the antecedent conditions which these observers use for making internal or external attributions of mental illness: However, only a few studies have explicitly used attribution theory to establish a theoretical link between sex typing and the attribution of adjustment. Sherman et al. (1978) for example, directly asked psychotherapists their opinion about the reason for more females than males in therapy ("More women than men in this country seek therapy. How would you account for this?"). Only 1% of the responses (most therapists gave more than one response) indicated that women themselves were to blame, while 4% mentioned that people other than themselves were more likely to see women as sick or the person who would have to adjust to the family problems (N=208). Thus, this particular professional sample seems to make relatively few internal attributions for women. However, in response to another question on an Information Scale designed to tap areas of knowledge that were considered important for therapists to know, 18% of the therapists were shown to agree that female victims of rape had been subtly seductive. This may be interpreted as an internal attribution of causality, yet it is never included

in the figures that the authors consider to directly assess attributional processes.

Judging from the types of designs and analyses that appear in current articles, two problems repeatedly appear in the application of attribution theory to sex differences. (1) many studies fail to specify the sex distribution of their sample which is making the attributions of behavior (Sherman et al., 1978); a related problem is the failure to analyze for sex when it is specified as an independent variable, and (2) many "observers" in the research are college students who are asked to respond in the experiment as though they were therapists. The generalizability of these results to a population of professional therapists is clearly in question. The effect of the sex variable on the attribution of mental illness is also a complex phenomenon to assess; an overall effect for client sex in judgements of mental illness is absent in numerous studies (Zeldow, 1975; Coie, Pennington & Buckley, 1974; Lewittes, Moselle, & Simons, 1973), but client sex is often shown to interact significantly with other variables to differentially affect clinical judgements of disturbance.

A study by Zeldow and Greenberg (1975) assessed the extent to which male and female raters judged the sex of another person to be a factor in explaining his or her behavior. The trend ($F=3.28$, $df=1/86$, $p<10$) although not significant, was for men to make more sex attributions than

women (i.e., judgements about a person based simply on his/her sex). Moreover, the sex attributions were inappropriately made by men. Sex was seen by them to determine attitude or behavior when it was not necessary to make such attributions (i.e., attributing to sex the fact that a female gets angry sometimes, a male doesn't care whether people really like him or not, that a female gossips a little at times, or that a male regards the right to speak his mind as very important). This finding does have limitations in applicability however, for it is unlikely that raters ever make judgements on the sex variable in so contrived a situation. Sex of actor, as a variable, never could realistically exert an effect without doing so in some contextual situation: the number and/or kinds of variables with which it interacts in the situation may alter the saliency of sex as a variable in determining attributions. However, this should not detract from what intuitively seems clear, and that being when we observe the behavior of others, at least part of that behavior is attributed to the sex of the actor.

A somewhat more ecologically valid analogue study was designed by Isreal, Raskin, LIbow, and Pravder (1978) in which male and female raters made judgements of mental disturbance for male and female clients who were depicted in varied sex role appropriate situations. This is one of the few studies in which both sex and sex role behavior are manipulated as independent variables. The authors hypothesized that a sex

by role-appropriateness interaction would have a greater effect on judgements of pathology for role deviation by females. This prediction was based on evidence for the derogation of the female sex role and the harsher judgement of inappropriate behavior when engaged in by women (Abramowitz, Abramowitz, Jackson & Gomes, 1973; Zeldow, 1976). Male and female students trained in the use of the Diagnostic and Statistical Manual of Mental Disorders were required to make clinical judgements concerning four case histories (paranoid, schizophrenic, depressed neurotic, phobic compulsive and alcoholic), with each case being modified in two ways - by client sex and sex role appropriateness. The results of this study showed that (1) depressed neurotic females are seen as more disturbed than males, (2) females are seen as less responsible than males[3] and (3) both male and female neurotic and phobic clients adopting a female role are regarded as more immature than male-role clients. The overall pattern reflects the now familiar double standard of mental health. The authors feel that these findings suggest that "women are perceived as 'sicker' than men", and that the at-

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[3] Although the meaning of 'responsibility' is ambiguous in this study, it appears that the authors do not intend this to represent a locus of causality variable. The term may also be used to represent 'dependability' or 'reliability'. In the context of the article, the word may be interpreted as meaning 'accountability' in the way one would "assume responsibility for one's actions" (p. 407). If no assuming responsibility for one's behavior is regarded as a criterion for mental illness, women in this study are represented as conforming to the criterion of personal responsibility by virtue of their sex alone - which could be interpreted to suggest an anti-female bias.

tribution of pathology represents therapist bias in judgement. Isreal et al. also show a sex of rater effect, with more negative judgements made by female raters. Unfortunately, the raters in this research were not practicing clinicians, and the usefulness of this data as it may apply to real-life clinical situations is limited. No significant effects were found for sex role variables on diagnosis, reflecting a high variability in psychiatric diagnosis that might be eliminated by using a trained professional sample.

Coie et al. (1974) also hypothesized that locus of causality attributions would be related to degree of conformity to role expectation, so that the greater the deviation, the more likely the behavior of the actor would be attributed to internal dispositions. Assuming that a judgement of a psychiatric disorder represents a case of an internal attribution, it is argued by Coie that as deviance from role expectation increases, the likelihood of mental illness attributions and concomitantly, internal attributions, would also increase. Because of the differing sex roles of males and females, it was predicted that pathology would be differentially attributed to men and women, depending upon the context within which their behavior was judged (i.e., some contexts are male salient, or instrumental in character, conforming to masculine stereotypic definitions; others are female salient or expressive in character and are stereotypically feminine, Parsons & Bales, 1958). Essentially, the

latter prediction was confirmed. Situational stress was shown to have a different effect on the attribution of pathology to males and females depending upon the saliency of the situation. Thus, role deviation alone is not sufficient justification for attribution of pathology to males and females depending upon the saliency of the situation. Thus, role deviation alone is not sufficient justification for attribution of pathology. In a male salient situation (i.e., where the social role of instrumentality is attached to masculinity, an example being a case where a man would be threatened by events disrupting progress toward a career goal) males engaging in deviant behavior are ascribed less pathology than females behaving in the same way in the identical situation (i.e., for males we are to assume that their behavior is determined by environment). The converse of this for the female salient situation (i.e., where the social role of expressive orientation is attached to femininity, an example being a case where a woman is stressed by the disruption of a personal goal, such as breaking a date) is not as clear. Although females were never judged as significantly less disturbed than males, professional help, at times, was seen as less appropriate for females. Unfortunately, Coie et al.'s study does not explicitly test the relationship between the sex of actor, degree of role deviation, and locus of causality. We can only make an assumption, based on Coie's initial formulations about the

relationship between disorder and internal attribution, that attribution of greater pathology for females in the male-salient situation indicates greater attribution to internal factors for women.

Calhoun, Selby, and Wroten (1977) also explored the typicalness of behavior as a variable affecting perceived mental illness. However, they only used a female actor and typicalness was related to situational constraints rather than to a more specific sex role conformity/deviance variable. However, their findings are in keeping with other related research, and they do show the expected relationship between situational appropriateness, internal causality, and degree of attributed pathological disturbance. Strong (1970) also suggests that behavior which is perceived as atypical will also be perceived as internally caused.

