Sex Roles, Psychological Adjustment, and Presenting Problems: Their Relation to Preferred Therapist Characteristics in Clinical Subjects

by

Cheryl B. Lanktree

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

Winnipeg, Manitoba

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ABSTRACT

Despite the crucial role of the therapist-client relationship in therapeutic improvement, the nature of client preferences and expectations upon entry into psychotherapy has yet to be fully understood. Most notably, the effects of subject gender, sex-role orientation, sex-role attitudes, presenting problems, and psychological adjustment on preferences for type and gender of therapist have been studied infrequently. Moreover,analogue research has dominated this field, limiting the relevance of such findings for clinical practice. The few clinical studies available have often relied upon small samples and methodologically flawed designs. Further, correlates of psychological adjustment and presenting problems including subject gender and sex-role orientation have seldom been studied with clinical subjects.

Two hundred and sixteen men and women participated in this study as they entered psychotherapy at a university-based clinic. Variables examined were: preference for therapist gender prior to the first interview, subject gender, previous therapy experience, sex-role orientation (Personal Attributes Questionnaire), sex-role attitudes (Attitudes Toward Women-Short Form), psychological

adjustment factors (California Psychological Inventory-Short Form), presenting problem factors (Personal Problems Rating Scale created by the author), and "ideal" therapist trait factors (Counsellor Rating Form).

Multivariate analyses of variance revealed several significant findings: liberal-undifferentiated subjects reported the strongest preference for a female therapist while conservative-undifferentiated subjects reported the strongest preference for a male therapist; subjects with more anxiety-related and identity-depression problems expressed a stronger preference in general; and a female therapist was more frequently preferred than a male therapist at a rate exceeding previous findings. Feminine subjects preferring a male therapist rated their ideal therapist as significantly more agentic but masculine subjects preferring a female therapist rated communal-expressive skills highest.

Androgyny as a model of mental health was supported for women and men in relation to general psychological adjustment. Androgyny and masculinity alone reduced the risk of psychological problems. Feminine and undifferentiated subjects were least adjusted and reported more problems. Sex differences found were: women were generally better adjusted and more other-oriented but men scored higher on confident-outgoing traits. Nevertheless, sex-role orientation emerged as a more potent predictor of mental health and therapist preferences than did sex alone.

ACKNOWLEDGEMENTS

The completion of this dissertation and my Ph.D. marks the culmination of several years of learning, growth, and challenge. The satisfaction that I feel, at this time, is surpassed only by the gratitude that I owe to some people who have enhanced this adventure.

To John Schallow, my advisor, I wish to extend my gratitude for his thoughtful guidance, support, imagination, and friendship, throughout all the stages of this project, as well as during those years spent in the clinical program. His inimitable wit and good humour made the experience more pleasant and often, quite enjoyable. I am also grateful for the guidance and assistance provided by my thesis committee: Nina Colwill, Neena Chappell, and Ross Hartsough, in preparing this dissertation.

To Denise, Audrey, Marsha, Robin, and Pat, I wish to express my appreciation for their extensive assistance and energy in implementing this research in the day-by-day process of data collection.

I am indebted to very dear friends who have, at different times, provided me with the social diversions and the caring necessary to continue. Thank you, Mindy, Dick, Cornelia, Chris, Lillian, Jaye, and Pat!

To my family and especially, my parents, I am grateful for their encouragement to pursue ambitious goals, their patience, and love throughout the years. With particular fondness, I wish to acknowledge my husband, John, for providing me with the love, the humour, and above all, the unconditional support to sustain me. Sharing this entire experience so completely with him has given it a special meaning.

Finally, I owe my appreciation to the Manitoba Mental Health Research Foundation for providing me with the funding to support this research.

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INTRODUCTION

It has been argued that client perceptions of psychotherapists and of the therapeutic process are the most important determinants of continuation and progress in psychotherapy (Bent, Putnam, Kiesler, & Nowicki, 1976; Goldstein & Stein, 1976; Strupp, Fox, & Lessler, 1969). Bowden and Burstein (1974); Marmor (1975); Schaeffer and Abales (1977); Strupp (1973); Strupp et al.(1969); Strupp (1977); Watzlawick, Weakland, and Fisch (1974) agree that a positive relationship between therapist and client (particularly with respect to the client's feelings toward the therapist) is closely related to therapeutic improvement, regardless of the therapeutic system used. Specifically, the client's attraction to the psychotherapist and his/her expectations regarding the likelihood of success should be major determinants of the client's behavior in psychotherapy (Schaeffer & Abales, 1977) and the success of psychotherapy (Gardner, Heller, & Goldstein, 1961).

The therapist (and her/his personality), rather than the therapeutic orientation may be integrally related to whether the client improves in therapy (Dent, 1978). Fiske (1977), Gurman (1977), Lambert, DeJulio, and Stein (1978), and Mitchell, Bozarth, and Krauft (1977) agree that the

therapist's empathy, warmth, and genuineness are related in some complex, unspecified way to client change. However, it is presumably the patient's perception and experience of the therapist's warmth, empathy, and genuineness that really matter (Fiske, 1977). In addition, it has been suggested that disconfirmation of client expectancies may have deleterious effects (Pope, Seigman, Blass, & Cheek, 1972).

Despite the acknowledged significance of the client's expectancy of improvements in determining therapeutic gain (e.g., Krause, Fitzsimmons, & Wolf, 1969; McGlynn, Reynolds, & Linder, 1971), very little empirical evidence has been generated that demonstrates the effect of the expectancy state (Williams, 1973) or the exact nature of client's biases (Franks, 1979). Although it is widely believed that persons enter psychotherapy with expectations (Bordin, 1955; Frank, 1968; Goldstein, Heller, & Sechrest, 1966), it is quite possible that the effects of expectancies will not be clearly understood until the nature of client expectancy is studied more comprehensively.

If the relationship between therapist and client is accepted as a major element for therapeutic improvement, it would appear to be especially important to consider the effects of gender on the relationship between client and psychotherapist (Franks, 1979). Gender as it relates to psychotherapy is rarely discussed by traditional therapists other than to reiterate nebulous psychoanalytic concepts such as penis envy and oedipal desire (Franks, 1979). For

example, in a recent article, Cavenar and Werman (1983) concluded that "sex of the therapist is more apparent than real in insight-oriented psychotherapy" on the basis of their brief interpretations of five psychoanalytically treated case studies. Despite a lack of empirical evidence, these authors asserted that the important issue is not the therapist's gender but whether psychotherapy is conducted with "due regard for defenses, resistance, and transference reactions". These theories dominating the field of psychotherapy have influenced the training of professionals for the last 40 years (Garfield, 1981), and continue to influence psychotherapy research in encouraging an individual, internal mode rather than recognizing the socio-cultural influences that impact on the individual. These theories also specify women's innate nature as passive, dependent, and morally inferior to men (Hare-Mustin, 1983).

A meta-analysis of psychotherapy outcome research presented by Smith and Glass (1977) illustrates how gender-related variables have been consistently ignored. Nearly 400 controlled evaluations of psychotherapy and counselling were included in this analysis. Effect size was evaluated in relation to 16 independent variables; none of them were sex of therapist or sex of client. Smith and Glass reported that "therapists who resemble their clients in ethnic group, age, and social level get better results". Despite the inclusion of so many variables, however, no mention was made

of the effects of gender on therapeutic outcome, probably because much of the psychotherapy literature did not report the sex of therapists and clients.

At this point in time, psychotherapeutic research that does explore the effects of gender as it relates to the outcome or process of psychotherapy tends to be somewhat equivocal (Davidson, 1976). The literature available investigating client-therapist sex-pairings is often presented as contradictory and confusing because of the selection of different populations and use of different instruments (Tanney & Birk, 1976). Such methodological differences may well account for discrepant findings in this research (Feldstein, 1979). Brodsky and Hare-Mustin (1980) also suggest that the inconsistencies in this research may be more a result of the confounding of salient variables that interact with gender than support for the nonexistence of gender effects. Nevertheless, male and female therapists have often been considered to have different goals with respect to concepts of productiveness (Marmor, 1975) and psychological adjustment (e.g., Broverman, Broverman, Clarkson, Rosenkrantz, & Vogel, 1979). It is, therefore, likely that "the nature of the relationship between male psychotherapist and female client may differ in alternative dyads, male-male, female-female, or female-male" (Franks, 1979, p. 454).

Most psychotherapists continue to be male and most of their clients female (Barrett, Berg, Eaton, & Pomeroy, 1974; Cates, 1973; Chesler, 1971a, 1972; Franks, 1979; Goldman & Mendelsohn, 1969; Gove, 1978, 1979, 1980; Gove & Tudor, 1973; Henry, Sims & Spray, 1971; Howard & Orlinsky, 1972; Lerman, 1978; President's Commission on Mental Health, 1978; Rice & Rice, 1973; Schofield, 1969; Tennov, 1975). The effects of the sex of the participants in the therapeutic dyad, i.e., whether certain clients do better with female or male therapists (Franks, 1979; Kaplan, 1979b), is becoming more of an issue of interest in contemporary research. A common criticism regarding the nature of clinical services to women is that the authoritarian, hierarchial therapist-client relationship model is particularly promoted by the male therapist-female client relationship which does not facilitate feminine emancipation from male authority figures (Brodsky, 1973, 1980; Chesler, 1971a, 1971b; Franks, 1979; Fishel, 1979; Hare-Mustin, 1983; Marecek & Kravetz, 1977; Stephenson & Walker, 1979). Hare-Mustin (1983) further criticizes mental health services to women: clinicians share the same culturally restrictive attitudes that denigrate and disadvantage women as well as ask women to accept and adjust to traditional roles and behaviours that have unhealthy consequences. These issues are of particular concern to feminist therapists and researchers who doubt that any male psychotherapist growing up in this society could ease a woman's psychological difficulties when they

are (at minimum) uninformed about a woman's nature and experience. Biases against women persist as reported by Sherman (1980) who reviewed several clinical studies and found that men stereotyped more than women, older people more than younger people, and those with Freudian orientations more than those with other orientations.

Other researchers suggest that while male psychotherapists may be useful to female clients, in today's society it may be particularly advantageous for a female client to be treated by a female psychotherapist (Barrett et al., 1974; Brodsky, 1973; Kronsky, 1971; Westervelt, 1973). This female psychotherapist may serve as a role model while also facilitating the expression of feelings as she communicates understanding and empathy (Brodsky, 1973; Kronsky, 1971; Lerman, 1978). Rawlings and Carter (1977); Carter (1971) have pointed out that there may be particular circumstances when a woman rather than a male psychotherapist is the "more appropriate choice". Despite the criticisms directed at the therapeutic establishment, the treatment of women has not been seriously addressed, reflecting the prevailing attitudes toward women in our society (Brodsky & Hare-Mustin, 1980; Hare-Mustin, 1983).

It has been suggested that perceptions of female and male clients by female and male therapists may be quite different. Biases and stereotypes affecting therapist perceptions may also differentially affect female and male

clients in their perceptions of therapists. Undoubtedly, these perceptions and preferences warrant more attention and are quite crucial to the therapeutic process (Tanney & Birk, 1976). The specific effects of different gender configurations in the therapeutic dyad have yet to be articulated.

Sex of Therapist: Client Perceptions and Preferences

Over almost 40 years, the claim has been made that women physicians and therapists are less preferred by people, in general, than are men (Boulware & Holmes, 1970; Chesler, 1971a; de Beauvoir, 1971; Engleman, 1974; Fabrikant, 1974; Jackson, 1972; Levy & Iscoe, 1963; Lewis, 1976; Report of Task Force on Sex Bias and Sex-Role Stereotyping in Psychotherapeutic Practice, 1975; Rice & Rice, 1973; Rogow, 1970; Simon, 1973; Tennov, 1975; Williams, 1946). Williams (1946) and Engleman (1974) reported essentially the same results although separated by nearly 30 years: male physicians were preferred, suggesting little change in the general public's acceptance of women in the medical profession.

Jackson (1972) postulated that because the female role is denigrated in our society, to be assigned to a woman psychotherapist is to be given "second best", and suggested that serious negative effects on the therapist-patient interaction (including both female and male patients)

result. However, most recent researchers (e.g., Fabrikant, 1974) report that a growing trend is occurring where the female client selects a female therapist, particularly the young, well-educated female client (Brodsky & Hare-Mustin, 1980a). Brodsky (1980) describes women as no longer perceiving themselves as "difficult cases" that only a strong man can handle. She also views women as more receptive to being independent of men and working with other women. Also, female therapists are now more acceptable to male clients (Clopton & Haydel, 1982).

Walker and Stake (1978) report that recent sex-related research suggests that previously held notions about the superior competence of male professionals are disappearing (Chobot, Goldberg, Abramson, & Abramson, 1974; Levenson, Burford, Bonno, & Davis, 1975). Nonetheless, the majority of clinical psychologists and psychiatrists is male. An occupation is considered "sex-typed" when a majority of its practitioners belong to one sex combined with an associated normative expectation that it should be this way (Epstein, 1970). Very little research has so far explored the question of the relationship of sex-role stereotyping to perceptions of women in male-dominated professions. It has also been suggested that women must frequently field questions regarding their competence, marital status, children, and suitability in dealing with the client's problem (Davidson, 1976; Kaplan, 1979b). Such general

perceptions of therapists which are screened through a filter of sex-role stereotypes undoubtedly influence process and outcome of psychotherapy.

Process and Outcome Literature

It might be useful to explore initially, the effects of therapist-client pairings by sex, on the process and outcome of psychotherapy to determine the possibility that success may reflect benefits of certain pairings. If effects can be demonstrated in the existing literature, then the rationale for investigating preferences by clients will be strengthened because effects may be influenced by the perceptions of certain characteristics in female therapists vs. male therapists.

In Parloff, Waskow, and Wolfe's (1978) review of therapist variables affecting process and outcome of therapy, they agreed with previous authors (Meltzoff & Kornreich, 1970; Tanney & Birk, 1976; Johnson, 1978) that few conclusions could be made. Same-versus opposite-sex therapeutic pairings and their relation to outcome have often been overlooked in such investigations (Berzins, 1977). Few researchers have "focused on the effect of sex of the therapist and/or client on the process and outcome of psychotherapy" (Kaschak, 1978, p. 272). Nevertheless, Sherman, Koufacos, and Kenworthy (1978) found that 69% of the psychotherapists (of both sexes) polled, considered the

sex of the therapist to be an important variable in psychotherapy, while psychiatrists were more likely to think that the sex of the therapist had no influence. Shullman and Betz (1979) found that regardless of presenting problem, clients were overwhelmingly referred at intake to same-sex counsellors in a counselling centre.

More recently, Clopton and Haydel (1982) surveyed Ph.D. clinical psychologists and found that subjects indicated a preference for the therapist of hypothetical clients to be of the same sex. This preference was strongest when the subject was the same sex as the client. Such same-sex pairing of therapists and clients may reflect an effort to satisfy anticipated client preference (Clopton & Haydel, 1982).

Bloom, Weigel, and Trautt (1977) concluded that the research literature concerned with the effects of client-therapist pairings is characterized by equivocal findings. For example, Howard, Orlinsky, and Hill (1970) found that female clients were more satisfied with female therapists and Hill (1975) found that same-sex pairings were most advantageous to successful psychotherapy outcomes. However, Scher (1975) found that sex pairing was unrelated to therapy outcome. As Garfield (1978) has stated, there is no clear relationship between the sex of the client and outcome (in fact, most studies show no differences in outcomes). He also asserted that the problem appears to be more complex,

involving interaction effects between the sex of the psychotherapist and that of the client. Only when investigations of such interactions are pursued methodically and carefully, will researchers arrive at some clarity.

However, harmful effects of particular therapist-client gender matches must also be considered with the existence of sexual exploitation and other forms of sexism in psychotherapy (Butler & Zelen, 1977; Lerman, 1978). In an important survey of erotic practices among licensed psychologists, Holroyd and Brodsky (1977) found that 1 in 20 males and 1 in 200 females admitted to having sexual intercourse with opposite-sex clients.

Therefore, despite methodological problems and the contradictory nature of the process-outcome literature, a review of available studies is essential. Persons, Persons, and Newmark (1974) reported that male clients were more responsive to male therapists, females more responsive to female therapists. Ludborsky, Chandler, Awerbach, Cohen, and Bachrack (1971) reviewed several studies concerned with the outcome of psychotherapy. They concluded that superior results occurred when the psychotherapist and client were of the same sex. Kaschak(1978) found that women clients when paired with women therapists reported significantly greater change than did any of the other three therapist-client pairs. Male clients who had consulted with male therapists, did not, as in the Persons et al. (1974) study, report

greater success than those who had consulted with women therapists (Kaschak, 1978). He recommends that "those responsible for the delivery of therapeutic services must ... take heed of the effect of sex upon therapeutic process and outcome" (Kaschak, 1978, p. 277). This recommendation is particularly pertinent to women clients, who may in fact benefit most from therapy with women therapists.