Another variable related to locus of causality is role perspective. Snyder et al. (1976) and Snyder (1977) have researched the effect of role perspective on causal attributions, and have shown that factors generally tend to attribute their behavior to situational factors, whereas observers tend to attaribute the identical behavior to internal factors. These findings substantiate the formulations of Jones and Nisbett (1971), Batson (1975) and Storms (1973). The tendency for observers to make personal attributions for the behavior of others is strengthened when the information which they have about those others is cast in a

medical model. This focuses the therapist's attention on the client as being the source of the problem. Shenkel et al. (in press), in a recent study, demonstrate the usual tendency toward personality attributions by clinicians (in this case graduate and advanced undergraduate students in social welfare). Results also show that this tendency could be attenuated by presenting situational information to the clinician after hearing the client. Clients' problems that were diagnosed as personality oriented were also considered significantly more severe than problems which received a situational diagnosis. This "bias" of clinicians toward personality attribution may be problematic in therapy if it at all challenges tha client's credibility is a judge of his or her own behavior. As Shenkel points out, "If the client is truly 'maladjusted' because of situational problems and the clinician insists on exploring the more 'serious' personality variables, therapy may become a dissatisfying expe-rience for both" (p. 9). A good illustration of this is provided by Snyder et al. (1976). Although a direct comparison of attributions for male and female clients was not made, the bogus female client in their research clearly attributed the cause of her problems to situational factors; nonetheless the counselor-observers regarded her problem as being personality based. It is possible that this does represent a general observer bias, but it may also be related to the sex of the client. Further comparisons between males and females are needed to provide a more direct test.

One of the factors that has been shown to affect therapists' attributions of causality is their professional orientation. Therapists with a psychodynamic bias tend to make significantly more personal attributions than therapists who consider themselves to be behavioral-clinicians (Snyder, 1977). Whether type of professional training overrides any effect of the client sex variable remains to be seen.

Perceived degree of maladjustment is another variable which can affect locus of causality attributions. It has been shown that the greater the estimated maladjustment the more likely is the observer to make a person-based attribution and vice versa (Calhoun, Johnson, & Boardman, 1975; Snyder, 1977; Calhoun, Pierce, & Dawes, 1973). some contradictory evidence is provided by Johnson, Calhoun and Boardman (1975), who demonstrated that a sample of clinicians made an environmental attribution for severe depression when that depression was seen as having occurred in the past. (Other evidence by Kelley, 1967, who also explored attribution as affected by consistency over time, would have led one to expect that the behaviors of long duration i.e., having occurred in the past, would be associated with internal attributions). Johnson et al. (1975), interestingly enough, attributed their unexpected finding to the uniqueness of their sample (an internal attribution).

How sex of actor affects the relationship between degree of maladjustment and locus of causality is, again, not specifically established. Given that feminine stereotypic behaviors are more negatively valued than masculine traits, and that female characteristics are considered less healthy, or indicate more maladjustment, we may predict that more internal attributions would be made for females than for males. The converse of this should also be true. Given the bias towards seeing women as personally responsible for their problems, they should be rated as more maladjusted than males presenting with the identical problem.

One final variable to consider in the attribution of pathology is the "false consensus" effect as it relates to causality judgements. False consensus has been referred to by Heider (1958) as "egocentrism" and it is used to describe people's tendencies to believe that their own perceptions reflect most others' views as well; one tends to think that their own responses are relatively common. Ross, Greene, and House, (1977) showed that observers' social inferences were affected by the false consensus bias. When observers (raters) rated others reponses as similar to their own, they considered the responses to be common and unrevealing concerning the actor's distinguishing personal characteristics. On the other hand, when responses differed from the observers', the responses were regarded as uncommon and personally revealing of the actor. In a related experiment Bennett

(1972) demonstrated that perceived similarity between the subject and a target person decreases the probability that deviant behavior will be seen as mentally ill. Target subjects who were seen as dissimilar on tasks thought of as important were rated as significantly disturbed; severely disturbed behaviors were generally attributed to personality traits of the target person, while in contrast, normal/mild deviation from societal expectation was attributed to situational factors.

That perceived similarity in values between client and therapist is important in effecting therapeutic gain has been previously documented (Rosenthal, 1966; Pepinsky & Karst, 1964). This leads one to speculate that gender similarity may be a basis for assuming a common or shared value system among therapists and clients. It is possible that cross-sex differences in a therapist-client dyad underlines the uncommon and dissimilar values, whereas the converse of this may be true in same-sex pairings. Since most practicing therapists are male (Barrett et al., 1974) and most clients (at least in private practice) are female (Shofield, 1963), perhaps the effects of false consensus bias become exaggerated in the overall picture. Many situations occur where diagnostic judgements must be and are made on relatively little information about the client. With little actual information about a client's past performance (as is frequently the case in an intake interview with a client),

early stereotypic expectations may weigh heavily in subsequent judgements. With an opposite sex client (most frequently this will be female client with a male therapist) the therapist may assume dissimilar values based on stereotypic expectations and may be more prone to attribute the client's perceived uncommoness to personal factors (and subsequently make attributions of mental disorder, as we are led to expect from the research).

Summary and Conclusions

It has been hypothesized that powerful negative biases against women may be important variables in the attribution of mental disorder by psychotherapists. Various studies of the attitudes of women and men toward women's roles have provided the background for understanding the influences on therapists' personal values. This area of research has not been without vigorous controversy. Challenging questions have been raised about how the implicit value systems therapists maintain regarding women are translated into explicit treatment decisions involving who to treat, what diagnostic categories to assign, which treatment goals to set, and which techniques and strategies to employ. Although the controversies are not yet resolved, they have been well defined. In particular, the feminist issue in psychotherapy has been a "hot" topic. The centrally debated dynamics of this issue are that sexist therapeutic approaches are char-

acterized primarily by their acceptance of traditional/cultural definitions of women, where the traditional role is demeaning, powerless and negatively valued. Such therapy is seen to inaccurately place the blame for women's problems on intrapsychic factors, which encourages women to seek individual solutions to what are essentially social problems. The pervasive adherence to the mental illness model itself is implicated in fostering the tendency of therapist to personalize women's social problems (the model brings into focus the individual as being the causal locus of psychological distress).

Polemic aside, what does the literature reveal of scientific response to the issues raised? Basically, there is much theroetical discussion, but little systematic development or research on theory or practice. The current research has been beset with multiple methodological problems. At the risk of oversimplifying, many design and procedural difficulties are related to confusion about the conceptualization of socio-cultural sex roles and their measurement. Evidence accumulated to date suggests that sex roles emphasizing masculine or androgynous orientations are favored in terms of adjustment advantages and other measures of perceived desirability. However, this is by no means universal, and we find the effect of sex role is moderated by the situation, the measurement used, the task or the sex of the experimenter-observer. The implication of this is that re-

search designs must specify the limiting conditions under which certain results can be anticipated.

Other research difficulties stem from the fact that, almost without expection, the research data on the psychotherapeutic treatment of women has been derived from analoque studies, making conclusions from the data, by definition, largely inferential. Thus little direct evidence exists about how professionals do, in fact, treat women, and whether there is any ecological validity to the claim that such professionals show bias in their assessment and treatment of women clients. Although there are many conclusions in the research pointing to sexism in therapy, the data do not necessarily provide such evidence. The source of sexism must be made clearly explicit - to demonstrate that therapists evaluate or treat women differently is not sufficient. It is not clear whether sex role stereotyping, which has been shown to exist as a general phenomenon, exerts a systematic influence on a therapist's judgement of individual cases, especially to the point where the type of treatment offered to women is not only different from that offered to men, but is of inferior quality.

Lastly, in assessing sex as one of the main parameters of the therapeutic judgement process, as a final note it must be said that sex, while not constituting a theoretical model, is nonetheless an important contributing variable; client sex may be shown to significantly interact with other

variables to affect clinical judgement differentially for males and females. Studied from within a framework of attributional theory, client sex may be shown to moderate highly specific explanations that bear directly on ascriptions of mental illness. While we could examine a range of alternative explanations which a therapist could offer for the behavior of a client, in the simplest terms we could limit our search for causes of psychological distress to either the person or the situation. The attributional distinction between internal and external causality has constituted a major factor in the feminist dictum, and is perhaps the one variable related to sexist therapy research with the least empirical support. Differences in attributional style have already been demonstrated for women and men within the context of success-failure situations. Few studies have examined the internal-external dimension for outcomes of behavior that vary along a wide range of non-achievement situations. To increase our confidence in the generalizability of the finding that men and women engage in very different patterns of attributing positive and negative outcomes, we must assess attributional style across diverse situations and explore the interaction of attributional style with various factors.

The possibililty is raised that the tendency to make either internal or external attributions of causality may be of central importance in men and women's estimates of their

own mental health. The attributional style of men and women, as clients, may correspondingly affect the therapist's estimates of the client's mental health. Previous research has shown that attributional style may be related to the variable of self-esteem. The literature would also support an investigation of the hypothesis that attributional style may also be related to assumptions and expectations of sex role behaviors of men and women, both as therapists and as clients.

Appendix B

INSTRUCTIONS TO SUBJECTS AND ATTRIBUTIONAL QUESTIONNAIRES

Client Recruitment and Assessment Forms

The information from the following questions is to be used for research purposes. You are not required to answer these questions. If you choose not to answer, be assured that this will not affect the quality of treatment which you will receive at the Grace Hospital or Psychological Service Centre. If you wish to answer, be assured that all information will be kept confidential and that you will remain anonymous. Your cooperation in providing the following information would be greatly appreciated.

Dear Participant,

The following is a questionnaire concerning your opinion about the reasons why people seek therapeutic help. The purpose of this assessment is to evaluate the extent to which patients and therapists agree about the reasons for which adults seek psychiatric or psychological treatment. This questionnaire is being given to many different individuals of varied ages, backgrounds, and occupations. Your re-

sponses will assist us in obtaining an assessment of the opinions and attitudes of a cross-section of the population who make use of therapeutic services.

Consent Form

The purpose of the experiment in which I have been asked to participate has been explained to me. I understand the nature of this experiment, and I am aware that my participation is voluntary. I hereby give my consent to be used as a subject in this research project.

(Signature in writing)

(Date)

Please indicate whether you wish to receive a brief summary of this research upon its completion. Check one: Yes No If Yes, please address the envelope which has been provided.

What is the main problem for which you are currently seeking treatment? If you feel that there is more than one problem, please list the problems in order of importance to you. For each problem that you specify, please indicate what you personally feel is the reason for the problem. Please use the space provided to answer these questions.

1. The main problem for which I am seeking help is ...

I feel the reason for this problem is ...

2. In order of importance to me, other problems that I have are ...

I feel that I am having these problems because ...

PLEASE ENCLOSE THESE FORMS IN THE BROWN ENVELOPE AND MAIL THEM ON THE SAME DAY THAT YOU FILLED THEM OUT OR LEAVE THEM WITH THE SECRETARY. THANK YOU.

Therapist Instructions and Assessment Forms

After you have finished an intake-interview, please answer the questions on the next page about the client(s) you have just seen (it does not matter whether you will be the individual who is later assigned as the client's therapist). It is preferable that you do this immediately following the intake session, while the impressions you have of the client are fresh in your mind. If this is not possible, complete the forms as soon as you can after the assessment. It is essential, however, that the forms be completed on the same day as the intake.

If you are the only person conducting the intake, when a couple has been seen, fill out a separate form for each person. Do not fill out a form for any client who is under the age of 18.

If you are a part of a co-therapy unit conducting the intake, have each intake - therapist individually complete an assessment of the client or clients. It is important that every assessment reflect an individual opinion and not a consensual agreement. Try to complete the forms before extensive discussion of the case with your co-therapist.

Place the completed forms in the envelope which has been provided and leave the envelope with the secretary.

REMEMBER TO FILL OUT A SEPARATE FORM FOR EACH CLIENT THAT YOU SEE.

Client's name: This client was seen as (a) part of a couple

(b) part of a family

(c) individually I saw this client

(a) by myself

(b) as part of a co-therapy team including

(indicate other therapists by name)

What is the main reason for which this client is seeking treatment? If you feel that there is more than one problem, please indicate what these problems are. For each problem that you specify, please indicate what you think is the reason for the problem.

2. We would like you to evaluate the client in terms of psychological well-being,. How adjusted would you estimate the client to be? Please circle the appropriate scale value.

1	2	3	4	5	6	7	8	9
highly maladjusted								very well adjusted

3. What are the main treatment goals that you would recommend for this client? Specify at least two goals.

Appendix C

THE ATTITUDES TOWARD WOMEN SCALE (AWS) AND ITS SCORING KEY

(The most conservative alternative, scored 0, is shown)

Attitudes toward Women

The statements listed below describe attitudes toward the role of women in society which different people have. There are no right or wrong answers, only opinions. You are asked to express your feelings about each statement by indicating whether you (A) Agree strongly, (b) Agree mildly, (C) Disagree mildly, or (D) Disagree strongly. Please indicate your opinion by marking the column on the answer sheet which corresponds to the alternative which best describes your personal attitude. Please respond to every item.

(A) Agree strongly (B) Agree mildly (C) Disagree mildly (D) Disagree strongly

1. AS Women have an obligation to be faithful to their husbands.
2. AS Swearing and obscenity is more repulsive in the speech of a woman than a man.
3. AS The satisfaction of her husband's sexual desires is a fundamental obligation of every wife.
4. DS Divorced men should help support their children but should not be required to pay alimony if their wives are capable of working.
5. AS Under ordinary circumstances, men should be expected to pay all the expenses while they're out on a date.
6. DS Women should take increasing responsibility for leadership in solving the intellectual and social problems of the day.
7. DS It is all right for wives to have an occasional, casual, extramarital affair.
8. DS Special attentions like standing up for a woman who comes into a room or giving her a seat on a crowded bus are outmoded and should be discontinued.
9. DS Vocational and professional schools should admit the best qualified students, independent of sex.
10. DS Both husband and wife should be allowed the same grounds for divorce.
11. AS Telling dirty jokes should be mostly a masculine prerogative.

12. DS Husbands and wives should be equal partners in planning the family budget.

13. AS Men should continue to show courtesies to women such as holding open the door or helping them on with their coats.

14. DS Women should claim alimony not as persons incapable of self-support but only when there are children to provide for or when the burden of starting life anew after the divorce is obviously heavier for the wife.

15. AS Intoxication among women is worse than intoxication among men.

16. AS The initiative in dating should come from the man.

17. DS Under modern economic conditions with women being active outside the home, men should share in household tasks such as washing dishes and doing the laundry.

18. DS It is insulting to women to have the "obey" clause remain in the marriage service.

19. DS There should be a strict merit system in job appointment and promotion without regard to sex.

20. DS A women should be as free as a man to propose marriage.

21. DS Parental authority and responsibililty for discipline of the children should be equally divided between husband and wife.