Geer and Hurst (1976) found that the male counsellor was more effective with female clients than the female counsellor, while the female counsellor was more effective with male clients than with female clients. However, interpretation of their statistical analysis is questionable. Since there was only one counsellor of each sex (Parloff et al., 1978) and clients may have been presenting vocational problems only, generalizations from Geer and Hurst's findings are not possible. Also, such a finding of better outcome with opposite-sex-pairings, particularly for female clients, is most unusual.

Orlinsky and Howard (1976) reanalyzed data collected from 118 female outpatients, 78 having had male therapists, 40 having had female therapists. The data had actually been collected from 1964 to 1966, at the beginning of the development of the Women's Movement. They reported that a considerable number of women in treatment with male therapists viewed their therapists as more demanding, more detached, and less expansive. Clients with female

therapists, particularly single, young women (18-28 years old) and depressed women reported significantly higher levels of satisfaction and encouragement.

Gould (1975) found that when clients were assigned randomly to female or male counsellors, female clients remained with female-led groups, and those who did, reported themselves to be more satisfied. Kirshner, Genack, and Hausek (1978) found that among upper middle-class subjects, greater patient satisfaction and self-rated improvement in both self-acceptance and main problem was related to having had female psychotherapists. These findings, although limited, support the contention of Chesler (1971a, 1971b), Jackson (1972), Rice and Rice (1973), and Shaeffer and Abeles (1977) that the female psychotherapist is more effective with female clients. Fabrikant (1974) felt that female psychotherapists were more effective than males regardless of therapist orientation or type of client.

Jones and Zoppel (1982) have provided the area of psychotherapy process and outcome literature with some strong evidence based on well-designed research indicating some interesting effects of client and therapist gender. One of their studies involved therapists at a university clinic who completed Rating Scales for Therapy Outcome and adjective checklist descriptions for 160 former therapy clients. They found that female therapists rated themselves as more successful than male therapists, particularly with

female clients. In the second study, clients regardless of gender indicated in their ratings of therapists, that female therapists formed more adequate therapeutic alliances than did male therapists. Although both male and female clients of male therapists reported significant improvement as a result of therapy, female clients appeared to benefit particularly with female therapists. Therapists of both sexes (but especially women) rated same-gender pairings higher on improvement expected at the beginning of therapy and also tended to enjoy same-gender clients more. Such results provide evidence that the impact of gender in an interactional manner has clear implications for therapeutic outcome and that its influence is complex and multifaceted (Jones & Zoppel, 1982).

A major problem with the earlier psychotherapy research is that many outcome studies were not originally designed with therapist sex as a factor and are, therefore, fraught with such inadequacies as lack of random assignment, confounding variables (e.g., level of therapist experience), and inadequate attention to relevant outcome measures (Parloff et al., 1978). Small samples have also been a problem (Jones & Zoppel, 1982). Analogue studies are limited in their generalizability, since the effectiveness of therapy as it is actually conducted in naturalistic research designs provides a superior mode of investigation (Maffeo, 1979). It would seem that only with more complex,

multivariate research designs considering many variables simultaneously can statements regarding the effects of therapist and client gender on psychotherapeutic outcome be made with certainty. This seems to be the direction of the more recent research (Jones & Zoppel, 1982).

"Intermediate" outcome or process measures have also been used by several researchers. Hill's (1975) counselling centre clients who saw same-sex counsellors reported more satisfaction after the second interview (i.e., expression of feelings, self-disclosure, self-exploration). Same-sex counsellors reportedly offered an increased level of empathy to clients (Hill, 1975) although all clients were most satisfied with female counsellors. Brooks (1974) found that greater patient expression of feelings and self-disclosure were related to opposite-sex dyads. The Brooks study was limited by a non-patient sample and the fact that significant effects were found only in the first three minutes of the interview. Berzins (1975) found that female psychotherapists tended to be less sex-typed than males, and therefore, probably better able to help female patients. With respect to process research, the results on the expression of feelings and self-disclosure are complicated by interactions with the experience level (Fuller, 1963; Hill, 1975) and status of the psychotherapist (Brooks, 1975).

From these process and outcome studies (e.g., Hill, 1975; Orlinsky & Howard, 1976; Persons et al., 1974), it is possible to conclude that primarily young female clients find that working with female psychotherapists enables them to express more feelings and to experience more satisfaction with their psychotherapists. However, other researchers suggest that it is difficult to conclude whether same-sex or opposite-sex pairings are predictors of successful therapeutic process or outcome (Breisinger, 1976; Petro & Hansen, 1977). Some evidence exists suggesting that the combination of a male therapist and a male client may lead to certain limitations in the expression of feelings and self-disclosure by clients (Clopton & Haydel, 1982). Orlinsky and Howard (1976) state that there is no reason to believe that male therapists are any less able and sensitive than female therapists. "Whether a therapist is able and sensitive may be less important than what a male or female therapist means to the patient" (Orlinsky & Howard, 1976, p. 87). For unattached young women who are not emotionally committed to a traditional lifestyle, the female therapist may well be the most satisfying psychotherapist.

It is obvious from this research that gender of both client and therapist interact with other (not yet clearly specified) variables in affecting the process and outcome of psychotherapy. This area of research is no longer considered a simple matter of sex pairing (Feldstein, 1982).

Factors which affect the therapist-client relationship include the nature of the client's presenting problem (Johnson, 1978) and counsellor's sex-role orientation (Feldstein, 1979; Highlen & Russell, 1980), to name a few. Therefore, it seems apt to refer again to the preference research which has been designed with the sex of therapist and sex of client interactions as the primary variables of interest.

Therapist Preference Research

Due to a paucity of research available that has been based on clinical samples, some consideration will first be given to analogue studies concerned with preferences and perceptions of therapists in simulated therapy situations. Davidson (1976) has criticized as inadequate analogue studies concerned with client attitudes toward the sex of therapist (e.g., Wyrick & Mitchell, 1969). She further states that investigations into preferences, process, and outcome of psychotherapy as affected by sex of patient or therapist have not been applied adequately to the research of the real patient-therapist relationship. Of particular importance is the fact that clinical analogues have failed to produce impressive evidence of sex bias, whereas naturalistic studies have produced supporting data (Brodsky & Hare-Mustin, 1980; Davidson & Abramowitz, 1980; Feldstein, 1979). The relative absence of findings in analogue studies

of sex-role stereotyping does not adequately reflect the complex therapy situation and pressures in service agencies (Hare-Mustin, 1983).

Nevertheless, it seems valid to assess nonclinical subjects' views of psychologists/therapists as well as those views of clinical subjects for information that invites potential comparisons. Unfortunately, minimal research is also available regarding investigations of nonclinical subjects' attitudes toward the sex of a therapist.

Briere and Lanktree (1983a) exposed 129 male and female undergraduates to three levels of sexist noun and pronoun usage (e.g., he, he or she, she or he) in a description of the "Ethical Standards of Psychologists". All subjects then rated the attractiveness of a career in psychology for males and females, and their own willingness to refer a male or female friend to a psychologist (sex unspecified). The results indicated that female subjects were more willing than male subjects to refer a male friend to a psychologist under the "she or he" condition. Presumably, the psychologist in this condition was more likely to be perceived as a female. Female subjects were also most likely to refer a male friend under this condition as compared to either the "he" or "he or she" condition. It might be suggested, if one can assume that a male subject identified with a "male friend", that men when presented with a choice for a male or female therapist, may be

inclined to prefer a male. It is not clear why female subjects were not correspondingly reassured by the "femaleness" in the stimulus paragraph ("she or he" condition) such that they would be more willing to refer female friends (Briere & Lanktree, 1983a). This could relate to Lewis's (1976) comments that due to the socially-defined competence assigned to the male role, female clients may indicate less confidence in female psychotherapists. On the other hand, female subjects may have assumed that a female therapist would best provide the nurturance and support stereotypically expected of women in the presence of troubled men (Kaplan, 1979b).

Cashen (1979) considered sex to be a possible factor in research examining preferences for particular counselling approaches. She found no significant difference between male and female nonclinical subjects in their preference for a counselling approach (after viewing videotapes) but described several factors as being important: sex of therapist, type of presenting concern, subjects' expectations and personal characteristics of counsellors. These factors were not, however, examined in Cashen's study. Johnson (1978) reported, with another nonclinical sample, that same-sex preferences occurred significantly more often than opposite-sex preferences with approximately 24% of both the male and female groups having no preference. More males preferred female counsellors than in previous studies (e.g.,

Fuller, 1964). These preferences were, again, not related to self-ratings of problems that might be discussed in a therapeutic relationship. Simons and Helms (1976) also studied nonclinical subjects, but only females, and found that they preferred female counsellors to male counsellors. With a younger sample (high school students), Littrell and Littrell (1982) found that across all concerns (personal and vocational) subjects of both sexes preferred same-sex counsellors.

Chesler's (1971a, 1971b) research has been cited as supportive of the claim that most female and male psychotherapy clients prefer male therapists, with a higher proportion of women than men preferring male therapists. Davidson (1976) takes issue with Chesler's evidence and states that her data do not bear out this contention. Chesler's analysis involved interviews with 1001 middle-income clinic outpatients seeking therapy in New York City from 1965 to 1969. They were not asked about their preference for sex of therapist and only one-quarter voluntarily expressed a preference or voiced no preference. Davidson (1976) suggests that there is no indication that this self-selected sample is representative of a much larger one. More respondents in the Chesler study voiced a preference for a male therapist than for a female therapist, but it should not be concluded that most patients prefer a male therapist.

Davidson (1976) asked male and female middle-income applicants for out-patient psychiatric treatment to indicate whether they had a preference for the sex of their therapist and what that preference was. Self-administered questionnaires were given to patients as part of the registration (intake) process. Patients were also informed that choices made on the questionnaire would not affect the treatment course in the clinic. She found that 50% of the total female and male sample expressed no preference for sex of therapist, while 35% preferred male therapists and 15% preferred female therapists. There were no sex of respondent differences. Neither were there significant differences in preferences for sex of therapist among or within the various demographic categories, except for age and marital status. With increasing age, Davidson found an increasing tendency to prefer male therapists (sex of subject was controlled). Males in the "widowed-separated-divorced" category had a greater preference for male than female therapists, but preferred a female more often than did single or married men. Davidson suggests that as feminists have concluded that women may be seeking a male therapist for "man-seeking" reasons, perhaps some male patients are drawn to female therapists for similar sex-related reasons. Female respondents were also more likely to prefer a therapist of the opposite sex when in the "single" or "widowed-separated-divorced" category. Therefore, patients in different marital categories may have differing therapeutic needs, or

may vary in their response strength to sex of therapist depending on their marital category. Young patients were more likely to express no preference for sex of therapist and to be in the group most likely to prefer female therapists.

Helms and Simons (1975) reported that when age and sex of therapists were taken into account, that clients were influenced by both variables and did not choose the therapist on the basis of sex alone. Schaffer (1980) also considers variables such as age, race, marital status, and experience level as well as sex to be important to clients when they choose a therapist. Obviously, other interacting factors in addition to sex of therapist and client will affect psychotherapy (Franks, 1979). Consideration of some of these variables, including the client's symptoms or presenting problems, will follow.

Walker and Stake's (1978) research further underscores the distinctive differences between clinical and nonclinical samples that occur in the therapist preference research. They found that more clients than nonclients expressed preferences, with fewer male counsellor preferences occurring than had been reported previously in the literature. Both undergraduate students (nonclinical) and students applying to a university counselling centre (clinical) were white, middle-class, and urban-suburban. The nature of presenting problems was not considered. Male

clients did not state a significant preference for therapist gender. Of the female clients, 50% stated a preference, with significantly more having a preference for female therapists. Only 10% of the total clinical sample preferred male therapists at the point of entry into psychotherapy. Among those clients stating a preference, they were more likely than nonclients who stated a preference to prefer a same-sex counsellor. Walker and Stake (1978) concluded that most present day undergraduate clients do not view male counsellors as superior to female counsellors. In fact, women had a strong preference for female therapists. Data were also analyzed for effects of experimenter's sex, with nonsignificant results.

With respect to the nonclients in Walker and Stake's (1978) study, more than 70% gave no preference, with more males than females having no preference. Among the male nonclients who had a preference, significantly more stated a preference for a female therapist. Among female nonclients, significantly more stated no preference with those stating a preference being equally divided for each sex of therapist. These nonclinical subjects did not seem to view male counsellors as superior to female counsellors. Again, a nonsignificant relationship was found for the effect of experimenter's sex, so that the decrease in preference for male therapists cannot be explained by the presence of female experimenters.

With such disparity of results in the preference research involving clinical and nonclinical subjects as well as a particular paucity of research with clinical samples, further research should explore preferences in relation to attributions of characteristics by clients to therapists that may be affected by the client's and/or therapist's sex.

Client Expectations in Relation to Sex of Therapist Evaluation of Competence and Attributed Characteristics

As Bent et al. (1976) and Strupp et al. (1969) have stated, how the client perceives his/her therapist plays a significant role in therapy outcome. Duckro, Beal, and George (1979), following Kelly's (1955) theorizing, hypothesized that clients bring to psychotherapy certain preconceived ideas about the psychotherapist's role and the nature of the psychotherapeutic relationship. The patient's behaviours and predilections may have a direct effect in changing and, possibly, biasing therapist behaviour (e.g., Fisher & Greenberg, 1977; Heller, Moyers, & Kline, 1963; Mueller, 1969). The evidence, thus far, is somewhat equivocal with respect to how necessary confirmations of client expectations are for client satisfaction and therapeutic success (Duckro et al., 1979). However, the possibility that part of the therapy sexism controversy arises because of differential demands from male and female clients (Greenberg & Zeldow, 1980) remains an issue. Some research has reported that competence is differentially

assessed in relation to the sex of the person being evaluated.

Osmond and Martin (1975) reported that college males were not willing to accept women in leadership and supervisory roles but college women indicated that women should be able to occupy such positions. Goldberg (1968) found in presenting academic articles to college women for critical evaluation that women were consistently devalued in areas of professional expertise, particularly in traditionally male-dominated areas. These findings were replicated with both sexes (Etaugh & Rose, 1975; Etaugh & Sanders, 1974; Gold, 1972). However, other researchers have reported equivocal results (Deaux & Faris, 1975; Levenson et al., 1975; Soto & Cole, 1975). Multiple factors are seemingly moderating this anti-female bias: sex-appropriateness of field, perceived levels of competence (Mischel, 1974; Ward, 1981) and perhaps, the personal characteristics of assessors (Ward, 1981), including their familiarity in the area assessed (Pheterson, 1969). Devaluation trends appear to be variable and elicited by selective factors. Abramson, Goldberg, Greenberg, and Abramson (1977) and Ward (1981) found that when performance of females and males was reported to be equal, that women were more positively evaluated. However, Ward also reported a marked tendency of male subjects to denigrate women in terms of their competence and status.

Brischetto and Merluzzi (1980) found that using the Counsellor Rating Form (Barak & LaCrosse, 1975), female and male therapists introduced as expert were perceived as equally expert and trustworthy. It was suggested by these researchers that since actual experience with interviewers was the basis of the attributions that the demonstration of reasonably competent behaviour may eliminate preconceived or sex-typed perceptions with respect to expertness. Previously held notions regarding superior competence of male professionals may be disappearing (Chobot et al., 1974).

Contrasting opinions are of the sort stated by Kaplan (1979b) that the female psychotherapist continues to be regularly questioned regarding whether her age, theoretical orientation, marital status or level of training renders her the most suitable psychotherapist for the patient's particular problem. Ruble (1983) and Huston-Stein and Higgins-Trenk (1978) agreed that negative sex stereotypes of feminine competence remain strong and pervasive, although attitudes about work and family roles have changed. Deaux (1984) stated that gender stereotypes are pervasive and that additional research is needed to understand the precise nature of these stereoptypes in their relation to judgements and evaluations of females and males. It remains to be seen the relative extent to which these attitudes prevail in the minds of clinical populations.

In terms of the general therapist characteristics associated with positive therapeutic process and outcome, there is no doubt that warmth and understanding have been identified as quite important by nonclinical and clinical subjects alike. Bent et al. (1976) found that among outpatient subjects seeing psychology interns, psychiatric residents, and social work trainees, those who were very satisfied with psychotherapy as opposed to those not very satisfied, described their therapists as warmer, more likeable, more active, and more involved. These satisfied subjects perceived therapy as having more generalized and noticeable effects on their behaviour. Generally, "therapist understanding" is considered important in relation to expectancies and preferences (Bergin, 1966), as well as an important factor in successful process and outcome of psychotherapy (Boulware & Holmes, 1979; Rogers, 1957; Truax, 1963; Truax & Carkhuff, 1965).