22. AS Women should worry less about their rights and more about becoming good wives and mothers.

23. DS Women earning as much as their dates should bear equally the expense when they go out together.

24. DS Women should assume their rightful place in business and all the professions along with men.

25. AS A woman should not expect to go to exactly the same places or to have quite the same freedom of action as a man.

26. AS Sons in a family should be given more encouragement to go to college than daughters.

27. AS It is ridiculous for a woman to run a locomotive and for a man to darn socks.

28. AS It is childish for a woman to assert herself by retaining her maiden name after marriage.

29. DS Society should regard the services rendered by the women workers as valuable as those of men.

30. AS It is only fair that male workers should receive more pay than women even for identical work.

31. AS In general, the father should have greater authority than the mother in the bringing up of children.

32. AS Women should be encouraged not to become sexually intimate with anyone before marriage, even their fiances.

33. DS Women should demand money for household and personal expenses as a right rather than as a gift.

34. DS The husband should not be favored by law over the wife in the disposal of family property or income.

35. DS Wifely submission is an outworn virtue.

36. AS There are some professions and types of businesses that are more suitable for men than women.

37. AS Women should be concerned with their duties of childrearing and housetending, rather than with desires for professional and business careers.

38. AS The intellectual leadership of a community should be largely in the hands of men.

39. AS A wife should make every effort to minimize irritation and inconvenience to the male head of the family.

40. DS There should be no greater barrier to an unmarried woman having sex with a casual acquaintance than having dinner with him.

41. DS Economic and social freedom is worth far more to women than acceptance of the ideal of femininity which has been set by men.

42. AS Women should take the passive role in courtship.

43. AS On the average, women should be regarded as less capable of contribution to economic production than are men.

44. DS The intellectual equalty of woman with man is perfectly obvious.

45. DS Women should have full control of their persons and give or withhold sex intimacy as they choose.

46. AS The husband has in general no obligation to inform his wife of his financial plans.

47. AS There are many jobs in which men should be given preference over women in being hired or promoted.

48. AS Women with children should not work outside the home if they don't have to financially.

49. DS Women should be given equal opportunity with men for apprenticeship in the various trades.

50. DS The relative amounts of time and energy to be devoted to household duties on the one hand and to a career on the other should be determined by personal desires and interests rather than by sex.

51. AS As head of the household, the husband should have more responsibility for the family's financial plans than his wife.

52. DS If both husband and wife agree that sexual fidelity isn't important, there's no reason why both shouldn't have extramarital affairs if they want to.

53. AS The husband should be regarded as the legal representative of the family group in all matters of law.

54. DS The modern girl is entitled to the same freedom from regulation and control that is given to the modern boy.

55. AS Most women need and want the kind of protection and support that men have traditionally given them.

B. Sex Role Ideology Scale

* Item phrased in a traditional direction + Item phrased in a feminist direction

1. The husband should be regarded as the legal representative of the family group in all matters of law. (T)*
2. A wife's activities in the community should complement her husband's position. (T)
3. A woman sshould have exactly the same freedom of action as a man. (F)+
4. The best thing a mother can teach her daughter is what it means to be a girl. (T)
5. A married woman should feel free to have men as friends. (F)
6. Woman's work and man's work should not be fundamentally different in nature. (F)

7. Swearing by a woman is no more objectionable than swearing by a man. (F)

8. A woman is not truly fulfilled until she has been a mother. (T)

9. When a man and woman live together she should do the housework and he should do the heavier chores. (T)

10. A normal man should be wary of a woman who takes the initiative in courtship even though he may be very attracted to her. (T)

11. It is an outdated custom for a woman to take her husband's name when she marries. (F)

12. Women should be paid a salary by the state for the work they perform as mothers and home-makers. (F)

13. Women should be much less concerned about make-up, clothing and body care. (F)

14. Every child should be taught from an early age to feel a special honour and respect for Motherhood. (T)

15. A woman should be appreciative of the glances and looks she receives as she walks down the street. (T)

16. It should be perfectly all right for a mature woman to get involved with a young man. (F)

17. Marriage should not interfere with a woman's career any more than it does with a man's. (F)

18. A man's main responsibility to his children is to provide them with the necessities of life and discipline.

19. A woman should be careful how she looks, for it influences what people think of her husband. (T)
20. A woman who dislikes her children is abnormal. (T)
21. Homosexual relationships should be as socially accepted as heterosexual relationships. (F)
22. More day care centres should be available to free mothers from the constant caring for their children. (F)
23. Women should be allowed the same sexual freedom as men. (F)
24. A man's job is too important for him to get bogged down with household chores. (T)
25. A woman should be no more concerned with her physical appearance on the job than a man. (F)
26. Abortion should be permitted at the woman's request. (F)
27. The first duty of a woman with young children is to home and family. (T)
28. For the good of the family, a wife should have sexual relations with her husband whether she wants to or not. (T)
29. A woman should be more concerned with helping her husband's career than having a career herself. (T)
30. Women should not expect men to offer them seats in buses. (F)

Appendix D

PROCEDURAL MANUAL FOR CONTENT ANALYSIS

Rules for Forming Thematic Units

The first decision in the coding of content data is to decide on the boundaries of the data to be coded, or "unitized". This task consists of differentiating the content under investigation according to distinct themes of causal attribution. A theme is not a "natural" unit for which clear physical guides exist, such as a paragraph set off by indentation, or a complete sentence structure. Each theme is identified primarily on the basis of content, and thematic units will differ from one another only on the basis of content. Often sentences will contain more than one theme, and identifying the proper boundaries between them is a judgemental process for which it may be difficult to formulate rules that cover every type of theme that may occur. The following instructions are intended to serve as a practical guide for assisting raters in their initial task of dividing free response data into thematic units.

Unitizing: Targets and Elaborations

A theme is an assertion about a subject matter. For this particular content analysis the subject matter consists of causal attributions for psychological problems which individuals present at a treatment facility. The designation of a thematic unit is a two-step process. It involves (1) identifying the target, or focal point, which best represents the major motif of any one causal attribution, and (2) identifying elaborative material which either operationally defines the target, defines the meaning of the target, or gives a specific instance of the major theme. Thus, any content which is judged to be an example, development, or description of the target is included with the target as a single unit. The rater must record verbatim all content judged to comprise a unit in its entirety.

Examples of thematic units

Simple thematic units

Single target, no dynamic elaborations

"depression"

"anxiety"

Single target, single elaboration

"stress in his/her marriage" In this example, stress is considered to be the target of the attribution and marriage is a specific instance of a stress-inducing factor.

"resentment over partner's reticence to marry"

In this example resentment is the target and partner's reticence to marry is an elaboration in the form of a causal factor.

"The client is having a hard time dealing with a depression (restlessness, insomnia) that resulted when his/her fiance broke up with him/her".

The major focus of this thematic unit is depression. Restlessness and insomnia are descriptive elaborations of the target and are not considered to have different connotations than depression. The breakup of the relationship is treated as a causal elaboration.

Complex thematic units

Single target, multiple elaborations.

"Nervousness, tension , inability to relax caused by doubts about self as a parent, conflict in role as person with own needs, death of two husbands - one recently, conflict with son, inability to release feelings in a functional way".

The target of this response is nervousness. Both tension and inability to relax are viewed as elaborative descriptions of nervousness, or as additional characteristics of the target. They do not in themselves indicate a change in content that is significantly different than

that denoted by the target. The major theme of nervousness is expanded by the inclusion of three causal factors, parenting, relationship loss, and affective expression. These causal elaborations, being of different contents, suggest three thematic units are involved in this example. The response should be unitized as:

"Nervousness, tension, inability to relax caused by doubts about self as a parent, conflict in role as parent - person with own needs,conflict with son".

"Nervousness, tension, inability to relax caused by death of two husbands, one recently".

"Nervousness, tension, inability to relax caused by inability to release feelings in a functional way".

"Unitize Everything" Rule

Content data is to be divided into separate thematic units, each of which defines a cause and/or reason for which a client is seeking psychological help. On occasion, either a client or therapist will provide a response which is not a causal attribute of a client's psychological disorder. Such responses may be either Uncertain or Uncodable. In the case of Uncertain responses, the meaning of a thematic unit is ambiguous. For example, a therapist causally attributed the client's problems to "high expectations of parents - little warmth or approval". In this example , it is unclear wheth-

er it was the client who held high expectations of his or her parents, thus focusing on a client attribute, or whether it was the parents who held high expectations of the client, thus focusing on parental attributes. Thematic units which have multiple meanings and are unclear in their interpretation must nonetheless be specified in their entirety in the same fashion as scorable units. The rater is to report verbatim the entire unit of analysis.

Responses are Uncodable if they do not identify and/or describe causal attributions of clients' problems. Any response having content unrelated to the task requirement of specifying causal attributions is irrelevant and therefore uncodable. For example, denial of problems by clients is a special case of an uncodable response since this constitutes non-compliance with the task demand. For example, if a client responds by stating:

"I have no problems".

"Not applicable to me".

"I do not have a problem, but my husband/wife does".

the problem denial should be regarded as a separate thematic unit, which will ultimately be categorized as 'Uncodable'. As with Uncertain responses, the rater is to specify the uncodable thematic unit in its entirety. To illustrate this point, a therapist responded as follows when asked to specify the reason for which a client was seeking treatment:

"The client is a bright, verbal, highly intellectualizing, and very defensive person who gives the impression of wanting to engage in therapy yet at the same time standing off". This data is considered to be an entire and distinct thematic unit which describes the client's behavior and cognitive style within the therapeutic relationship. This thematic unit does not describe the reason for which the client is seeking treatment, and therefore does not meet the specified task requirement.

Respondents will frequently present their ideas and perceptions about events in a disorganized fashion. Thus legitimate thematic units may be interspersed with miscellaneous material. This may create a problem for a rater who finds that an otherwise consistent thematic unit has been interrupted by essentially uncodable or uncertain responses. The procedure should be: (1) specify the unit which is miscellaneous, and (2) if the material immediately preceeding and following this unit is connected by virtue of having similar or identical content, include the preceeding and following material together in a single thematic unit. For example:

> "My main problem is anxiety. Actually, I don't really think of this as my main problem and I have other things on my mind. But I am somewhat nervous and I would like to be able to relax more".

My main problem is anxiety and But I am somewhat nervous and I would like to relax more are one thematic unit. The statement "Actually, I don't really think of this as my main problem and I have other things on my mind" is scored as Miscellaneous, Uncodable.

Rules for Ordering Thematic Data

In some cases, open-ended data will be presented in numerically ordered sequences. Usually, this does not present any particular difficulty in unitizing themes, but certain problems do occur, and specified rules of procedure must then be followed. In general, ordered thematic data is of two types, Consistent and Mixed.

Consistent Data.

In some cases, causal attributions of differing content will be arranged in serial order, and the arrangement of data by content corresponds to a specified numerical rank order. In such instances, it will be a simple matter for raters to differentiate various thematic units by order, both numerically and serially, in which they occur. For example:

"1. My main reason = marital conflict. Other reasons = 2. stress related to physical condition, i.e. diabetes and heart problem and gout. 3. self-confidence".

In this example, three different contents are presented in a serial order which corresponds to the numerical rank order given by the respondent. This suggests that there are three separate thematic units contained in this data.

Mixed Order Data.

In other cases, a rank order of causal attributions will be specified by the respondent, but such numerical order may be inconsistent with the given arrangement of themes. In other words, the actual sequence in which the respondent arranges causes may not correspond to their numerical ranking. Ordering of causal attributes may be mixed for several reasons:

a. Multiple causal attributes may be presented within the same numerical rank.

> "The main reason = marital conflict and stress related to physical condition of diabetes. 2. Loss of job".

In this example, the respondent has specified two causal atributes by numerical order. However, two different and unrelated themes are presented within the same rank; an attribution to relationship factors and to stress factors are both presented within the first rank. When the given arrangement of content is at variance with a specified rank order, presentation by content must be given priority. Thus, in this example, three thematic units are to be specified as follows: 1. marital conflict, 2. stress related to physical condition of diabetes, and 3. loss of job.

b. Identical and/or related attributes may be presented in different rank orders.

> "The main reason is 1. marital conflict and other reasons are 2. inability to get along with his/her spouse since the client lost his/her job".

In this example, what the respondent specifies as a second, and separate causal attribution is an elaboration of the theme presented in the first rank. Again, the rule is to differentiate thematic units by content when the actual arrangement of content and numerical ordering of content are at variance.

Rules for Unitizing Specified Causal Data

In some types of open-ended data, a respondent will explicitly relate attributes that may differ in thematic content. The most common instance of this occurs when a respondent specifies a problem, and then deliberately specifies the cause of that problem.

> "Main reason = marital conflict. Other reasons = 2. stress related to physical condition of client. 3. self-confidence. Reason for problem with self confidence: a. change in physical condition e.g. heart difficulties and perhaps fear of dying. b. sexual dysfunction related to diabetes.

Here, the respondent relates, in causal fashion, physical and sexual problems with the third thematic unit of self-confidence. Thus, even though heart difficulty, fear of dying, and sexual dysfunction are not identical in content, they have been explicitly presented as examples of factors which contribute to a client's problem with self confidence. The rule in this case is that a reason or cause for a problem, when it is specified as such, must be included with the problem as an entire thematic unit.

In some cases, targets and their elaborations will be presented in such a manner that it is unclear as to which target belongs with which elaboration., even though the respondent labels the elaborations as causes of the target problems or behaviors. For example:

Presenting problems - anxiety
difficulty trusting others
highly self-critical
difficulty expressing anger

Causes:background variables
(a) lack of intimacy in family
(b) high expectations of parents

Causes: present variables
(a) marital relationship
(b) drugs

In this example, the respondent specifies 4 causes for several target themes, but there are no indications as to which specific elaboration causes a particular target problem. In this case, each of the targets must be seen as caused by all of the specified elaborations. Thus, the first target 'anxiety' is seen as caused by both background variables and both present variables. If the causes are similar in content, they may be considered together with the target as a single thematic unit. If however, the content of each cause is highly distinct, unitize the data as outlined under 'Complex Thematic Units, Single target, multiple elaborations'. Thus, in the above example, the target 'anxiety' and 'lack of intimacy in family' are one unit; 'anxiety' and 'high expectations of parents' are a second unit; 'anxiety' and 'marital relationship' are a third unit, and 'anxiety' and 'drugs' are a fourth unit. In similar fashion, 'difficulty trusting others' and 'lack of intimacy in family' is a single unit, and so on with the remaining targets and causal elaborations.