Apfelbaum (1958), in a classic descriptive study using outpatients of a university psychiatric clinic, found that there were three major types of therapist-role expectations:

1. nurturant therapist - giving, protecting, guiding without pushing or criticizing
2. model - well-adjusted, diplomatic, permissive listener but not protective
3. critic - analytical, critical, demanding considerable responses from client

Begley and Lieberman (1970) also identified clusters of patient expectations of the therapist's role: 1) active, directive, and warm versus 2) more passive, detached, and objective. Tinsley and Harris (1976) found with nonclinical subjects that the therapist was expected to be both expert and genuine in personal communications. These researchers did not examine the effect of therapists' sex on these expectations.

Davidson (1976) found that the reasons most frequently checked for preferences of either sex of therapist were "feeling comfortable" and ability to "talk freely". Bloom et al. (1977) measured perceived characteristics of qualification, dynamism, safety, total credibility, and willingness to recommend a therapist to a friend who needs psychological counselling, in relation to manipulation of therapist sex and office decor (traditional versus. humanistic).

Although Waskow (1976) has postulated that the attitudes and values of the therapist are of primary importance rather than the therapist's sex, it will be argued that gender is, in fact culturally-bound to attitudes and values.

Schroeder and Bloom (1979) examined further the concept of perceived credibility in therapists of different orientations, but in each videotaped vignette, the same male therapist was used. The dependent variables of credibility

that were considered were: qualifications (also considered important in Simon's 1973 study), dynamism, safety, and total credibility. The most frequently mentioned characteristic influencing preference in open-ended questionnaires given to nonclinical subjects was the degree to which the therapist was perceived as having personal involvement with and concern for the client (always female, in the simulated vignettes) and her problems. A second cluster of comments focused on the more general therapeutic traits of empathy, warmth, and sensitivity. A final cluster involved the degree of competence, expertise, and professionalism demonstrated by the psychotherapist. Although the psychotherapist was male, the subjects seemed to be particularly conscious of traditionally female sex-role characteristics such as sensitivity, warmth, and understanding (Schroeder & Bloom, 1979).

In view of previous research (e.g., Fuller, 1964; Johnson, 1978; Orlinsky, & Howard, 1976; Simon, 1973) that has demonstrated that various sex-pairings of clients and therapists influence clients' perceptions of therapist attractiveness, Schroeder and Bloom's (1979) study must really be considered incomplete in using only the male therapist-female client dyad without comparisons to other therapist-client combinations. Perceptions of therapists by clients in relation to attributed sex-related characteristics cannot be overlooked in future research

investigating clients' expectations of therapists' behaviour. Indeed, therapists may actually differ in choices of treatment goals, e.g., male psychotherapists may choose more feminine (communal-expressive) treatment goals while female therapists choose significantly more masculine (instrumental) goals, regardless of client's sex (Billingsley, 1977). Subjects also, undoubtedly, have sex-related biases affecting their expectations of therapist behaviour.

In an analogue study, Subich (1983) found with undergraduate students that sex of client rather than sex of therapist was the significant factor in affecting expectations about counselling. Female subjects expected the psychologist to be more accepting, more confrontive, more genuine, more nurturant, more tolerant, and more trustworthy than male subjects. Males expected more counsellor self-disclosure. Subjects were not presented with the choice of counsellor gender but were randomly assigned to a male therapist, a female therapist, or gender-unspecified therapist. Their responses on the Expectations About Counselling questionnaire were related to the condition to which they had been assigned.

In contrast to earlier research (e.g., Jackson, 1972; Osmond & Martin, 1975), Vargas and Borkowski (1983) found that male college students in simulated therapy sessions generaly attributed a higher level of skilfulness to the

female counsellors than did female clients. Also in analogue research with college students, Hardin and Tanico (1983) found that women expected more attractive and trustworthy counsellors while men expected counsellors to be more directive and self-disclosing. Hardin and Yanico's findings also confirmed Subich's findings in that no significant differences in expected behaviour was related to counsellor gender.

Therapist behaviour may be differentially anticipated and perceived by clients and nonclients in relation to the sex of each participant and whether they are seeking therapy. These attributions of therapist characteristics could conceivably influence the preference for sex of therapist stated by the subject. Again, there is an obvious need for this research to focus on clinical subjects whose expectations of therapist behaviour may be quite different from those expressed by college students not entering therapy. Davidson (1976) described the fantasized ideal of the female physician-psychiatrist as sustaining infinite capacities for empathy, genuineness, and warmth (the "veritable earth mother"; Scher, 1973). Female undergraduates have also described their anticipations of women counsellors demonstrating significantly more genuine interest in their problems than would the male counsellors (Simons & Helm, 1978). In at least one study of co-therapy with opposite-sex group leaders, males were perceived as

leaders and females as providers of warmth in the group (Wright & Gould, 1977). The study of the actual incidence of these characteristics in women is lacking. This is especially surprising when so much research has been done on those "feminine" characteristics: empathy, warmth, and genuineness.

Boulware and Holmes (1970) found in their relatively early study in which male and female undergraduate students preferred a male therapist, that subjects also expected male therapists to be more empathic, more knowledgeable, more experienced, and better adjusted. The male-preferred therapist was also expected to be active and competent, while the female therapist was expected to be passive and understanding. More recently, Feldstein (1979) has further clarified such client expectations; in simulated counselling interviews,males preferred feminine counsellors and females, masculine counsellors. In a later study, Feldstein (1982) found that students (regardless of sex) preferred feminine counsellors, apparently a counsellor who is "warm, supportive, feelings-oriented, and empathic".

Lewis (1976) felt that a preference for a male therapist related to clients seeing the male therapist as more qualified and placing greater trust in the male therapist's wisdom. Kaplan (1979b) described the male's affinity to the authority-based structural components of being a therapist while women patients especially, would expect women

therapists (at least at the beginning of therapy) to be exclusively empathic, nurturant, and supportive. These sex-role related attributions may explain Briere and Lanktree's (1983a) finding of greater female willingness to refer a male friend to a psychologist with the "she or he" description of psychologists than with the "he" or "he or she" conditions. Perhaps, these female subjects assumed that a female therapist would best provide that support stereotypically expected of women in the presence of troubled men (Kaplan, 1979b). This explanation becomes quite plausible with findings such as those of Feldstein (1979), i.e., that male clients disclosed most to feminine female counsellors. She suggested that this seems to be related to role expectations of females to be responsive, sensitive, and understanding listeners; not unlike the description of the role of women stated more than 30 years earlier by Komarovsky (1946).

Broverman et al. (1970); Gilbert, Deutsch, and Strahan (1978); Spence, Helmreich, and Stapp (1974, 1975) reported that both sexes perceived the typical male as being more agentic ("masculine") and less communal ("feminine") than the typical woman. Spence and Helmreich (1978) agreed that the traditional view of men as possessing more "masculine" traits than women and women as possessing more "feminine" than masculine traits is alive and well.

Further clarification of sex role related perceptions and preferences for the ideal therapist was pursued by Greenberg and Zeldow (1980). These investigators were interested in whether males and females are looking for the same qualities in a therapist. Subjects were asked to check any of the 300 adjectives on the Adjective Check List (Gough & Heilbrun, 1965) that would describe their ideal psychotherapist. Heilbrun (1976) indicated that high scores on eight of the scales are consistent with sex role stereotypic descriptions of masculinity (i.e., self-confidence, self-control, achievement, dominance, endurance, order, autonomy, and aggression). Seven other scales are keyed such that high scores are consistent with stereotypic descriptions of femininity (i.e., lability, nurturance, affiliation, change, succorance, abasement, and deference). In every instance, women more than men, indicated that they would prefer a therapist whose characteristics are stereotypic of the male sex role, consistent with Feldstein's (1979) findings. In contrast, men more than women rated their ideal therapist as having characteristics more consistent with the stereotypic female sex role, also consistent with Feldstein's (1979) findings. Johnson (1978) also found that student subjects who had a preference for either sex of counsellor tended to stereotype counsellors according to sex, whereas students who had no preference did not have such differential expectancies dictated by sex.

It remains to be seen whether perceptions of the male therapist as more masculine (therefore, presumably more agentic/instrumental) and women as more feminine (presumably more communal/expressive) will occur and influence the preferred sex of therapist. Another area of interest was whether males would prefer a therapist possessing more feminine characteristics and whether females would prefer a therapist possessing more masculine characteristics.

It is quite possible that the sex-role stereotypes found with mental health workers (e.g., Broverman et al., 1970) may also be operating for prospective clients in their perceptions of therapists' characteristics. Franks (1979) has stated that "there is no therapist who can honestly say that he or she does not have a value judgement stereotype in mind when thinking of the terms feminine or masculine". It is likely that this is inherently true of much of the nontherapist population since clients as individuals are affected by the same cultural sex-role expectations (Robinson, 1981).

Delk and Ryan (1977) found that among patient and therapist groups, the male subjects stereotyped significantly more than their female counterparts. In addition, patients stereotyped significantly more than therapists. Aslin (1977) found that female therapists accepted a wide range of options and behaviours as healthy for women (e.g., competence, independence) while male

therapists accepted more sex-role stereotypes. Jones and Zoppel (1982) found that male therapists described former patients in less socially desirable terms on the Adjective Check List (Gough & Heilbrun, 1965) than did female therapists, particularly in their descriptions of female clients. Males checked adjectives such as "affected", "awkward", and "conceited" in describing female clients significantly more than did female therapists. Male and female therapists' descriptions of male patients appeared to be balanced. This general tendency of female therapists to endorse socially desirable adjectives in describing clients of both genders parallels the work of Haan and Livson (1973). Berzins (1975)and Light (1975) also found that more female counsellors have a balance of masculine and feminine characteristics than do male counsellors. There seems to be a shift in attitude since the Broverman et al. (1970) research, with women therapists particularly less inclined to hold rigid stereotypic beliefs. Throughout the empirical literature, conservatism in gender roles is more characteristic of males, especially older men (Rice & Rice, 1973). Consistent with these findings, Gilbert et al. (1978) found that female subjects described an androgynous ideal for women but a sex-typed one for men while male subjects described the ideal male as masculine sex-typed and the ideal woman as feminine sex-typed.

Franks (1979) hypothesized that "if men and women have been trained to be stereotypic in their thinking and if they both have learned to view the world and themselves in different ways (according to gender), this may influence interactions which occur in the psychotherapy situation". Therefore, it is possible that male psychotherapists would be viewed as more dominant and female psychotherapists as more nurturant, particularly if the individual adheres to certain sex-role stereotypes within their own personality. This issue will be explored further at a later point.

Due to the paucity of research that has examined the relationship of client sex-role stereotypy to attributions of sex-role related characteristics in therapists, it is not yet evident whether these attributions reflect actual therapeutic differences or endorsement of sex-role stereotypic behaviour by clients. Davidson (1976), in her therapist preference research, found that intelligence of therapist was a relatively unpopular item in stating reasons for clients' preferences, although it was checked more often for women than men therapists. This might suggest that, in our culture, male intelligence (particularly in a professional) is assumed. "Understanding my problem" was frequently checked by women seeking women therapists, suggesting that more understanding from a same-sex therapist may be an expectation for many women. Women seeking male therapists did not rate "understanding" as an important

expected characteristic of a male therapist. Davidson (1976) also found that persons of both sexes expect to be able to "talk more freely" with a therapist of the same sex. Same-sex dyads cite greater therapist interest, concern, insight, encouragement, self-disclosure, honest feedback, encouragement to express anger, support (Kaschak, 1978; Persons et al., 1978), and empathy (Hill, 1975).

Bloom et al. (1977); Merluzzi, Banikiotes, and Missbach (1978) suggest that therapist gender when combined with other traits may yield different patterns of results for therapist preferences and evaluation. Nonclinical subjects tended to endorse the credibility of female therapists if they displayed the traditional trappings of the professional role, i.e., expertness, low self-disclosure, and a traditional office (Bloom et al., 1977). Male therapists, however, were perceived as being more credible in the humanistic setting. Gender of therapist itself did not seem to be a significant potentiating factor in the perception of credibility.

In view of the reported research, and in agreement with some clinical researchers (e.g., Davidson, 1976), the relationship of sex-role behaviour of both patients and therapists has yet to be adequately investigated regarding actual preferences for therapists. It is not yet clear as some researchers have suggested (e.g., Johnson, 1978), whether clients with no sex preference may be more flexible,

psychologically androgynous, and comfortable with their own masculine and feminine characteristics. Investigation of this and other hypotheses seems warranted. Furthermore, exploration of the expectancies and characteristics of the "ideal" therapist may also be related, in that sex of therapist preferences could be related to more stereotypic sex-role expectancies of the ideal therapist's characteristics (Johnson, 1978).

Attributed Characteristics of the Ideal Therapist

It seems fairly evident at this point that a client's perceptions of a therapist's behaviour determines to a large extent the effectiveness of the therapist-client relationship (e.g., Goldstein, et al., 1966; LaCrosse, 1977, 1980; Strong, 1968, 1970). Goldstein et al. (1966) emphasized how client perceptions of the therapist might be influenced by counsellor behaviour indicative of expertness, credibility, trustworthiness, and attractiveness, in particular. Their work stemmed from social psychology research that suggested the importance of a communicator's perceived credibility (expertness and trustworthiness) and attractiveness, for inducing attitude change (Hovland, Janis, & Kelley, 1953). Strong and Dixon (1971) then posed the question of whether expertness, trustworthiness, and attractiveness were perceived independently or whether they were inseparable.

Researchers who followed Strong's (1968, 1970) thesis (Dell, 1973; Kaul & Schmidt, 1971; Schmidt & Strong, 1970, 1971; Strong & Dixon, 1971: Strong & Schmidt, 1970a, 1970b; Strong, Taylor, Bratton, & Loper, 1971) provided some evidence that the constructs of expertness, attractiveness, and trustworthiness may be important dimensions affecting subjects' perceptions of counsellor behaviour.

Barak and LaCrosse (1975) tested the validity of the three-factor model related to the three dimensions of counsellor behaviour proposed by Strong (1968). A list of 83 adjectives was rated for representativeness of the 3 attribute dimensions by 4 judges familiar with these constructs. From this list, 36 adjectives that reached interjudge agreement of at least 75% were selected, with 12 adjectives representing each of the three dimensions. Using these 36 adjectives and their antonyms (e.g., agreeable-disagreeable), 7-point bipolar scales were constructed, anchored at each end by one of the adjectives from the item pair. Undergraduate students then viewed videotapes of Carl Rogers, Frederich Perls, and Albert Ellis from the film Three Approaches to Psychotherapy (Shostrom, 1966) and rated the adjective pairs for each therapist.

From this research, Barak and LaCrosse (1975) reported that three factors identified by the three dimensions of perceived counsellor behaviour (expertness, trustworthiness, and attractiveness) comprised the most appropriate factor

solution (by a scree test). Barak and Dell (1977); Barak and LaCrosse (1977) reported that this Counsellor Rating Form (CRF; Barak & LaCrosse, 1975) differentiated these same attribute dimensions within and between counsellors, although moderate intercorrelations among the scores on the three dimensions were found. LaCrosse and Barak (1976) reported Spearman-Brown reliability coefficients ranging from .85 to .91 for the three scales. The Counsellor Rating Form has become the most widely used instrument for assessing therapist competence and credibility, usually assuming the existence of 3 orthogonal factors (expertness, trustworthiness, and attractiveness) (Barak & Dell, 1977; Beutler, Johnson, Neville, Elkins, & Jobe, 1975; Corrigan & Schmidt, 1983; LaCrosse, 1980; Lee, Hallberg, Jones, & Haase, 1980).

Considerable research has subsequently reported a significant, positive relationship between perceived counsellor expertness, attractiveness, and trustworthiness, and willingness to refer oneself to the observed counsellor for a variety of counselling problems (Barak & Dell, 1977; Dell & Schmidt, 1976; Peoples & Dell, 1975; Strong & Dixon, 1971; Strong & Schmidt, 1970). LaCrosse (1977) found that client and observer ratings of facilitativeness were highly correlated with ratings of attraction and expertness. A client's initial ratings of a counsellor on the CRF (with expertness being the most powerful predictor) appear to be

significantly related to counselling outcome (LaCrosse, 1980), thereby demonstrating satisfactory predictive validity of the CRF.