Occasionally, a respondent uses graphic symbols to indicate relationships among variables . For example:

quilt re. masturbation } obsessional thinking
chronic insecurity

fear of homosexuality } obsessional thinking
chronic insecurity

In such cases where a bracket is used, the responses contained within the bracket are to be considered as independent elements with primary and therefore target status. Material outside the bracket is thought to apply to each element within the bracket; thus, it is of secondary importance, and is to be regarded as elaborative material. The data in the above example should be unitized as follows:

guilt re. masturbation - obsessional thinking

guilt re. masturbation - chronic insecurity

fear of homosexuality - obsessional thinking

fear of homosexuality - chronic insecurity

marital problem - result of first two

Note that obsessional thinking and chronic insecurity are of sufficiently differing contents to warrant the independent unitizing. Also, in this example, we may assume that obsessional thinking and chronic insecurity are descriptive manifestations of the target: cause may or may not be implied. Marital problem is a separate thematic unit; 'result of the first two' is ambiguous and uncodable.

Scoring for Location and Stability

In order to systematically analyze the comments given by clients and therapists now requires a method of quantification. The final task in the analysis of content data consists of assigning directional and intensity scale values to the attributional dimensions of location and stability.

Scoring for Location: Direction and Intensity

Perception of locus of causality is basically an act of categorization (Bruner, 1957). Attributional themes with essentially the same meaning may be classified along a dimension of locus of causality. The categories of causal attribution fall along a continuum which ranges from a highly internal locus of causality at one polar extreme, to a highly external locus of causality at the opposite pole. The scale is represented as follows:

+3	+2	+1	0	-1	-2	-3
highly internal	moderately internal	slightly internal	mutual	slightly external	moderately external	highly external

Scoring for location is a two-step process which first involves judging the directional category of a thematic unit to be either Internal, Mutual, or External, and secondly, judging the intensity of the locus of attribution by assigning a numerical value ranging from +3 to -3. The basic units of analysis consist of the attributional themes, which include targets and their elaborations. The target of a thematic unit will be, in most cases, an abbreviated description of the problem that brought the client into therapy. In the case of treatment goals, it will be the specified modality of therapy. The elaborative material which appends the target will often consist of the client's or therapist's causal attribution for the presenting problem, or the therapist's perceived attribution for the locus of change in

treatment (it should be noted that elaborative material also can be simply descriptive in nature, without implying cause or reason; elaborative material that is descriptive is still to be given more weight than a target in scoring for location). In layman's terms, the target is the word or phrase that designates the problem, and the elaboration will often be the reason or cause for that problem. It is this elaborative data which is to be given the most weight in forming a judgement about the locus of causality and the intensity of that directional attribution. When no elaboration is given, the choice of location and intensity must be made on the basis of the target alone.

Internal Locus of Causality.

Attributions for Client Problems. To make an attribution for causality to internal factors means that we assign responsibility for outcomes and events to personal dispositions or to intrapsychic factors. This refers to all of an individual's behaviors, including thoughts, perceptions, feelings, attitudes, and overt actions. Examples of attributions made to personal dispositions include perceiving a problem as caused by mood or feelings, cognitive factors (including thinking, planning, obsessing, or ruminating), motivation and incentive, behavioral factors (such as attributions to acting, doing, behaving), and self-esteem and conditions of worth. Some examples taken from subjects' records are:

"Agoraphobic reactions"

"Chronic insecurity caused by low self-esteem and feelings of worthlessness"

"My main problem is anxiety attacks over pressure from law school. The reason for this problem is that I am a very insecure person and I don't have a lot of confidence in my ability"

"Highly self-critical"

Attributions for Therapy Goals. Therapy goals are also to be scored for location. The judgement procedure parallels that for the rating of location in the case of clients' presenting problems. However, a cautionary note concerning the scoring of therapy goals is best introduced at this point. All directional categories for therapy goals have in common the ultimate purpose of all therapeutic intervention - which is to benefit the individual who is seeking treatment. Thus, client change (or an internal attribution), whether specified as a direct goal of treatment, or whether seen as a 'by-product' of other therapeutic interventions which perhaps do not even focus on the client directly, is always under consideration when a therapist formulates goals of treatment, treatment modalities, or specific treatment techniques. It is important to be aware of the fact that directional determination is not made on the basis of whether, or

how much, the individual client benefits from a therapeutic intervention. This is primarily because we are making the assumption that regardless of type of intervention, the client will, theoretically at least, always benefit to some extent.

Determination of causal attribution is to be made on the basis of the extent to which a treatment plan focuses on the client as the source of change. Thus, attribution to internal factors that therapy goals have as a focus, implies that dispositional variables are the locus of change. For example, a goal of personality change, whether basic or more superficial, is seen as the most highly individualized and internal focus of treatment. Other elaborations which are appropriate for inclusion under internal attributional categories are themes of symptom relief when the symptom is intrapsychic in nature (e.g. reduction of anxiety, elimination of depression, or reduction of nervousness), themes of a cognitive nature (e.g. insight into a problem, understanding, accepting, awareness of how one behaves, coping, or planning), and themes focusing on over-all adjustment (e.g. sense of responsibility, increase in feelings of worthwhileness, increase in self-esteem, or increase in independence).

All themes in this class must have as their focus intrapsychic change as the primary therapy goal. The modality of treatment can often be used as a guideline for assessing

this dimension. Individual therapy as a choice of modality will usually imply that the individual client is seen as being the source of therapeutic change.

Intensity Ratings.

a. Highly Internal, ±3. Causal attribution is made to basic or core personality factors. Core aspects of personality delineate features that do not change much in the course of living, and exert an extensive and pervasive influence on behavior. Treatment goals are of the type involving fundamental personality change. Individual therapy would be the preferred psychological treatment. Prescription of anti-psychotic drugs (chlorpromazine, reserpine, megavitamin therapy) or drugs used in the treatment of depression (imipramine, lithium) and/or hospitalization for treatment of 'personality breakdown' are of a +3 nature. Whether seen as adjuncts to other forms of therapy, or as primary therapies, both treatments are viewed as vehicles for inducing fundamental personality-behavioral change. Some examples of +3 ratings are:

"I am depressed and anxious all the time"

"I have high anxiety attacks because I have no self-esteem and I have no respect"

"The main treatment goal would be individual therapy for alleviation of depression, focusing on insight into the problem"

b. Moderately Internal, +2. Causal attribution is made to more peripheral personality factors. Statements about such attributes of personality are more concrete and closer to behavior that can be readily observed. These attributes have , relative to core aspects, a more circumscribed influence on behavior. Thus, behavior is seen to be somewhat more situation-specific than those behaviors which receive a +3 rating. Therapy goals would still focus on intrapsychic change, but group treatment might be a preferred modality because it is seen as focusing more on generalized iteractive processes than individual treatment. Hospitalization would be a +2 goal if the purpose of treatment is to provide a therapeutic community to reduce psychological stress upon individuals and enhance community adaptation of discharged patients. The use of minor tranquilizers (meprobamate, valium, diazepam) would be given a +2 rating when the goal of treatment is likewise to reduce psychological stress and maintain the client in the home environment. If a +3 rating is reserved for behaviors manifesting a drug-personality interaction, a +2 rating would be for a drug-personality-environment interaction. Relaxation therapy and systematic desensitization therapy would also fall into this category. Examples of +2 attributions are:

"This client has somewhat poor social skills and is awkward in interpersonal situations"

"This client should have group therapy so he/she can interact with others. This would provide feedback about how he/she deals with others"