These traits of expertness, attractiveness, and trustworthiness undoubtedly relate to the characteristics of an "ideal" therapist. Whether these attributes are distinct and orthogonal or interrelated and subsumed by a unitary perceptual dimension similar to Bergin's (1971) "good guy" (sic) factor remains a controversial issue in the research using the CRF. Even Barak and LaCrosse (1975) noted that expertness and trustworthiness were "highly related" and may be "part of the more unitary dimension of credibility". Moderately high intercorrelations have been consistently reported among the 3 dimensions measured by the CRF: LaCrosse and Barak (1976; range, .53-.93), LaCrosse (1977; range, .54-.80), LaCrosse (1980; range, .57-.93), Zamostry, Corrigan, and Eggert (1981; range, .79-.87). Investigators have repeatedly suggested two dimensions (Corrigan & Schmidt, 1983) or even a unitary (single) dimension, rather than three dimensions (e.g., LaCrosse, 1977, 1980; LaCrosse & Barak, 1976; Zamostry et al., 1981). Nevertheless, most researchers using the CRF to examine client perceptions of therapist behaviour have based their findings on 3 scale scores (as dependent variables) corresponding to these factors (trustworthiness, expertness, and attractiveness) as if they were distinct and orthogonal (e.g., Barak & Dell,

1977; Barak & LaCrosse, 1977; Barak, Patkin & Dell, 1982; Claiburn, 1979; LaCrosse & Barak, 1976; McKee & Smouse, 1983; Merluzzi, Merluzzi, & Kaul, 1977; Siegel & Sell, 1978).

Given the controversy regarding the existence of three factors with subsequent research based on the assumption of such factors, it is essential that the original factor structure reported by Barak and LaCrosse (1975) receive a closer examination. It can be seen that for each analysis of therapist traits (Rogers, Ellis, Perls), the first factor accounts for 79.6 to 83.0% of the variance and includes the 12 items of the expertness dimension as well as 1 to 4 items of the attractiveness dimension (depending on the therapist rated), and 8 to 9 of the items on the trustworthiness dimension which load at a level of at least .35. It would seem, then, that the interpretation of 3 distinct othogonal factors is not supported by Barak and LaCrosse's data.

Although the CRF undoubtedly measures important therapist traits with sufficient reliability and predictive validity, the current research attempted to clarify the factor structure of this questionnaire with a clinical sample. In addition, the extent of generalizability and validity to clinical samples remains at issue. Most of the validation studies for the CRF have been conducted on samples drawn from college populations using analogue procedures to represent actual counselling situations (Corrigan & Schmidt,

1983). Heesacker and Heppner (1983) studied client perceptions at a university counselling centre to examine the psychometric properties of the CRF. They performed a principal components analysis which revealed one major factor (accounting for 56% of the common variance) underlying client's perceptions of counsellors. However, the analysis also yielded 5 factors with eigenvalues > 1.00, accounting for 71% of the common variance. These researchers concluded that real clients at the point of termination of therapy do not clearly distinguish among perceived counsellor expertness, attractiveness, and trustworthiness. Instead, Heesacker and Heppner contended that one major construct operates in the client's perceptions of counsellors, suggesting the notion of a "powerful, unitary dimension of counsellor behaviour" (LaCrosse, 1980). They suggested that the intercorrelations among the three scales increased over time, with the three constructs being more distinct at the beginning of therapy. Since the current research was conducted upon entry into a therapeutic relationship, such an issue could be considered. Whether actual client expectations can be defined more precisely than previously (Duckro et al., 1979) was also investigated. The enduring feature of the CRF as a valid measure of therapist competence and credibility (particularly "expertness") justifies further use of it in the exploration of client perceptions of an "ideal" therapist.

Preferences for Sex of Therapist and Presenting Problems

In his overview of psychotherapy research and practice, Strupp (1978) emphatically stated a significant question worthy of close consideration: which patient characteristics and problems are most amenable to which techniques conducted by which type of therapist in what type of setting? Franks (1979) agreed that it is important to fit the treatment and disorder to both therapist and patient. This is especially true for women, as the number of women seeking psychiatric help is rapidly increasing (Frieze, Parson, Johnson, Ruble, & Zellman, 1978). A proportionately greater number of women than men seek psychiatric and psychological treatment in various mental health care facilities (Dohrenwend & Dohrenwend, 1969; Gove & Tudor, 1973; Luce & Wand, 1976; Russo & Sobel, 1981; Statistics Canada, 1970); therefore, these issues are especially pertinent to women.

A frequent failure to delineate type of client concern in the therapist preference literature can be viewed as a serious methodological problem, given that the type of problem has been demonstrated to influence therapist preferences (Boulware & Holmes, 1970; Lee et al., 1980; Mezzano, 1971; Schneider, Laury, & Hughes, 1976).

As early as 1956, Koile and Bird found that individuals preferred a same-sex therapist for "personal" problems. Fuller (1964) also found a tendency for female nonclient

subjects to indicate a preference for a female counsellor for some counselling problems, suggesting that the nature of the problem is quite important. Although Boulware and Holmes (1970) pointed out that much of this research is confounded by other factors and methodological problems, they supported these findings. A male psychotherapist was generally preferred to a female psychotherapist for vocational problems. Female subjects significantly preferred a male therapist for vocational problems but preferred a female therapist for personal problems. Boulware and Holmes commented that such findings seem to reflect the popular notion that males know more about vocational matters because they are involved in them, while people of the same sex may understand better, personal problems, having been through the same thing (presumably). Vice (1975) found that preferences of female subjects for male counsellors related primarily to educational/vocational problems, while those of male subjects for female counsellors were primarily related to personal/social problem areas. More recently, Lee et al. (1980) reported that for a vocational concern, both male and female students indicated a strong preference for a male rather than a female counsellor. Male therapists may be perceived as more instrumental and female therapists more expressive, thereby, influencing such choices. Some research seems to support these earlier findings. Haviland, Horswill, O'Connell, and Dynneson (1983) found that male native American college students preferred male counsellors for vocational and

personal problems while females expressed a preference for female counsellors only if they had a personal problem. It is not entirely clear how cultural/racial issues may have interacted in this research.

In contrast, Persons et al. (1974) found that college-age women dealing with identity, role, and sexual issues, as well as loneliness, anxiety, and vocational choices, experienced more help and understanding from female therapists. Howard, Orlinsky, and Hill (1970)and Orlinsky and Howard (1975, 1976) found that the impact of therapist sex was also great for depressed women patients who reported their experience with women therapists as most supportive and satisfying (i.e., less self-critically aroused, felt more open and less inhibited). Those women diagnosed as having personality disturbances were least reactive to the sex of therapist. This finding may suggest that women presenting with more "sex-role appropriate" symptoms may have a greater preference for same-sex therapists. Orlinsky and Howard (1976) reported that differences between patients who had male or female therapists in other diagnostic categories were generally less salient and less controlled with respect to probable outcome.

Simons and Helms (1976) found that both college and noncollege women preferred female counsellors when the counsellors were described as working in the area of "women's problems". It remains to be seen what the specific parameters of such problems might be.

As Bloom et al. (1977) have so aptly stated, "it is certainly conceivable that the nature of the client's problem might be significant in understanding the apparent contradictions of sex-pairing research", so that "different types of problems might be better handled by same-sex or opposite-sex therapists". For example, a client concerned with personal and sex-related problems (e.g., feminist issues, rape, masculinity) might benefit from same-sex pairing. In contrast, for a client's problems that are relatively nonsex-related (e.g., general dissatisfaction or phobia, perhaps even vocational difficulties), sex matching might be less crucial. Such "therapeugenic" factors as characteristics of the client and the client-therapist relationship may possess secondary (possibly, primary) therapeutic benefits and should not be considered as inert or incidental to the psychological treatment of psychopathology (Bloom et al., 1977).

Sex Roles, and Attitudes Toward Women in Relation to Therapist Preferences, Adjustment, and Psychological Problems

As previously stated, few researchers have investigated the conditions under which gender and sex-role-related variables affect the processes and outcomes of psychotherapy (Berzins, Welling, & Wetter, 1978). Berzins et al. (1978) also suggest that with "the ascendancy of psychological androgyny as a model of mental health ... such research has

high priority". As attempts to delineate firm data demonstrating that sex of therapist and patient systematically affect the course of psychotherapy fail, it becomes more apparent that this research may indeed, be "too simplistic" (Franks, 1979). In addition, it is crucial that research go beyond the traditional focus on models of individual psychopathology (e.g., disease-model, intrapsychic model) to consider the social context and social roles demanded by that context. It is also time that clinical researchers explore the antecedents and correlates of psychological adjustment in moving toward a more positive model of mental health.

Sex Roles and the Concept of Androgyny

It is generally accepted that sex roles are cultural expectations concerning the "appropriate" behaviour of women and men (Schaffer, 1980). The cultural expectations about appropriate behaviours are associated with consensual beliefs about the personality attributes women and men should possess (Gilbert, 1981). There is also general agreement in the literature with respect to which personality traits are primarily either masculine or feminine in nature (Bem, 1974; Rosencrantz Vogel, Bee, Broverman, & Broverman, 1968; Spence, et al., 1975). The stereotypes of masculine and feminine personality traits are consistent with Parson and Bales's (1955) description of

instrumental qualities in men and expressive qualities in women. They are also consistent with Bakan's (1966) concept of agency or sense of self (masculine principle) and communion or sense of selflessness (feminine principle).

Theorists beginning with Bakan (1966), Carlson (1971), and Constantinople (1973) proposed that feminine and masculine qualities be viewed as two independent dimensions. Therefore, coexistence of masculinity and femininity in the same person is theoretically possible (Marecek, 1979). Androgyny combines the traits and behaviours of men and women while, ideally, not being limited to sex-typed prescriptions (Bem, 1974; Gilbert, 1981; Kaplan, 1976, 1979a, 1979b; Rossi, 1964, 1969). An androgynous person, then, may display characteristics and engage in behaviour that s/he views as most effective for the situation, regardless of whether cultural expectations label them as appropriate for either women or men. Gilbert (1981) and Spence and Helmreich (1978); have further defined psychological androgyny as the possession of <u>high</u> degrees of masculine (instrumental) attributes and of feminine (expressive) attributes.

<u>Measurement of Masculinity, Femininity, and Androgyny</u>

Before discussing androgyny and its relationship to therapist attributions and adjustment, it is essential to discuss in detail the measures assessing sex-role stereotypy

and the rationale for selecting the Personality Attributes Questionnaire (Spence et al., 1974) and the Attitudes toward Women Scale (Spence & Helmreich, 1972b; Spence, Helmreich, & Stapp, 1973).

With the Bem Sex Role Inventory (BSRI; Bem, 1974), separate masculinity and femininity scales were first devised using items selected on the basis of sex-typed desirability and with items that Bem considered to be positive in context. The relationship of the masculinity and femininity scores was considered essentially orthogonal rather than strongly negative as implied by the bipolar model (Foushee, Helmreich, & Spence, 1979). With the original scoring method devised by Bem (1974), a t-ratio or difference of the masculinity and femininity scales produced a measure of androgyny (low difference between scores) which included low masculinity-low femininity individuals as well as high masculinity-high femininity individuals.

With the development of the Personality Attributes Questionnaire (PAQ; Spence et al., 1974), the scoring method of the BSRI (Bem, 1974) has become subject to increasing criticism. As White (1979) has stated, the additive approach used with the PAQ allows for distinguishing the high androgynous group (high on both masculine and feminine characteristics) and the low androgynous group (not high on both scales) or later labelled "undifferentiated". Bem (1977) conceded that these two definitions of androgyny

should be distinguished and recommended the median split method which then re-assigns those low-low subjects considered androgynous with the t-ratio to the undifferentiated group. The median split method assigns those individuals scoring above the sample median on both femininity and masculinity as androgynous (above 50% of one's comparison group in the endorsement of both feminine and masculine traits; Sedney, 1981). Sex-typed individuals score higher than 50% of their comparison group in either femininity or masculinity. Therefore, the two scoring methods can produce disparate results when variables are related to the androgynous group defined differently by both methods. Research based on the t-ratio method will be considered only generally related to the proposed research, since the median split method is considered preferable (Bem, 1977; Jones, Chernovetz, & Hansson, 1978) in assigning those subjects who score above the medians of the masculinity and femininity scales to the androgynous group. Bernard (1980) evaluated the impact of various scoring methods on data and concluded that for research purposes, the scoring method of choice was the median split method. Most investigators in this area use this procedure (Bem, 1977; Berzins et al., 1978; Kelly & Worell, 1977; Spence et al., 1974, 1975; Spence, Helmreich, & Holahan, 1979; Strahan, 1975; Worell, 1978).

Another criticism of the BSRI is that the femininity scale contains a number of items not clearly measuring expressive and/or communal traits (e.g., shy, soft-spoken) and which may be socially undesirable for women as well as men (e.g., yielding, flatterable, gullible), (Helmreich, Spence, & Holahan, 1979; Spence & Helmreich, 1979). Briere, Ward, and Hartsough (1983) added that the problems (confusion, conflicting results) associated with all the scoring methods used with the BSRI, make it an extremely problematic method of measuring androgyny.

In other studies (Waters, Waters, & Pincus, 1977; Whetton & Swindells, 1977), Bem's Sex Role Inventory was subjected to a factor analysis. These studies found that there were more than just three factors (masculinity, femininity, and social desirability) that Bem said the scale was measuring (Hoyenga & Hoyenga, 1974). Instead, one study found that the test measured five independent traits or factors: empathy, power, honesty, autonomy, and neuroticism. The other study found four similar factors: biological sex, expressiveness (empathy), dominance-aggressiveness, and independence (autonomy). These analyses indicate that although the simplistic, inaccurate way of predicting behaviour of the bipolar model is avoided with the dualistic model, that there are still great complexities (Hoyenga & Hoyenga, 1979).

Gaa, Liberman, and Edwards (1979) factor analyzed the BSRI and PAQ, providing results inadequate to substantiate the assumption of independent scales. With the factor analysis of the BSRI, 16 factors were identified, and with the second order analysis, 16 additional factors were identified. Examination of these factors of the BSRI clearly indicates that no single masculinity or femininity factor was identified for the instrument as a whole (Gaa et al., 1979).

In contrast, the first order factor analysis of the PAQ identified six factors accounting for 45.8% of the variance (Gaa et al., 1979). The four major factors were empathy, emotional, aggressive, and self-confidence. Given the small number of factors, no attempt was made to identify second order factors. With the PAQ, only the Empathy factor seemed to represent a sex-typed feminine scale.

Given some of the problems discussed with the BSRI, the PAQ was considered a preferable instrument. The dominant practice (Bem, Martyna, & Wilson, 1976; Spence et al., 1975) to examine sex-role orientation groups on dependent measures appears to involve the use of at least two-way analyses of variance followed by comparisons of the four subgroup means (as advocated by Lenney, 1979), with females and males considered separately (Taylor & Hall, 1982).

The Personality Attributes Questionnaire. The PAQ (Spence et al., 1974) is a self-report instrument consisting of a number of 5-point trait descriptions, each set up on a bipolar scale. The content of the M scale contains items referring to instrumental, agentic characteristics considered socially desirable for both sexes but that males presumably possess in greater abundance (Spence & Helmreich, 1978, p. 35). The content of the F scale contains items referring to expressive, communal characteristics considered socially desirable for both sexes but that females presumably possess in greater abundance (Spence & Helmreich, 1978, p. 35). The items on the Masculinity-Feminity (M-F) scale consist of characteristics the social desirability of which appears to vary in the two sexes while also containing both agentic and communal characteristics (Spence & Helmreich, 1978, 1979).

The four-way classification (masculine, feminine, androgynous, undifferentiated) from the median split method may be expanded into an eight-way classification by dividing individuals in each of the four cells into those falling above and below the overall median of the M-F scale (Spence & Helmreich, 1978, p.35). This method, then, allows for comparisons of subjects with extremely high endorsement of masculine or feminine traits vs. less extreme scores.

Spence and Helmreich (1978, 1979, 1980) caution that the masculinity and femininity scales of the PAQ are only

minimally related to many sex-role behaviours that do not directly require instrumental or expressive skills. Women typically score higher than men on the femininity-expressiveness scale and men typically score higher than women on the masculinity-instrumentality scale across a wide spectrum of age and socioeconomic groups (Bem, 1974; Deaux, 1984; Spence & Helmreich, 1978). O'Connor, Mann, and Bardwick (1978) also replicated Spence et al.'s (1975) findings: significant positive correlations between men's masculinity scores and the use of masculine stereotypes, and positive correlations between women's femininity scores and use of feminine stereotypes. The use of stereotypes was measured by the willingness to describe "typical" men and women in sex-stereotyped terms. Sex-appropriate sex-role attribution self-ratings were negatively related to feminism for women and men (O'Connor et al., 1978).

White (1979) cites problems with measuring sex-role identity only with college populations since these individuals are "experiencing certain socio-biological needs characteristic of the mating and nesting stage of life", but there are very few studies that have obtained data on older adults. Nevertheless, White (1979) using the Gough Adjective Checklist (ACL; Gough & Heilbrun, 1965) found that androgyny in adulthood was defined by high competency in both agentic and communion skills. O'Connor et al. (1978) found that upper-class adult men described themselves as

more masculine than younger college men. It remains to be seen to what extent responses give on the PAQ by college students, especially in terms of classification into sex-role categories, compare with an older adult sample.

A further caution regarding generalizability between data using different sex-role inventories involves discrepancies between categories to which subjects are assigned. Kelly, Furman, and Young (1978) found that there was 60.8% agreement (sexes combined) between PAQ and BSRI assignments with 60.0% agreement for males and 61.5% agreement for females.

Attitudes Toward Women Scale-Short Form. This scale (AWS; Spence & Helmreich, 1972b; Spence et al., 1973) contains statements describing "rights, roles, and privileges women ought to have or be permitted". It requires respondents to indicate their agreement with each statement on a four-point scale: agree strongly, agree mildly, disagree mildly, and disagree strongly. Spence and Helmreich (1972b) found that women score higher (are more profeminist) than men and that college students score higher than their same-sex parent.

Spence et al. (1973) found that college women scored significantly higher than college men, while mothers of college students also scored significantly higher than fathers of college students. Other studies have also

demonstrated that men score more traditionally than women on the AWS-Short Form (Goldberg, Katz, & Rappeport, 1979; Helwig, 1976; Minnigerode, 1976; Zuckerman, 1978). For example, Goldberg et al. found that the mean score for women (out of 75) was 64.01 and for men, the mean score was 57.29.

Using the PAQ, Spence & Helmreich (1978) found that individuals who conspicuously violate traditional expectations by being high in psychological attributes stereotypically associated with the other sex (i.e., cross-sex-typed and low in attributes associated with their own sex) tend to be more eqalitarian in their attitudes than their contemporaries. However, Spence and Helmreich reported that low correlations between these measures generally indicate that the association between abstract attitudes toward appropriate role behaviours for men and women and the psychological attributes of masculinity and femininity is slight.

Using the BSRI and AWS, Mezydlo and Betz (1980) found that nonfeminist males and females described ideal men and women in terms of traditional sex-role stereotypes. Feminists of both sexes viewed the characteristics of the ideal women as similar to those of the ideal man, those characteristics suggestive of masculine sex-typing. Bem (1977) confirmed these findings; masculine men were significantly more conservative in attitudes than anyone else, while femininity in men was positively related to

liberal attitudes toward women. Bem found that attitudes toward women did not relate significantly to masculinity or femininity in women. It is possible to hypothesize that more conservative men, especially if also masculine, would be much less inclined to select a woman therapist than would feminine, liberal men.

Jones et al. (1978), however, found that significant differences in the relationship of sex to feminist ideology were found only for women. Masculine females indicated significantly more favourable attitudes toward feminist issues than either androgynous females or feminine females. There was also a trend for androgynous females to show more favourable attitudes than feminine females. All women, regardless of sex type showed significantly higher scores on the Women's Liberation Ideology Scale than did males (Jones et al., 1978). These researchers state that construct validation for the BSRI is provided by these findings: being a woman, and particularly a less traditionally sex-typed woman, was related to greater endorsement of contemporary women's issues. Previously, BSRI scores failed to correlate with two separate measures of attitudes toward women (Kamens & Liss-Levinson, 1975; Zeldow, 1976).

Schaffer (1980) reports that as the level of education increases, attitudes become more liberal, especially in relation to attitudes toward women. Also, younger individuals and women currently employed tend to be more

liberal, while married or widowed individuals (especially female homemakers) are less supportive of changes than are single or divorced people of both sexes (Chandler, 1972; Tavris, 1973).

Zeldow and Greenberg (1979) studied attitudes toward women and the orientation to seeking professional help in a college student sample. Liberal attitudes toward women were associated with positive help-seeking in women and men. Also, the orientation to seeking professional help was correlated with actual help-seeking in women and men. "People who embrace traditional opinions with regard to women's role in society display more negative attitudes toward seeking help" (Zeldow & Greenberg, 1979). Zeldow and Greenberg (1980) replicated these results by finding that although liberals and conservatives (as determined by the AWS-Short Form) seemed equally willing to say that they would seek psychological help, liberals would more readily seek psychotherapy and remain for more than five sessions. These findings suggest that the AWS is a good predictor of actual help-seeking. Given this relationship between liberal attitudes and willingness to seek help, it is important to mention that Logan and Kaschak (1980) found that male and female college students with more liberal scores on the AWS scored higher on the Well-Being Scale of the California Psychological Inventory. In other research, women who scored in a more liberal direction on the AWS

achieved a greater sense of self-actualization than did those women with more traditional sex-role attitudes (Hjelle & Butterfield, 1974).

Some methodological considerations concerning the Attitudes Toward Women Scale have been suggested by Goldberg et al. (1979). They have suggested that the AWS, like most attitude scales, is vulnerable to falsification, that there are social desirability aspects of AWS items, and scores on AWS do not necessarily predict behavioural commitment.

Androgyny, Flexibility, and Therapist Preferences

Berzins et al. (1978) defined psychological androgyny as incorporating a "relative balance of masculine- and feminine-typed attributes in the context of high social competence (openness to interpersonal and intellectual experiences)". Such "openness" or potential behavioural flexibility (Bem, 1972, 1974, 1975; Bem & Lenney, 1976; Bem et al., 1976; Kelly & Worell, 1977) may also predict a lack of sex-role stereotypy in stating preferences and characteristics of prospective psychotherapists.

Some researchers (e.g., Spence, 1979; Spence & Helmreich, 1979, 1980) have suggested that the possession of expressive and instrumental skills may enhance the person's ability to take on various life roles and activities, without dictating what roles will be preferred or adopted. Another perhaps

more common view presented by Bem (1974, 1977), Jones et al. (1978), Marecek (1979), and Worell (1978) is that personality measures of psychological masculinity and femininity are indicators of sex-role preferences and behaviours. Gilbert (1981) supports the available empirical data (Helmreich et al., 1979) providing stronger evidence for the former view than the latter. Gilbert (1981) describes masculinity and femininity as inner psychological attributes, not observable patterns of behaviour that a given culture deems appropriate for each sex. Nevertheless, it is possible that such attributes could influence perceptions and preferences. For example, Motowidlo (1982) reported that highly androgynous subjects who were low-to-middle-level business managers showed more acceptance of nontraditional jobs and support for persons in jobs unusual for their gender.

Merluzzi and Merluzzi (1981) explored client sex-role orientation as a variable that may contribute to differential perceptions of female psychotherapists. Unfortunately, perceptions of male psychotherapists were not included. Also, analyses were done across sex of subject, without any comparisons between female and male subjects. Merluzzi and Merluzzi hypothesized that previous results (e.g., Bloom et al., 1977; Merluzzi et al., 1978) could be a function of the tendency of sex-role stereotypic subjects to make differential judgements as a function of therapist

gender and behaviour. In other words, less sex-role stereotypic subjects (i.e., androgynous) might be less critical of female psychotherapists. They also hypothesized that sex-role stereotyped subjects would perceive female psychotherapists differently as a function of therapy experience (e.g., new Ph.D. in Psychology versus B.A. in English) and disclosure level. Unfortunately, their comparisons were limited to only androgynous and stereotyped subjects using the median split method with the BSRI, and without regard to undifferentiated or cross-sex-typed subjects. Nevertheless, the thrust of the Merluzzi and Merluzzi (1981) study was consistent with Bem's (1979) conceptualization of sex-orientation as a cognitive schema or filter, screening information and interpreting it in a fashion consistent with the particular sex-role orientation of the individual.

After being assigned to the expert or nonexpert condition and high or low disclosure, the subjects completed counsellor rating forms on dimensions of expertness,social attractiveness, and trustworthiness. Merluzzi and Merluzzi (1981) found that the perception of trustworthiness in female psychotherapists was moderated by sex-role orientation of the subject. Androgynous subjects did not differ in perceptions either as a function of disclosure level or experience. Stereotyped subjects perceived high disclosing female nonexpert therapists as significantly less

trustworthy than low disclosing nonexperts. As long as the female psychotherapists were defined as expert, a certain degree of trustworthiness was perceived by stereotyped subjects. High disclosing female therapists were perceived by stereotyped subjects to be highly emotional, unstable, or even capable of violating confidentiality. Low disclosing therapists were perceived by those subjects as stable, rational, and therefore, trustworthy. It is possible that androgynous subjects do not use role-bound notions of women to extract and interpret information, and therefore, do not vary substantially in their trustworthiness scores as a function of therapist experience or disclosure level (Merluzzi & Merluzzi, 1981).

It seems that perceived differences in psychotherapist credibility as a function of gender may be partially due to the subject's sex-role orientation. Furthermore, trustworthiness may be a variable particularly susceptible to differential perceptions by subjects as a function of therapist gender. Further investigations could explore such relationships as they involve male therapists.

Wilder, Hoyt, Zettle, and Hauck (1978) also commented on the lack of studies concerned with the association of client personality traits with client preferences for a counsellor's sex. They cite a failure to control for personality traits associated with client preferences for sex of counsellor as undoubtedly contributing to the

inconsistent results in research exploring the impact of counsellor and client sex on the counselling process (Boulware & Holmes, 1970; Brooks, 1974; Fuller, 1964; Hill, 1975; Persons et al., 1974; Scher, 1975).

Wilder et al. (1978) did not, however, include sex-role stereotypy as a variable in their study, which seems to be a serious oversight given the influence of sex-role stereotypy and gender on client attributions to therapists (e.g., Merluzzi & Merluzzi, 1981). Nevertheless, after using personality measures (Opinion, Attitude, Interest Survey; Fricke, 1963; a college student questionnaire; and the California Personality Inventory; Gough, 1957, 1968), they concluded that male and female students preferring a same-sex psychotherapist are "acquiescent, conventional, conformist...rather conservative, retiring, rather pedestrian, in all probability...a response to an underlying lack of self-confidence and fear of inferiority ... submissive, introverted, compliant, self-abusing" as well as being less emotionally adjusted than the no-preference students. It is possible that the subjects stating a same-sex preference had particular difficulties that dictated this choice, or may have been "open" to the opportunity of therapy and viewed it more seriously, therefore, making the preference for sex of therapist a more pertinent issue. In any event, Wilder et al.'s (1978) speculations with respect to inadequate client motivation in the same-sex preference

subjects, were not justified by their data. This study can be considered only exploratory, and without the benefit of sex-role stereotypy information (as it relates to personality traits), seriously lacking justification for the conclusions made.

Jones et al. (1978) suggest that studies in this area raise questions regarding the generalizability of current demonstrations of flexibility of androgynous individuals. Jones et al. (1978) found in their research that sex-typed females and cross-sex-typed females with very few exceptions, showed the most flexible and competent pattern of responses. Their conclusion must be viewed with caution since the assignment of subjects to sex-role groups was done using the subtractive method with the BSRI.

In summary, the androgynous person cannot be defined as generally "flexible" across all sex-role behaviours. Such flexibility is reportedly related closer to instrumental skills (Helmreich et al., 1979; Spence & Helmreich, 1979, 1980). In fact, masculinity has predicted greater flexibility for both sexes in some research (e.g., Jones et al., 1978), but may not be related to flexibility in preferences for therapist sex and in attributions of therapist characteristics.

Sex-Role Stereotypy, Androgyny, and General Adjustment

Although sex-role stereotypy has been related to the judgement of mental illness (e.g., Broverman et al., 1970; Tilby & Kalin, 1980), it has not been extensively studied in relation to actual psychological difficulties. Worell (1978) points to the importance of comparing subcultures in that it is quite possible that pertinent differences exist in the cultural norms and/or sex-role practices of clinical and college populations. Analogue research, again, dominates this area of research thus far. There remains an immediate need to study how sex-role stereotypy relates to individuals who are seeking therapy, presumably because they are experiencing psychological difficulties. How then, does sex-role orientation relate to personal adjustment within this group?

Traditional formulations of sex-typing (e.g., Cheek, 1964; Kohlberg, 1966; McClelland & Watt, 1968) have suggested that adoption of sex roles appropriate to one's masculine and feminine gender is developmentally desirable, particularly in determining greater psychological adjustment. Biller (1973) maintains that college women who have a more masculine orientation might be more predisposed to psychopathology, while a more feminine orientation will lend itself to problems in college academics.

LaTorre and Gregoire (1977) reported that mental health clients (who were college students) were more androgynous than the group of subjects seeking medical treatment at the university. Rather than interpreting these results as indicating that androgynous individuals may be more willing to admit psychological difficulties and seek help, they stated that "confusion regarding role adoption" related to adjustment difficulties. A further problem with this study is that the t-ratio method of scoring the BSRI was used so that undifferentiated subjects were also included as androgynous. Furthermore, their assumption that individuals seeking psychological help are less well-adjusted than those not seeking help is not based on empirical evidence. In addition, it is commonly agreed that seeking the help of a psychologist or psychiatrist in our culture is viewed as less appropriate for males than for females (e.g., Coie, Pennington, & Buckley, 1974). The sample of males found at a psychological clinic is therefore, not necessarily representative of all males experiencing psychological difficulties. Actual measures of adjustment and psychological problems may clarify the role of sex-role orientation more directly.

Recent thinking influenced by the reconceptualization of masculinity and femininity within the same person has led to the hypothesis that androgynous rather than sex-typed individuals set standards for mental health and personal

effectiveness (e.g., Kaplan, 1976, 1979a; Schaffer, 1980; Spence & Helmreich, 1979a, 1979b). Within a sociopolitical context established by Bem (1974, 1975) it has become a general belief that androgyny is "good" and that mental health is synonomous with androgyny scores on sex-role measures (Deaux, 1984) despite the central issue concerning the meaning of the scales themselves and what they measure. It has been argued that highly sex-typed persons may exhibit behavioural deficits in situations calling for opposite-typed responses (Bem, 1974, 1975; Bem & Lenney, 1976; Bem et al., 1976). Thus far, androgyny has been compared to the presence of sex-typing in personality/behaviour in relation to: 1) adaptive,flexible, and effective interpersonal behaviour (previously discussed), 2) broad life-style coping variables (not relevant to the present study), 3) freedom from obvious pathology (to be discussed), and 4) self-esteem or positive self-evaluation (also to be discussed); (Jones et al., 1978; Schaffer, 1980; Worell, 1978).

A controversy continues regarding whether androgyny or masculinity epitomizes a more adaptive mode of human functioning (e.g., Antill & Cunningham, 1979; Jones et al., 1978). Taylor and Hall (1982) presented persuasive evidence for the position that the main effect contributions of the masculinity (instrumentality) and the femininity (expressiveness) scales provide more predictability of behaviour than does the unique prediction of androgyny.

However, Deaux (1984) asserts that "measures of psychological health promise to go beyond the construct validity (of these individual scales) and offer a test of some of the basic assumptions of androgyny theorizing." Spence and Helmreich (1979a, 1979b, 1980) maintain their earlier position (Spence et al., 1975) that since masculinity and femininity relate independently and positively to self-esteem and psychological adjustment, androgyny contributes a unique potential for a greater sense of well-being and general adjustment.

The research in this area continues to be complicated by methodological problems. Sex-role functioning as defined by the PAQ and the BSRI may lead to discrepant predictions for many psychopathology variables. Generalizations concerning adjustment and psychological well-being should be confined to the particular instrument used to assess sex roles as well as the particular scoring method adopted (Worell, 1978). Jones et al. (1978) stated that much of the available data did not directly address the issues of mental health and social competence. Many studies have also failed to include cross-sex-typed subjects or males in their design while others have combined males and females, or cross-sex-typed individuals with conventionally sex-typed individuals. Nevertheless, some consistency regarding the potential benefits of androgyny occurs in this literature.

Nevill (1977) reported a positive relationship between self-concept and androgyny. There were, however,serious methodological flaws in this research: only 86 of the original 1000 subjects provided usable data and subjects were classified only as androgynous or non-androgynous (Hinricksen, Follansbee, & Ganellen, 1981). Rodriquez, Nietzel, and Berzins (1980); Kelly, O'Brien, and Hosford (1981) found that androgyny was associated with effective social skills and undifferentiated roles were connected with ineffective skills. Kaplan (1976) suggested that sex-typed traits themselves are not pathological, rather "pathology accrues from either of the two extremes: overly sex-typed reactions and/or the absence of responses that are assigned to the opposite sex". Orlofsky and Windle (1978) reported that androgyny in undergraduate subjects related to greater behavioural flexibility and high levels of self-esteem and personal adjustment. However, high levels of adjustment were also observed in masculine males and feminine females. Orlofsky and Windle stated that appropriate sex-typing may lead to lower self-esteem in women, but will also relate to a sense of social acceptability due to the prevailing cultural stereotypes. Such an interpretation may have validity only for this particular group (young college students). In addition, there were extremely small numbers of subjects in certain cells (e.g., 5 undifferentiated females, 9 feminine males, 9 masculine females) further limiting the conclusions that can be made from this data.