"The client should be maintained on valium so that he/she can relax a bit about job pressures. I think that this would help the client function better in the work situation which seems like a pressure-cooker for the client"

c. Slightly Internal, ±1. This rating is neither clearly internal (as are attributions rated as 3 or 2), nor clearly mutual (as are attributions rated 0) in direction. Movement along the scale towards zero (or mutual) implies that interactive processes between personal dispositions and situational factors are implicated as causal agents. A +1 rating suggests that attributions may be made to interactive factors, but the onus of responsibility for outcomes is placed on the individual client's dispositions. Treatment goals suggest that while interpersonal processes or client/situation interactions are desirable as a focus for change, internal dispositional factors are a more salient focus. Examples of themes receiving a +1 rating are:

"My husband and I are having problems communicating. I get too tired to care about it sometimes and I know that I don't initiate very much in the way of conversation"

"Marital therapy would be the main treatment goal and I would focus on the wife's hesitation to talk to her husband"

Mutual Locus of Causality

Attribution for Client Problems. Attributing the locus of causality to mutual factors implies that the perceived source of an outcome or event is due to an interaction between personal dispositions and situational factors, including other persons. This more social orientation which concentrates on the interaction between factors, conveys the idea that the source of responsibility is shared. Thus, attributions to either the interpersonal process of communication or behaviors which occur between socially interacting persons or to interactions between personal and situational (or impersonal) factors implies a mutual or conjoint locus of causality. Examples are :

"My husband/wife and I are considering adopting a child. However, we both seem uncomfortable with some things and we need some help sorting out some of the difficulties"

"I am still living at home with my parents and we fight a lot. We all want different things and we can't see eye-to-eye"

"I am under a lot of pressure to finish a course I am taking. I'm not sure I'm doing too well, but it's hard

for me to say why. I don't have a lot of self-confidence in myself, but on the other hand, this is a really demanding course with a lot of work"

"Well, it's everything really. It's my situation and how I feel about it. I really don't want to have any more kids, but I am Catholic, and my husband wants kids."

Attributions for Therapeutic Change. Therapy goals having a mutual locus of causality include both the individual client and the situational factors with which the client interacts as the focus for therapeutic change. This attribution conveys the idea that the underlying reasons for treatment are perceived as a shared or conjoint responsibility between personal and situational factors; in a complementary fashion, therapeutic manipulations reflect his causal attribution by locating the locus for change in the interactive process. Responsibility for change is thus shared by personal and situational factors.

Therapy goals which focus on interpersonal interactions include themes involving the client and mother/father (parent themes), siblings, husband/wife (marriage themes), peers (friendship themes) or authority figures as sources for therapeutic change. Thematic units focusing on increasing social interactions or increasing communications may also be included in this category. Treatment modalities such as marriage, counselling, group therapy, or family therapy

usually imply that therapy will focus on interactive processes.

Intensity Ratings. Any attribution to shared or mutual factors must always receive an intensity rating of 0. For example, the following attributions illustrate this conjoint assignment of locus of causality:

> "This couple seems to have a very strained relationship. They are unable to express their need in a way that can lead to mutual satisfaction"
>
> "Treatment goal: marital therapy to help this couple explore ways of communication that would meet both of their needs"

Therapy goals or causal attributions for clients' problems which focus on shared or mutual factors, but for some specified reason give weighted emphasis to either personal or situational factors as having more responsibility as a causal agent, are given a rating of +1 or -1 respectively (see Internal and External Locus of Causality for further illustration).

External Locus of Causality

Attributions for Client Problems. To make an attribution for causality to external factors means that we assign total responsibility for outcomes and events to situational or en-

vironmental events. Situational prescriptions are more salient as explanatory causal factors than are the characteristics of the individual client. Thus, the situation is perceived as placing more constraints upon behavior. An external attribution may be made to other people as long as the responsibility for outcomes is not seen as shared with any personal dispositions of the client. External factors may be immediate, having an effect upon contemporary behavior, or they may be more remote, thus contributing to a client's personal history. When outcomes are connected to local (contemporary) stimulus events, causal attribution is more external in nature, with the situation being viewed as the major determinant of the outcome. Factors that are connected to events or outcomes in a remote or historical context are seen to be more in concert with internal and personal factors. Such situational factors are not as likely to be perceived as major determinants of current and on-going behaviors, and are given less weight as explanatory factors.

Attribution to societal/cultural factors (roles, norms, values, and religion) are to be treated as external attributions. Attributions to luck, life in general, things are just that way may be included in this category, as attributions to purely accidental and random occurrances. Examples of external attributions are:

> "Things at work aren't going well. The recession hit my business really hard"

"The client is having problems because of the trauma that a separation can cause (in this example, 'trauma' and 'separation' are given an impersonal quality, suggesting that an interpersonal interpretation may not be the best judgement).

"I am seeking help to deal with the recent death of my spouse"

"Men (or women) are just like that"

"My role as a wife/husband is changing. The times for women/men are different now"

Other themes tending toward external attributions emphasize organic contributions to behavior. Reference to pain, specific disabilities, physical handicap, or disease are to be included in this class. Reference to any body state, such as fatique, or to inherited aspects of physical appearance (such as height) are appropriately included in this category. Examples are:

"I have a heart problem and I can't be as active as I like"

"I have diabetes and this affects my sexual relationship"

"I don't have any energy. I am tired all the time and I get sick a lot"

Attributions for Therapeutic Change. Therapy goals of an external attribution represent a class of themes all of which focus on some ecological manipulation as a source of therapeutic change. Any manipulation or alteration in a stimulus situation external to the client is representative of an environmental change factor. This would include reference to work, job, school, or other living conditions or contexts. For inclusion in this category, no references are to be made to an interpersonal interaction where the source for change is shared by persons in conjunction with the client or to the client him or herself as a source for change.

Intensity Ratings.

a. Highly External, -3. Causal attributions are made to factors totally external to the individual. The individual is seen as not sharing any responsibility for outcomes or events. A therapy goal receiving a -3 rating would involve an ecological manipulation where change in the environment is both possible and desirable, and the manipulation of personal factors is not regarded as necessary for the individual to experience positive outcome. Examples are:

"Have the husband/wife removed from the home through a court order"

"Find a job placement for the client more suitable to the client's level of skill; this may involve contacting Manpower"

"I have a child with a learning disability and I need some help in finding some special educational programs. I think that this would relieve my husband/wife and myself from a responsibility that is better handled elsewhere"

b. Moderately External, -2. Causal attribution is primarily made to external factors, but location or responsibility is shared somewhat with personal dispositions. For example:

"My husband left me and the kids for no reason - just like that. He's done that a lot before and I should have left him when he did it the first time. Now it's too late"

"My wife's family are the cause of all my problems. They don't like me because of my religion, but I guess I knew that when I was dating my wife, and I didn't have to get married"

With therapy goals, ecological manipulations, while desirable as types of therapeutic interventions, are not always feasible nor possible to execute. For example, we may place responsibility for men's and women's contemporary role confusion on changing social values. This is an external attribution and refers to a large social context as a causal factor related to individual problems. However, treatment cannot focus on the entire social context as a place where change can occur in any immediate and realistic sense as far as the client's benefits are concerned. Problems having a social origin may, however, be dealt with by changing some individualized behaviors. Thus, if a client presents with a problem which they attribute to 'role identification' for example, and therapy goals focus on re-evaluation of attitudes about roles, role behaviors, etc., this implies that social change may be effected through individual change. This type of therapy goal would be of a -2 nature. Another example would be the following type of client attribution:

> "I was raped last night when I was walking down a dark alley. I know that is a dangerous thing to do"
>
> A corresponding treatment goal might be:"Help the woman resolve some of the issues related to the rape and counsel her in self-protection measures to prevent future occurrances"

In the above example, the individual client must contribute something in order to effect change, but personal dispositions are not the vehicle for change. These -2 manipulations would apply to most people (i.e. they are not personalized and idiosyncratic) who wish to achieve the same goals.

c. Slightly External, -1. As with the slightly internal (+1) rating, this is neither clearly external nor clearly mutual. A -1 rating suggests that interactive processes are the locus of causality, but that personality factors are less responsible as causal agents. Therapy goals would suggest the desirability of interpersonal change, but situational factors are seen as the more appropriate source for change. For example:

> "My husband and I are having problems communicating. He is too tired to care about it sometimes, and he doesn't initiate much in the way of conversation"
>
> "The main treatment goal would be marital therapy focusing on the husband's hesitation in talking to his wife"

It should be noted that any material designated as 'Miscellaneous' is not scored for location and stability.