In any event, androgyny as a model of mental health has been researched and supported to the extent of offering a plausible hypothesis of psychological adjustment (Bem & Lenney, 1976; Gilbert, Waldroop, & Deutsch, 1981; Heilbrun, 1976; Spence et al., 1979).

From a different position, it is possible that androgynous people are seen at psychological clinics not only because they are more willing to admit difficulties (Frank, 1979), but because they are emitting sex-role discrepant behaviours that may be judged by others as more maladjusted (e.g., Broverman et al., 1970; Sherman, 1980). Many researchers (e.g., Sobel & Cummings, 1981) are not convinced that androgynous persons will be well-adjusted individuals in today's society. It is possible that androgynous people may have the potential for greater behavioural conflict (Kelly & Worell, 1977). Due to traditional sex-role standards still being enforced, achievement of androgyny and corresponding greater flexibility of sex roles may create stress and anxiety-related problems for those who do manage to attain androgynous behaviour (Tilby & Kalin, 1980).

In some research, women with a more masculine orientation (who violate sex-role expectations) seem to be more adaptive,competent, and secure than either androgynous or sex-typed women (Jones et al., 1978). Behavioural and self-report data from a number of studies uniformly show, in both

sexes, positive correlations between masculine instrumentality and many indices of mental health, often to a substantial degree (Kelly & Worell, 1977; Spence & Helmreich, 1978). Feminine expressiveness, in contrast, has a weaker or zero-order association with the same indices (Gilbert, 1981). These results have been replicated in other samples of differing age and backgrounds (Bem, 1977; O'Connor et al., 1978). Androgynous and masculine subjects have reported adjustment and higher self-esteem than feminine and undifferentiated subjects, with no differences occurring within each pair of categories (Antill & Cunningham, 1979; Gilbert et al., 1981; O'Connor et al., 1978). Gilbert et al. concluded that androgynous individuals only sometimes have an advantage over masculine individuals but typically do have an advantage over feminine individuals. Antill and Cunningham suggest that the level of masculinity may be the major contributing factor to self-esteem.

Baucom (1980) conducted a study with a large sample (287 undergraduate students) which confirmed that masculinity and femininity are related to different aspects of adjustment but that androgynous individuals may be the most psychologically adjusted. Sex-role typology was constructed for each sex (including all four groups) using masculinity and femininity scales developed on the California Psychological Inventory (CPI; Gough, 1957); (Baucom, 1976).

Scores on these scales were related to psychological correlates of the CPI and the Adjective Check List (ACL; Gough & Heilbrun, 1965). Baucom found that the masculinity scale was positively correlated with the scales: dominance,capacity for status, sociability, social presence, self-acceptance,sense of well-being, self-control, tolerance, good impression, achievement via conformance, intellectual efficiency, psychological-mindedness; and negatively correlated with the scale, femininity. The femininity scale was positively correlated with responsibility, socialization, self-control, tolerance, achievement via conformance, and femininity. He concluded that masculine persons are comfortable as leaders, understand other people, are accepting and nonjudgemental toward others, and have good intellectual skills. He also concluded that generally, feminine individuals are dependable and conscientious, emotionally sensitive, have good self-regulation, and are achievers. Masculine sex-typed and feminine sex-typed persons appeared to conform to stereotypic views of masculinity and femininity. The feminine and undifferentiated groups, however, presented on the ACL and the CPI a less favourable picture of themselves than either the androgynous or masculine groups, with the androgynous group presenting itself most favourably (Baucom, 1980). The CPI profiles of women and men within each sex-role were also remarkably similar, a finding that Baucom interpreted as meaning that individuals of both sexes with the same sex roles may perceive themselves similarly.

Jones et al. (1978) suggested that general adaptability varies as a direct linear function of a relative mix of traits dominated by such factors as assertiveness, decisiveness, and intellectuality as opposed to nurturance, responsivity, and emotionality. Obviously, the acquisition of instrumental traits may be adjustive in a patriarchial, male-oriented culture, whereas the adoption of expressive traits per se is not (Block, 1973; Gilbert, 1981; Gilbert et al., 1981; Tilby & Kalin, 1980). Greater social value has long been recognized in association with such traits labelled as masculine (Broverman et al., 1970; McKee & Sherriffs, 1959; MacBrayer, 1960). Also, there may be a contingent relationship between the manifestation of instrumental behaviours and the application of various social rewards (acceptance, approval, esteem, deference) (Jones et al., 1978). Therefore, due to such cultural sanctions, full empirical support cannot be provided at this time for the hypothesis that androgynous people are most effective and best adjusted. No doubt, feminine behaviour is accepted even less in men than in women so that androgyny within the context of a traditional culture, may lead to an adjusted state only in women. However, due to our culture's greater approval of masculine behaviour (especially in men), it is not surprising that masculinity has been reported as having a more positive effect on psychological health than does femininity (Antill & Cunningham, 1979; Bernard, 1980; Kelly & Worell, 1977; Kenworthy, 1979; Locksley & Colten, 1979; Silvern & Ryan, 1979; Spence et al., 1975). This

research also indicates, almost without exception, that rigid, stereotypically feminine sex roles are not those maximally associated with psychological well-being in either sex (Kelly, 1983; Taylor & Hall, 1982).

The Measurement of Adjustment: California Psychological Inventory

Researchers investigating androgyny and adjustment have studied the specific areas of well-being from the CPI (Logan & Kaschak, 1980), the entire CPI and the ACL (Baucom, 1980), self-esteem using Coopersmith's (1967) measure (Jones et al., 1978), the Texas Social Behaviour Inventory (Helmreich and Stapp, 1974; Helmreich, Stapp, & Ervin, 1974) used by Bem (1977); Spence et al. (1975); Spence and Helmreich (1978), as well as confidence in one's ability, political awareness, and creativity (Jones et al., 1978).

While these measures tend to be specific to limited areas of adjustment and usually do not reflect current general adjustment, other more general measures tend to be oriented toward detecting pathology (e.g., MMPI; Hathaway & McKinley, 1943; Psychological Screening Inventory; Bruch, 1977) and rarely toward interpersonal community coping skills (Sundberg, Snowden, & Reynolds, 1978). The California Personality Inventory (CPI) was designed for use with normal individuals and individuals with behaviour problems (Gynther & Gynther, 1976) with an emphasis on interpersonal behaviour and dispositions relevant to social interactions (Gough,

1968). This measure has become associated as a diagnostic measure of self-perceived adjustment with scales related to the characteristics of poise, social responsibility, and achievement (Sundberg et al., 1978). The CPI predicts future adaptive behaviour on the basis of assessing an individual's strengths (Gynther & Gynther, 1976).

The CPI is comprised of 480 True-False items; approximately 178 are virtually identical to MMPI items and 35 others are quite similar (Megargee, 1972). Most of the remaining items selected and scale construction were based on the "empirical technique" (Gough, 1968) where large samples of criterion subjects were obtained for empirical item analysis. First, a criterion dimension was defined. Then, "inventory statements which seemed to bear a psychological relevance to the criterion dimension were assembled in a preliminary scale" (Gough, 1968, p. 18). For example, on a given scale such as dominance,subjects were selected by having persons rate their acquaintances on dominance. Analyses were then performed, on the item responses of individuals with very high and very low ratings.

At least 20 factor analytic studies have been reported in the research (Megargee, 1972) and in general, the same 5 basic factors have been found (Gynther & Gynther, 1976). Factor 1, the largest factor, appears to be a measure of impulse management and socialization with high loadings in

the scales: self-control, good impression, sense of well-being, tolerance, achievement via conformance, and responsibility. Factor 2, the second largest factor extracted, can be characterized as a measure of interpersonal effectiveness (or even extraversion), with high loadings on the scales: dominance, capacity for status, sociability, social presence,and self-acceptance. The other three factors accounted for considerably less variance. Factor 3 was defined usually by high loadings on achievement via independence and flexibility (with sometimes, occasional loadings of tolerance and intellectual efficiency). Factor 4 has had high loadings on communality and socialization, and may be regarded as reflecting the internalization of conventional values. Factor 5 when it has appeared, has been defined by a high loading on the femininity scale.

The scales as Gough (1968) originally described them, together provide a profile of personal adjustment. See Appendix A which provides explanations of these scales. A score above the mean of a given scale suggests positive adjustment and one below the mean indicates a problem area.

Gough (1968) grouped the scales into four classes, partially on the basis of factor analytic findings and partially because of interpretive considerations. The first two classes of scales pertained to "intrapersonal effectiveness, style, and adequacy"; and "interpersonal controls, values, styles, and beliefs" (Gough, 1968),

relevant to adjustment. Class III ("of basic relevance to academic counselling and guidance"; Gough, 1968) includes the scales: achievement via conformance, achievement via independence, and intellectual efficiency which are not considered directly pertinent to the current research. Class IV reflecting "broad and far reaching attitudes toward life" (Gough, 1968), includes three scales which were considered relevant to the present investigation: psychological-mindedness, flexibility, and femininity. The present researcher's deletion of the third class of scales reduced the total number used to 15.

Burger (1975) and Schut, Hutzell, Swint, and Gaston (1980) have developed and validated two short forms of the CPI which include all 18 scales, but reduce the number of items by half. Burger (1975) reported that correlations of the short form with standard scales, factor structure of the short form, cross-validated regression equations to eliminate standard scale scores, and test-retest reliability coefficients indicating that a short form is a "reasonable alternative to the complete inventory in situations where time savings are required". It appeared that a sufficiently large portion of the variance of the full-version CPI scales (through a factor analysis) was accounted for in the scales of both short-forms (Schut et al., 1980). In the only known comparison of these two short-forms (Schut et al., 1980), the Repeated Items Short-Form (Schut et al., 1980) was equal

or superior to the other short-form (Burger, 1975) in approximating the full-version CPI (Schut et al., 1980). This short-form incorporating 223 CPI items was used in the current investigation.

Psychological Problems and Sex-Role Orientation

Women and men are at high risk for psychological disorders that dovetail with the female and male stereotypes (Marecek, 1979). Women are at heightened risk for disorders involving depression (Belle, 1980; Radloff, 1975; Rosenfield, 1980; Russo & Sobel, 1978; Weissman & Klerman, 1977; Woodruff, Goodwin, & Cruze, 1974); social withdrawal and agoraphobia (Bootzin & Acocella, 1984; Marks, 1969); low self-esteem, passivity, lack of assertiveness (Alberti & Emmons, 1974; Hollandsworth & Wall, 1977); as well as high anxiety and "hysteria" (Jones & Zoppel, 1982). Aggressive disorders, violence, psychopathy and alcoholism are reported more among males than females (Belle, 1980; Dohrenwend & Dohrenwend, 1976; Feshback & Feshback, 1973; Hetherington & Parke, 1979; Jones & Zoppel, 1982; Kelly, 1983; Marecek, 1975). The extent to which these labels reflect socio-cultural biases and the extent to which such diagnoses reflect actual behavioural manifestations of a particular sex-role orientation remains a controversial issue. Past definitions of mental health (and psychological disorders) have focused exclusively on the characteristics of the

individual, with little regard given to the sociological and cultural factors (Gilbert, 1981).

An issue which has received increasing attention in the 1970's and 1980's is whether these sex differences occur due to actual differences in mental illness or due to a higher likelihood that women will seek help for psychological difficulties than will men. These two views have been represented primarily by two groups of researchers, Dohrenwend and Dohrenwend (1976), and Gove and his colleagues (e.g., Gove, 1972; Gove & Tudor, 1973; Gove & Swafford, 1981). Dohrenwend and Dohrenwend conveyed the impression that extrapsychic factors were largely responsible for higher treatment rates of women. Gove and Swafford (1981) argue that real sex differences occur, unrelated to women having a greater propensity to seek help.

Kessler, Brown, and Broman (1981) gathered data from extensive national surveys of the health status of 6,913 noninstitutionalized individuals aged 25-74 years and surveys from the Centre for Epidemiologic Studies of the National Institute of Mental Health with 1,173 individuals, including the assessed use of treatment facilities as well as self-reported morbidity (e.g., depression, general lack of well-being). Kessler et al. found that men and women do not differ in the likelihood of their either perceiving themselves as needing help or seeking help once a problem is recognized. However, women were considerably more likely than men to recognize emotional problems when they existed.

These researchers concluded that this greater sensitivity plays an important role in the overrepresentation of women in treatment facilities. This sex difference in problem recognition was also related to the possibility that women had higher levels of true psychological distress than men. Also, the same (perhaps, nonspecific) feelings of depression or low well-being are more likely to lead women than men to perceive themselves as having a personal problem (Kessler, et al., 1981).

Kelly (1983) has criticized much of the current research on sex differences in psychological disorders that has not yet systematically taken into account the effect of sex-role orientation independent of a person's biological gender. He asserts that the disorders commonly found in women and men relate directly to stereotypic behaviours in each sex which when exaggerated become manifested as these disorders. Such disorders as dependent personality disorder, histrionic personality disorder, agoraphobia, and anorexia nervosa (where the numbers of women exceed men) represent caricaturized behaviour of the traditional female sex-role (Jones et al., 1978; Kelly, 1983; Kelly & Worell, 1977). Also, highly feminine sex-typed persons may use strategies that in western culture do not typically elicit environmental reinforcers (e.g., kindness, emotionality, self-subordination, gentleness), (Kelly, 1983).

The importance of women being particularly at risk for disorders of psychological functioning is gradually gaining more recognition (e.g., Russo & Sobel, 1981; Subpanel on Mental Health of Women, 1978). As Chesler (1972) asserted, women are diagnosed for both overconforming and underconforming to sex-role stereotypes. Women are not only punished (diagnosed) for acting "out of line" (i.e., not like a woman) (Sherman, 1980), but traditional roles may "drive" women crazy (Kaplan, 1983; Logan & Kaschak, 1980). Feminine traits are also not valued to the same extent as masculine traits (Tilby & Kalin, 1980). Rigidity of sex-role orientation may more accurately predict some sex-differentiated disorders than gender (Kelly, 1983). Nevertheless, the demands of traditional sex roles have been described as leading to more problems for women than men, e.g., the internalization of negative feelings, behaving to satisfy a male partner, passivity, learned helplessness, exaggerated femininity, and other-directedness (Hare-Mustin, 1983).

It would appear, then, that the endorsement of sex-role stereotypic and cross sex-typed behaviours by a woman or man will relate to the psychological difficulties that s/he reports. Rosenfield (1980) reported a study involving interviews of 60 married individuals including self-report items on depressive types of symptoms (e.g., problems with sleeping and appetite, being in low spirits). In comparing

women with men in the study, females were higher on the depression scale, especially if they were not working and if the division of labour in the home was traditional. When a woman was working and the family work roles were less traditional, men were more depressed. When traditional sex roles are challenged (such as through "consciousness-raising" groups), women report less of a sense of helplessness and depression (Weitz, 1982). Rosenfield (1980) concluded that sex differences in depressive symptoms are explained more by sex roles explanations than by biological factors or particular sociodemographic characteristics. The small sample limits the impact of these findings, however.

There are very few studies which have tested the relationship of sex-role orientation to specific psychological problems in a clinical sample. Androgynous individuals of both sexes and, secondarily, masculine individuals, have been reported by some researchers to be lower in anxiety, depression, and other indices of emotional distress than do feminine or undifferentiated individuals (e.g., Bem, 1977; Spence et al., 1975; Spence et al., 1979). Jones et al. (1978) reported that androgynous males were less effective than masculine males in coping ability in: adjustment, locus of control, alcohol problems, and introversion. Feminine males were more external, more neurotic, had lower self-esteem, and had more alcohol

problems when compared with masculine males. Feminine males were also more neurotic and had lower self-esteem relative to androgynous males. Masculine females were found to be more extraverted than either androgynous or feminine females. No other significant differences for women were found, although a trend suggested that masculine females had more problems with alcohol than did androgynous females. Only one comparison of androgynous and undifferentiated subjects resulted: low masculine-low feminine males manifested significantly greater problems with alcohol that did their high-high counterparts.

Burchardt and Serbin (1982) compared clinical and college samples on the BSRI and Faschingbauer Abbreviated MMPI. The clinical sample was extremely small (31 subjects) with no masculine females. As expected, feminine clinical subjects scored higher than androgynous subjects on depression and social introversion. Undifferentiated clinical subjects scored higher than androgynous subjects on paranoia, depression and social introversion scales. Within the college sample, androgynous women had lower scores than the feminine group on depression and social introversion and the masculine group on schizophrenia and mania scales. Also, androgynous women were less depressed than androgynous males but masculine men were less depressed than masculine women. Evidently, role flexibility (i.e., androgyny) in women was related to mental health in both the nonclinical and

clinical groups with a less distinct picture occurring among men. However, there were no masculine women in the clinical sample.

More recently, Thomas and Reznikoff (1984) compared clinical and nonclinical samples to discover whether feminine females would appear more frequently in the clinical sample. The PAQ was chosen, for "content purity of instrumentality and expressivity scales" (Thomas & Reznikoff, 1984). Although their research was an advance over previous research in terms of exploring overall personality structure (including overall emotional stability), only female subjects were included. Within the small clinical sample (47 subjects), most (39) were feminine and undifferentiated. Thomas and Reznikoff (1984) concluded that a lack of the instrumental component rather than femininity itself may be related to mental illness in women and that the possession of feminine expressive skills may enhance psychological well-being in women, only when combined with instrumentality. This is further supported by their finding that both androgynous and masculine "normal" subjects scored higher in emotional stability than feminine subjects.

The remaining studies that examined the involvement of sex-role orientation in self-reported psychological problems are based on analogue designs, thereby limiting the extent of generalizations to clinical subjects. Nevertheless,

similar results have been reported in the previous research comparing clinical and nonclinical subjects (e.g., Burchardt & Serbin, 1982; Thomas & Reznikoff, 1984). A discussion of the analogue research is, therefore, justified, despite the inclusion of clinical subjects only in the present research.

Carsud and Carsud (1979) studied the relationship of sex roles and levels of defensiveness to self-reports of fear and anxiety with undergraduate students. Feminine subjects regardless of sex or level of defensiveness perceived themselves as experiencing greater fear than either androgynous or masculine subjects. There were no differences in self-reported anxiety in relation to sex-role orientation; i.e., all groups: masculine, feminine, and androgynous subjects reported equal levels of anxiety. A serious methodological problem mitigates these findings the t-scoring method (Bem, 1974) was used with the BSRI, without any distinctions being made between truly androgynous and undifferentiated subjects.

Hinricksen et al. (1981) reported that androgynous college students reported fewer problems in general maladjustment, neurosis, and personality disorders. Cross-sex-typed (feminine) males manifested less self-satisfaction and a more negative sense of physical self than both androgynous and sex-typed males.

Briere and Lanktree (1983b) tested the relationship between sex roles and self-reported depression with 622 undergraduate students using the Beck Depression Inventory, the Bem Sex Role Inventory, and the Attitudes Toward Women Scale. Depression did not relate to sex or sex-role attitude but sex-role identity interacted with sex. Sex-typed (feminine) women were significantly more depressed than were sex-typed (masculine) men. Sex-typed males were less depressed than their cross-sex-typed or undifferentiated counterparts, with undifferentiated males being the most depressed. Androgynous females were less depressed than feminine, cross-sex-typed (masculine) and undifferentiated women (who were the most depressed). It would appear that within this college sample, masculinity benefited males in terms of reducing the risk of depression and androgyny did not provide males with unique benefits in this regard. In contrast, women who are cross-sex-typed may be more depressed than androgynous women because they experience interpersonal difficulties leading to a sense of depression when they violate social standards of sex-role appropriateness and do not endorse feminine traits (Briere & Lanktree, 1983b). Androgyny clearly benefited women but not men in this sample with respect to depression.

Baucom & Danker-Brown (1979) using the learned helplessness model as an analogue of depression (Abramson, Seligman, & Teasdale, 1978; Seligman, 1972, 1975) found that feminine and masculine sex-typed subjects demonstrated

cognitive and motivational deficits as well as dysphoric mood in the helpless condition. Androgynous subjects responded only to the helpless condition with a dysphoric mood while undifferentiated subjects were essentially unaffected by the helpless condition. It is interesting that the masculine sex-typed and feminine sex-typed subjects performed similarly throughout the experiment. Also, differential susceptibility to the helpless manipulation was solely a function of sex roles, not sex per se (Baucom & Danker-Brown, 1979). These findings implicate sex roles as an important factor in the etiology of depression. This study (albeit an analogue study) does point to the relative mental health benefits of androgyny. Masculine sex-typed persons may avoid helplessness situations, however, in natural settings (Baucom & Danker-Brown, 1979) as suggested by the instrumentality inherent in the male stereotypic role.

In view of the reported research concerning sex-role stereotypy, androgyny, and adjustment, with a considerable lack of specificity in the symptomatology described, it seems essential that further research pursue clarification of these issues. More sophisticated multivariate research designs (Cronbach, 1975) are required to explore the complexities of psychotherapy expectancies. It is hoped that such research will provide more conclusive evidence regarding the optimal conditions for personal growth within

the therapeutic relationship as well as the cultural context in which sex roles develop.

It may be possible that as some researchers (e.g., Heilbrun, 1984) have found, androgyny contributes to social competence only for women and may have no special advantages for men. Nevertheless, the assumption that "androgyny equals adjustment" has received mixed empirical support (Kelly, 1983). The relative benefits of masculinity versus androgyny to psychological health require further exploration particularly within samples more representative of our culture in general (Hinricksen et al., 1981; Kelly, 1983; Logan & Kaschak, 1980).

Summary

There is no doubt that previous psychotherapy research has firmly established client perceptions and preferences regarding a therapist to be crucial to therapeutic process (e.g., Tanney & Birk, 1976). For example, an increasing preference for female therapists, especially among female clients (when such information is solicited) suggests that expectancies are strong and have the potential to influence the therapeutic process. More information is required regarding the prevalence of such preferences and how they affect the client's perceptions of his/her therapist.

Gender differences have been suggested in terms of how therapists are perceived (Brodsky & Hare-Mustin, 1980) but, thus far, data are fragmentary and studies are inconsistent or lacking in positive results. Simple comparisons are no longer adequate. As several researchers have stated (e.g., Brodsky & Hare-Mustin, 1980; Cronbach, 1975; Kelly, 1983), sophisticated multivariate research is needed to assess gender in interaction with other variables, with particular attention to how sex-role variables are integrated into client expectancies and psychological functioning. The current investigation studied client gender, sex-role orientation, sex-role attitudes, psychological adjustment, and presenting problems in relation to each other and as they affected therapist preferences.

Hypotheses

1. It is hypothesized that feminine and undifferentiated subjects will report more psychological problems and be less well-adjusted than androgynous and masculine subjects.

2. It is hypothesized that sex of subject, sex-role orientation, and attitudes toward women will relate to:

a) the stated preference or lack of preference for the therapist's sex and

b) stated reasons for their preference for sex of therapist (e.g., comfortableness, attractiveness, etc.).

3. It is hypothesized that the nature of reported problems and psychological adjustment will relate to the sex of subject, the stated preference (or lack of preference) for sex of therapist, and sex-role orientation.

4. It is hypothesized that the sex of subject, sex-role orientation, and the stated preference or lack of preference for sex of therapist will relate to perceptions of the "ideal" therapist.

5. It is hypothesized that prior psychotherapeutic experience will influence the extent to which subjects prefer a same-sex or opposite-sex therapist, or state no preference at all.

METHOD

Subjects

Two hundred and sixteen subjects (126 females and 90 males) between 18 and 66 years of age participated in this research project. All individuals at least 18 years of age who presented between September 1982 and March, 1984 at the Psychological Service Centre (P.S.C.), University of Manitoba, Winnipeg, Manitoba were asked at the time of their first visit to complete a packet of research questionnaires, regardless of therapy mode requested. Three hundred and ten individuals accepted the packet, 19 refused, and 216 packets (69.67%) were returned to the P.S.C. The sample was comprised of 90 males (41.7%) and 126 females (58.3%). Of the 94 subjects who did not complete the questionnaire, 57 were women and 30 were men. Seven packets were either lost in the mail system or misplaced by subjects.

Although the P.S.C. is located within a university community, it does not serve this community exclusively, but referrals of clients, including self-referrals, are accepted from any area of Winnipeg and rural Manitoba. Subjects were paid a small honorarium ($3) upon receipt of their completed research packets.

Materials

This investigation involved two major sets of variables: subject characteristics and therapist attributions. Demographic information including sex, age, marital status, and education as well as prior psychotherapy experience (type of psychotherapy and gender of most recent therapist) was provided by subjects on a brief self-report questionnaire (see Appendix B).

Subject Characteristics

Questionnaires concerned with subject characteristics included: the psychological dimension of masculinity, femininity, and androgyny as measured by the Personal Attributes Questionnaire (Spence et al., 1974); attitudes toward women as measured by the Attitudes Toward Women Scale-Short Version (Spence et al., 1973); a Personal Problems Rating Scale developed by the writer to distinguish those problems which subjects would choose to discuss in psychotherapy; and a short form of the California Psychological Inventory (Schut et al., 1980).

Personal Attributes Questionnaire. Subjects completed the Personal Attributes Questionnaire (PAQ; Spence et al., 1974) generating scores for the Masculinity, Femininity, and Masculinity-Femininity scales (see Appendix C). The median split method was used to classify individuals on the

Masculinity and Femininity Scales (Spence & Helmreich, 1978, p. 35). The subjects above the median for Masculinity and below the median for Femininity were classified as masculine. Subjects who scored below the median for Masculinity and above the median for Femininity were classified as feminine. Subjects who scored below both medians were assigned to the undifferentiated group and those who scored above both medians were assigned to the androgynous group. In this manner, four sex-role orientation groups were determined. The Masculinity-Femininity scale was not used to further subdivide the subjects into eight groups (Spence & Helmreich, 1978) due to limitations imposed by the expected cell sizes.

With respect to validity, items selected for the PAQ were those that showed significant sex-role stereotypes in prior research using the Sex Role Stereotype Questionnaire (Rosenkrantz et al., 1968). The data collected from two groups of 530 and 164 college students indicated statistically significant sex-role stereotypes for both sexes on all items (Spence et al., 1974). Test-retest reliability on the PAQ was .91 for women and .80 for men, with the three subscales of the PAQ having test-retest reliabilities ranging from .65 to .91 (Spence et al., 1974). More recently, Yoder, Rice, Adams, Priest, & Prince (1982) reported test-retest reliabilities of military cadets: PAQ masculinity for males was .58, for females, .62 and PAQ

femininity for females was .67 with .54 for males. Yoder et al. (1982) reported that changes in males' scores occurred due to basic training intervening between PAQ administrations. Internal-consistency reliability for 248 college men was .73 and .91 for 282 college women (Spence et al., 1974).

Spence et al. (1974) constructed a short form of the PAQ which includes eight items from each of the three subscales: male-valued items, female-valued items, and sex-specific items. The items were chosen for the short form on the basis of the item-total correlations obtained when the long form was administered (Beere, 1979). The correlations between the short form of each subscale and the full-length subscale were .90 for each of the three subscales. The correlation between the total scores on the long and short forms was .94 (Spence et al., 1974). Therefore, the PAQ-short form was used in this investigation (see Appendix C for instructions and questionnnaire items).

Attitudes Toward Women Scale--Short Form. The Attitudes Toward Women Scale (AWS) measures attitudes toward the rights and roles of women in contemporary society (Beere, 1979). The AWS-Short Form (Spence & Helmreich, 1972b; Spence et al., 1973) will be employed to establish scores indicating the relative presence or absence of a profeminist, liberal attitude (Spence & Helmreich, 1977).

The AWS and AWS-Short Form have been used so extensively that more is known about their psychometric properties than most instruments now available for measuring attitudes toward women's issues (Beere, 1979). The 25 items that best discriminated among quartiles for each sex and that had the highest item-total correlations were selected for the Attitudes Toward Women Scale-Short Form (Beere, 1979). Items are objectively scored and equally weighted. Scores for the 25 items are summed to yield a total score, which can range from 0 (extremely conservative) to 75 (extremely liberal or profeminist), (see Appendix D for instructions and questionnaire items).

Spence et al. (1973) recommend that the AWS be used when information is desired on attitudes toward each of the issues represented by items. They recommend using the AWS-Short Form when one wishes to compare groups of persons on whether their attitudes toward women are more traditional or more liberal. Since the latter function was most pertinent to this investigation, the AWS-Short Form was used.

Spence et al. (1973) reported item-total correlations ranging from .31 to .73 for college students. Stanley, Boots, and Johnson (1975) found an internal-consistency reliability of .82 for 72 women and .89 for a sample of 150 college males and females on the AWS-Short Form. Correlations between the full-length and short-form of the AWS were .968 for college men, .969 for college women, .956

for mothers of college students, and .963 for fathers of college students (Spence et al., 1973). Yoder et al. (1982) reported test-retest reliabilities for male and female military cadets of .743 and .797 respectively.

Personal Problems Rating Scale. This questionnaire (PPRS) included a list of 23 symptoms on which subjects were instructed to rate, on a Likert-type scale ,from 1 to 7, the likelihood that they would discuss each problem in psychotherapy. In the absence of an appropriate validated instrument, the writer constructed this inventory from symptoms that have been suggested by other clinical researchers (e.g., Barak & Dell, 1977) as well as other items designed to provide information regarding general psychological problems (see Appendix E for questionnaire and instructions).

Factor analysis of this scale was performed to assess the internal-consistency reliability of this measure and to ideally reduce the number of items to fewer distinctive factors. Reliability coefficients were then computed with Cronbach's (alpha) procedure (Hull & Nie, 1981) for each factor. Test-retest reliability was not assessed, since considerable time usually lapsed from the time the subject initially accepted the questionnaire to it being received by the researcher. Follow-up at that point would in many cases have reflected radical changes in the subject's perception of problems due to the psychotherapy process and alterations

to the individual's situation, thereby reducing the questionnaire's apparent reliability. The PPRS was also intended as a self-report measure of likelihood of discussing several psychological problems upon entry into psychotherapy.

California Psychological Inventory-Short Form. As noted by Sundberg et al. (1978), objective inventories such as the MMPI were largely oriented toward detecting pathology. In contrast, the California Psychological Inventory (CPI; Gough, 1957) was developed to measure interpersonal coping skills and competence. The CPI was designed for use with normal subjects and individuals with behaviour problems (Gynther & Gynther, 1976). Such "positive" scales of the CPI, relating to characteristics of poise, social responsibility, and achievement have confirmed its uses as a measure of self-rated adjustment (Sundberg et al., 1978). On this basis, the CPI was selected for the present study as a measure of current, self-perceived adjustment.

The original CPI includes 18 scales and 480 items. For the purposes of the present research, a measure of such length potentially risks its own validity by causing boredom in the subject, resulting in haphazard responses. This is a particularly salient issue given that other questionnaires were included as well. Schut et al. (1980) developed and validated a short form of the CPI which includes all 18 scales but reduces the number of items to 223. Correlations

of the short form with the standard scales, the short form factor structure, and its test-retest reliabilities indicated that this shortened version is a viable alternative to the original version of the CPI (Schut et al., 1980).

One group of scales (the third class) "of basic relevance to academic counselling and guidance" (Gough, 1968) was eliminated since it included achievement via conformance, achievement via independence, and intellectual efficiency; scales not directly relevant to the present study. Consequently, the number of CPI items used was reduced to 203.

The data were analyzed for each subject on each of the remaining short-form scales: dominance, capacity for status, sociability, social presence, self-acceptance, sense of well-being, responsibility, socialization, self-control, tolerance, good impression, communality, flexibility, femininity, and psychological-mindedness (see Appendix A for descriptions of these scales and see Appendix F for instructions and personality inventory). Pilot data including 60 completed CPIs gathered prior to this study (Spring, 1982) were included in the factor analysis of the CPI. These data had been collected from clients who were being seen in therapy at the Psychological Service Centre, University of Manitoba, to strengthen the validity of the factor analysis that was performed on the CPI scales to

reduce the number of variables. Internal consistency and reliability were further assessed with Cronbach's alpha, (Hull, & Nie, 1981) procedure.

Therapist Attributions

Preference for sex of therapist. Subjects were required to respond to a brief questionnaire where the presence or absence of preference for sex of therapist was indicated as well as the strength of the preference. A 7-point scale, similar to that used by Johnson (1978), was used with one end representing a strong preference for a male therapist and the other, a strong preference for a female therapist. The midpoint of the scale represented no preference for the sex of therapist.

This Therapist Preference Form (TPF) also included a checklist of possible reasons for having that preference, adopted from research reported by Davidson (1976). Subjects could check any of these reasons as relevant to their choice as well as provide reasons of their own. In this manner, clarification was possible regarding the subjects' preferences for therapists and their expectations for therapy with a therapist of the preferred gender (see Appendix G for questionnaire and instructions).