Practical Considerations in Scoring Location

1. Isolate the target of the thematic unit from any elaborative material which is either causal or descriptive in nature. Do not make any directional or intensity ratings for the target. Rating the target may inadvertently bias you toward giving the target more weight than any elaborative material. When only a target is presented, it is obvious that you will have no other choice but to rate the target for location.

2. Many elaborations are complex in nature and present some unique scoring problems. One such problem is that there may be some diverse directional pulls within a single elaboration. For example, one aspect of an elaboration may have an internal pull, and another aspect may have an external pull. In such cases, there may be no clear directional sense to the attribution. When an elaboration is complex and has focal points of diverse location attributes, you may want to use an averaging technique. Do this by focusing on each aspect or segment of the elaboration that you feel has a distinct directional pull; assign each segment a location score and average all of the scores. This average will then represent the rating for the entire thematic unit. Indicate that you have used an averaging technique by placing an x in front of each rating arrived at by this procedure.

Scoring for Stability: Direction and Intensity

Individuals may attribute behavior or outcomes to either stable or unstable factors, and the scoring of this attributional dimension is a process of categorization similar to that used in the determination of location. The stability continuum ranges from attributions of high stability at one pole, to attributions of low stability at the opposite extreme. The 5-point scale is represented as follows:

+2	+1	0	-1	-2
highly stable	moderately stable	ambiguous	moderately unstable	highly unstable

The same elaborative material (or target in the case when no elaboration is presented) that is scored for location is also scored for stability. Determining stability is also a two-step process. First, determine the direction of the attribution by judging whether it is stable, ambiguous, or unstable; second, assign an intensity value to the attribution or elaboration. Once again, it is the elaborative data (causal or descriptive) which is to be given the most weight when scoring for stability.

If a person attributes behavior or outcomes to stable and more or less fixed factors, there should be fewer shifts in expectation for future behavior (or outcomes) than if the behavior is attributed to unstable or more variable factors. In more simple terms, if an outcome is attributed to a stable factor by a person, that person should expect the same outcome in the future. This suggeste that there is a tempo-

ral aspect to the stability of a perceived causal agent. To the extent that a person believes the cause of a past outcome has sufficient temporal extension to affect future behavior, his expectations for that behavior will be similar to his past outcome. This temporal aspect of stability of a causal agent thus implies endurance and continuing effect of the causal agent in time.

People in real life must not only deal with expectancies over time, but across situations. For example, a person may attribute outstanding performance on a test to their ability, a relatively stable factor influenced by success in past performance. However, the next test which that person will encounter will not be identical to past tests, and the individual will encounter a new, and therefore variable situation. If the person expects similar outcomes in the new situation, this suggests that the similarity (or dissimilarity) of expectancies depends upon the perceived extension of causal factors across different behavioral spaces i.e.there is a spatial aspect to stability. The concept of spatial extension can be applied to any element of the situation to which the outcome of behavior (or the behavior itself) can be attributed, whether the element is internal or external to the person. It is important to consider the spatial aspect of stability as well as the temporal aspect. The consideration of spatial extension necessitates a clear definition of the situation (or situations) in which past outcomes

have occurred and, more importantly, the criterion situation for which expectancies are to be predicted.

If a person attributes behavior or outcomes to more unstable factors, expectancy of future outcome or behavior should likewise be more variable. Thus, if causal factors are perceived to be unstable, there is no reason to expect the same behavior or outcome to occur in the future (i.e. temporal aspect). MOreover, behaviors or outcomes should be perceived as more situation-bound if they are attributed to unstable factors; the effects of causal agents are not seen as generalizing or extending across situations (spatial aspect), but are more constrained by the specific circumstances.

In summary, a stable causal factor is one that is relatively fixed and unchanging as a causal agent; it is both temporally and spatially stable. An unstable element is situational and variable; it is spatially and temporally unstable.

Practical Aspects of Coding

The stability dimension may be more difficult to code than the location dimension. However, there are several clues which will help you arrive at a final judgement. Both meaning and form of verbs and syntactical modifiers will be particularly helpful in coding stability. For instance, present and past imperfect tense imply a continuing state

that is relatively stable, e.g. "He tries hard" or "He has been trying hard". Also, consider a present perfect tense, such as "He has tried hard" to be a stable attribution. A simple past tense, "He tried hard", implies one action, past and finished. In such a case, code a simple past tense as unstable. An example of a syntactical modifier is "He usually tried hard". The 'usually' makes for an attribution to a stable disposition. The adverb 'always', meaning everytime, or, on every occasion, makes an attribution stable in nature. On the other hand, 'rarely' refers to the infrequency of events, or to the exception, and may imply a more unstable attribution.

Reference to outcomes or behavior that occurred in the past (i.e. reference to historical events, for instance, childhood) usually are examples of more stable attributions. Certain causal categories are normally stable (personality) while others tend to be unstable (mood). However, a person must specifically designate 'personality' as a causal factor (e.g."I am an anxious personality"; "I have no personality"; "I can't get along with him because of his personality"; "It's my personality") in order for this attribution to receive a stable rating. Personality must not be inferred from the context of an attribution and then coded as a stable factor (e.g. "I am dependent" does not necessarily mean that the respondent sees him or herself as having a dependent personality). The same applies to "mood" as a causal at-

tribute. Do not infer the stability of mood from statements such as "Anxiety" or "Depression". In order to code mood as unstable, an attribution must be made specifically to mood ("I am in a depressed mood"; "It's just my mood - I'm feeling bad lately"). A person's physical appearance may generally be regarded as stable if the physical attribute is one not normally likely to vary since it is beyond the individual's control, e.g. height, facial appearance. If the physical attribute can otherwise vary, such as weight, the response may be coded as unstable ("I just lost a lot of weight recently").

It should be noted that there is no Mutual category for the dimension of stabiltiy as there was for the location dimension. This is because a factor cannot be both stable and unstable at the same time. The code of ambiguous is to be used for responses that do not have any verbal or contextual clues indicating where on the stability dimension an attribute falls. In many cases the temporal and spatial sense of an attribute may be difficult to determine, particularly in the absence of verbs or modifiers.

Highly stable and unstable ratings (+2 and -2 respectively) are reserved for those cases where the sense of stabiltiy is unambiguous and the attribute is unequivocally stable or unstable. As a rule, to assign a +2 or -2 rating, the attribute must contain information about both the temporal and spatial aspects of the stability dimension. An attribution

is to be given a +1 or -1 rating when either the temporal or spatial aspect of the dimension is specified, but not both, or when temporal and spatial aspects are implied but not specifically stated. Always code Ambiguous when no clues are given about the temporal and/or spatial aspects of an elaboration or attribution.

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