The Counsellor Rating Form. The Counsellor Rating From (CRF) was designed to assess perceptions of counsellor behaviour (Barak & LaCrosse, 1975). This Likert-type scale

involving 36 sets of bipolar adjectives (e.g., unalert, alert; attractive, unattractive) has been demonstrated to measure counsellor expertness, attractiveness, trustworthiness, and many other traits found to be predictive of facilitativeness (LaCrosse, 1977) and outcome (LaCrosse, 1980). In this regard, it has been used reliably in a number of studies (Barak & Dell, 1977; Cash & Kehr, 1978; Krumboltz, Becker-Haven, & Burnett, 1979; LaCrosse, 1977, 1980; McCarthy, 1982).

Subjects were given the CRF in its original form (Barak & LaCrosse, 1975) but were instructed to indicate their ratings of how the "ideal" therapist should be, in their opinion (See Appendix H for instructions and rating form).

Factor analysis of this scale was performed to reduce the number of variables and to determine the comparability of factor structure for this clinical sample with previously reported factor structures (e.g., Barak & LaCrosse, 1975). Reliability coefficients were computed using Cronbach's alpha procedure (Hull & Nie, 1981) to assess the internal-consistency reliability of each factor generated.

Procedure

Upon arrival at the PSC for their "intake" interview, subjects completed registration material for the centre, and if they desired, the Therapist Preference Form (TPF) prior to being interviewed by an Intake clinician. It was emphasized by the receptionist/secretary distributing the materials, that the TPF was for research purposes only, that completion of the form was voluntary, and that their responses would not affect the eventual assignment of a clinician.

A female research assistant then met briefly in private with each client prior to the intake interview to explain the research that was being conducted for the writer's doctoral dissertation (see Appendix I). Each subject was told that the research was entirely voluntary and confidential as well as independent of the therapeutic contact they would receive. Subjects who agreed to participate were given a packet of questionnaires to complete at home. They were asked to return the completed forms as soon as possible either by mail (in the stamped return envelope) or when they returned for their next interview. Subjects were contacted by telephone a week later, usually by the same research assistant who initially contacted them. Any questions were answered at that time. Subjects were contacted a second time the following week if the research package had not been received by the

researcher. Subjects who stated that they had decided not to complete the questionnaires during the first follow-up call, were not contacted again.

The packet included all the questionnaires which were coded for anonymity as well as a cover letter describing the purpose of the research, the offer of a small honorarium once they returned the completed packet, and reiterating the confidential nature of the research. A space was provided for subjects to indicate whether they wished to receive general results once the research was completed (see Appendix J).

RESULTS

This chapter will begin with a description of the sample demographic data (sex, age, education, and marital status), previous therapy experience, and distributions of subjects according to their responses on the sex-role attitudes and sex-role orientation questionnaires. The factor analyses which were completed prior to the major analyses to reduce the data set will then be described. Each hypothesis will be presented in the order in which it was statistically analyzed. Some of the primary analyses involved factors derived from the factor analyses of the Counsellor Rating Form, the Personal Problems Rating Scale, and the California Personality Inventory. All data analyses followed the specified programs presented in the Statistical Package for the Social Sciences (SPSS), (Nie, Hull, Jenkins, Steinbrener, & Bert, 1975) and the SPSS Update Nie & Hull, 1981).

Description of the Sample

Subjects were aged from 18 to 66 years with a mean age of 32.5 years; 90% of the subjects were 44 years or younger with 50% being 31 years or younger.

In terms of marital status, 32.87% of the subjects were single, 47.22% were married, 3.24% lived with partners, 14.35% were divorced or separated, 1.85% were widowed, and 1 subject did not report marital status. Of the 216 subjects, 28.7% had less than a Grade 12 education, 23.15% were high school graduates, 35.65% had completed some college or had finished a degree, 7.87% had technical or vocational training (e.g., Community college, secretarial school), 3.24% reported having had some postgraduate training (e.g., Master's degree), and three subjects did not report their educational background.

Previous Therapy Experiences

Of the total sample, 116 subjects (53.70%) responded negatively to the question, "Have you ever, at any time, been in psychotherapy?", while 100 subjects responded affirmatively. Of these 100 subjects, previous therapeutic involvement included 78 individual, 26 marital, 9 family, 2 academic/vocational, and 15 other (did not report, brief consultation, etc.). Of the 100 subjects who had previously engaged in psychotherapy, 60 had a male therapist, 28 had a female therapist, and 8 subjects reported seeing male and female co-therapists. Four subjects who stated previous involvement in psychotherapy did not report the gender of their last therapist.

Responses to AWS and PAQ

Attitudes Toward Women Scale-Short Form

Separate median scores were found for the males (57.63; mean=56.19; standard deviation=10.40) and for the females (62.67; mean=61.36; standard deviation=8.34). The mean of the medians (60.15) was calculated for subsequent analyses as recommended by Spence and Helmreich (1978) when the groups of female and male subjects are unequal. Using the median-split method, those subjects who scored less than 60.15 on the AWS were considered conservative and those subjects whose scores exceeded 60.15 were considered liberal or profeminist. Normative data for this scale, in terms of standard median scores, does not exist. In fact, data collected from clinical samples as well as adults older than college-age are lacking. Also, researchers using the AWS have not typically reported the medians used for group assignment and have provided only the means. These means for college students have ranged from 51.14 to 63.25 for males and from 50.56 to 64.01 for females, with women more often having more liberal attitudes (Goldberg et al., 1979; Zeldow & Greenberg, 1979). Spence and Helmreich (1978) reported means for the AWS with students and their parents but unfortunately used the 15-item AWS, thereby precluding direct comparisons.

Of the 216 subjects, 116 scored below this median (60.15) and were classified as conservative; 94 scored above the

median and were classified as liberal. Six subjects could not be assigned to a group due to missing items. The scores for males ranged from 29 to 75, with 57 subjects classified as conservative and 29 as liberal. Females were more liberal in scoring from 41 to 75 with 59 subjects classified as conservative and 65 as liberal. This finding of greater endorsement of liberal sex-role attitudes in women was consistent with the data collected by Spence and Helmreich (1972, 1978) from nonclinical populations of college students and their parents.

Personal Attributes Questionnaire

The median split method (Spence & Helmreich, 1978) was used with the means of the medians of the M and F scales for the two sexes, providing the basis for assignment into sex-role orientation groups. This method was recommended by Spence and Helmreich (1978) for dealing with unequal numbers of males and females occur. On the M scale, the median for males was 17.583 (mean=17.59; standard deviation=4.68) and for females was 18.375 (mean=17.53; standard deviation=4.46). On the F scale, the median for females was 23.32 (mean=23.21; standard deviation=4.39) and for males was 21.86 (mean=22.00; standard deviation=4.45). Women scored higher than men on both the M and F scales. The medians used to classify subjects into the four sex-role orientation groups were: 17.98 for masculinity, and 22.59 for femininity.

Normative data for the PAQ are also lacking (as with the AWS), particularly for clinical subjects. Means, rather than medians, have typically been reported (e.g., 23.21 for fathers versus 19.58 for mothers of college students on the M scale and 21.06 for fathers versus 23.99 for mothers on the F scale; Spence & Helmreich, 1978). Spence and Helmreich (1978) also reported mothers having lower F scores and fathers having higher M scores than same-sex children suggesting some age-related differences in endorsement of masculine and feminine traits. Thomas and Reznikoff (1984) reported using a median of 23 on the F scale and 21 on the M scale for normal and clinical female subjects. These medians were not actually derived from their data, but recommended by Spence in a personal communication (Thomas & Reznikoff, 1984).

The M-F scale which is used to further divide the groups into eight classifications (including high and low masculine and feminine groups) was not used, as it was evident from the numbers within the four cells that some groups, e.g., highly feminine males, would include very few subjects. The sex-role orientation groups were classified as: undifferentiated if below the medians of both M and F scales, as feminine if below the median of M and above the median of F scales, as masculine if above the median of M and below the median of F scales, and as androgynous if above the medians of both M and F scales.

Female subjects were classified as: 32 undifferentiated, 25 feminine, 21 masculine, and 46 androgynous. Within the group of male subjects, 26 were undifferentiated, 19 feminine, 22 masculine, and 19 androgynous. Undifferentiated males were the most highly represented in the male group of this clinical sample while androgynous females comprised the largest group of female subjects.

Statistical Analyses

The following factor analyses of the Counsellor Rating Form, the Personal Problems Rating Scale, and the California Personality Inventory generated factors which were then used in subsequent relevant analyses.

Factor Analysis of the Counsellor Rating Form

All 36 items of the CRF (used by subjects to rate their "ideal" therapist) were analyzed with a Principal Factors Solution followed by a varimax rotation on all factors with Eigenvalues $\geq$ 1.

Factor analysis produced 10 factors (with Eigenvalues $\geq$ 1) which accounted for 63.8% of the variance. Previous research (Barak & LaCrosse, 1975; LaCrosse & Barak, 1976; Barak & Dell, 1977; Corrigan & Schmidt, 1983) supported the perspective of a 3-factor model of the CRF. Therefore, further factor analyses were performed, one forcing a

4-factor solution and another, a 3-factor solution. The first factor in both solutions was identical in relation to the items which had factor loadings $\geq$ .35. The second and third factors were also identical except for the "closed-open" item which did not load significantly ($\geq$ .35) on factor 2, at .34 in the 3-factor solution and the "suspicious-believable" item which did not load significantly on the third factor for the 4-factor solution and loaded marginally on the 3-factor solution (.35). (see Tables 1 and 2 for the factor matrixes following varimax relation for the 4-factor and 3-factor solutions.) The first three factors in the four-factor solution accounted for 92.1% of the variance, accounted for in the original factor analysis by the 10 factors with Eigenvalues $\geq$ 1, so that it was considered reasonable to adopt the 3-factor solution for future analyses.

Using the three factors, it was found that Factor 1 accounted for 68.8% of the variance (originally accounted for by the 10 factors with Eigenvalues $\geq$ 1) and reflected general Professional Competence, somewhat related to the expertness factor reported by Barak & LaCrosse, 1975. The item "inexpert-expert" did not load sufficiently on this first factor. The items which did load significantly to be included on this factor were, in order of loadings: skillful, responsible, logical, intelligent,

Table 1

Factor Structure Following Varimax Rotation of Four Factors of the Counsellor Rating Form

Scale	$\bar{x}$	(SD)	Factor 1	Factor 2	Factor 3	Factor 4
agreeable-disagreeable	3.1	1.3	.21	-.01	.05	-.35
unalert-alert	6.6	.9	.00	.19	-.10	.37
analytic-diffuse	2.5	1.4	.37	.06	.03	-.24
unappreciative-appreciative	5.8	1.2	-.01	.16	-.41	.29
attractive-unattractive	3.4	1.0	-.10	.10	.34	-.11
casual-formal	2.5	1.4	-.01	-.17	.13	.03
cheerful-depressed	1.8	.9	.10	-.39	.30	-.24
vague-clear	6.7	.8	-.09	.36	-.03	.26
distant-close	5.6	1.2	-.01	.04	.53	.22
compatible-incompatible	1.9	1.1	.12	-.19	.43	-.28
unsure-confident	6.5	.8	-.56	.16	-.04	.26
suspicious-believable	6.1	1.3	-.09	.22	-.26	.42
undependable-dependable	6.6	.9	-.16	.46	-.15	.36
indifferent-enthusiastic	6.0	1.2	-.03	.10	-.18	.62
inexperienced-experienced	6.2	1.1	-.49	.06	-.07	.30
inexpert-expert	6.1	1.0	-.32	.10	-.16	.39
unfriendly-friendly	6.5	.8	-.09	.46	-.49	.14
honest-dishonest	1.2	.6	.21	-.51	.22	-.25
informed-ignorant	1.3	.6	.24	-.53	-.00	-.05
insightful-insightless	1.6	1.0	.62	-.25	-.07	-.08
stupid-intelligent	6.6	.8	-.74	.05	-.09	.09
unlikeable-likeable	6.4	.8	-.16	.24	-.44	.15
logical-illogical	1.5	.9	.74	-.12	.08	-.02
open-closed	1.4	.7	.24	-.37	.54	-.04
prepared-unprepared	1.5	.9	.59	-.24	.13	-.00
unreliable-reliable	6.8	.6	-.27	.60	.02	.27
disrespectful-respectful	6.6	.7	-.22	.37	-.31	.09
irresponsible-responsible	6.7	.8	-.73	.40	.03	-.03
selfless-selfish	2.7	1.3	.36	-.01	.33	-.04
sincere-insincere	1.4	.8	.62	-.33	.15	-.14
skillful-unskillful	1.5	.8	.77	-.15	.07	-.12
sociable-unsociable	2.0	1.1	.14	-.07	.62	.08
deceitful-straightforward	6.6	.7	-.18	.61	-.14	.03
trustworthy-untrustworthy	1.2	.5	.21	-.45	.33	-.10
genuine-phony	1.3	.8	.57	-.22	.14	.06
warm-cold	1.6	.9	.07	-.17	.54	-.11
Percentage of total variance			24.8	8.9	5.1	4.8
Percentage of cumulative variance			24.8	33.6	38.7	43.5

Factor Loadings were considered significant where weights $\geq$ .35

Table 2

Factor Structure Following Varimax Rotation of Three Factors of the Counsellor Rating Form

Scale	Factor 1	Factor 2	Factor 3
agreeable-disagreeable	.21	-.12	.13
unalert-alert	-.02	.28	-.19
analytic-diffuse	.36	-.02	.09
unappreciative-appreciative	-.03	.24	-.46
attractive-unattractive	-.10	.06	-.37
casual-formal	.00	-.14	.10
cheerful-depressed	.12	-.44	.32
vague-clear	-.11	.42	-.07
distant-close	-.03	.08	-.58
compatible-incompatible	.15	-.25	.48
unsure-confident	-.56	.22	-.08
suspicious-believable	-.11	.34	-.35
undependable-dependable	-.19	.55	-.20
indifferent-enthusiastic	-.06	.28	-.32
inexperienced-experienced	-.49	.15	-.13
inexpert-expert	-.33	.22	-.23
unfriendly-friendly	-.12	.46	-.46
honest-dishonest	.24	-.55	.23
informed-ignorant	.25	-.50	-.04
insightful-insightless	.63	-.24	-.08
stupid-intelligent	-.75	.05	-.09
unlikeable-likeable	-.18	.27	-.43
logical-illogical	.74	-.09	.05
open-closed	.27	-.34	.49
prepared-unprepared	.60	-.20	.09
unreliable-reliable	-.29	.67	.01
disrespectful-respectful	-.24	.37	-.28
irresponsible-responsible	-.74	.34	.09
selfless-selfish	.37	-.00	.32
sincere-insincere	.64	.33	.14
skillful-unskillful	.78	-.15	.07
sociable-unsociable	.16	-.04	.53
deceitful-straightforward	-.21	.55	-.09
trustworthy-untrustworthy	.24	-.44	.31
genuine-phony	.58	-.15	.09
warm-cold	.10	-.18	.53
% of Total variance	24.8	8.9	5.1
% of Cumulative variance	24.8	33.6	38.7

Factor loadings were considered significant when weights $\geq$ .35

sincere, insightful, prepared,genuine, confident, experienced, selfless, and analytic (see Table 2). The second factor, accounting for 21.5% of the variance originally accounted for by the 10 factors, included these items with significant loadings in order from highest loading: reliable, straightforward, honest, dependable, informed, friendly, cheerful, trustworthy, clear, and respectful. This factor was labelled: Agentic Interpersonal Skills. The third factor, accounting for 9.7% of the variance originally accounted for by the 10 factors, included in order of loadings, the items: close, sociable, warm, open, compatible, appreciative, friendly, likeable, attractive and believable. This factor appeared to measure Communal-Expressive Interpersonal Skills. Although the three factors were somewhat distinct from each other, the first two factors seemed to identify characteristics related to general competence in an active, instrumental sense. These factors relate well to behavior considered more masculine in our culture. In contrast, the third factor included items compatible with the expressiveness of behaviour culturally-sanctioned as feminine (e.g., warm, sociable, open, and appreciative).

Scales based upon these factor analyses of the CRF were constructed by unit weighting and summing all items that loaded at least .35 on a factor. Cronbach alphas, reflecting internal consistency and reliability, were .86,

.81, and .77 for Factor 1, Factor 2, and Factor 3 respectively.

Factor Analysis of the Personal Problem Rating Scale

The means for the items reflect the extent to which subjects reported that they would discuss each problem in therapy (see Table 3). Since likelihood of reporting a given problem was rated on a scale of 1 to 7, with 1 referring to greatest likelihood, a lower mean reflects an overall tendency of subjects to report having that problem. The problem which had the lowest mean (1.94) and therefore, was rated most often as being a problem that subjects would discuss, was depression ("feeling low or depressed"). The problem which had the highest mean (4.36) and therefore, was rated least often as being a problem that subjects would discuss, was "sexual or physical abuse (including incest)." The 23 items of the PPRS were factor analyzed with a Principal Factors solution followed by a Varimax rotation on all factors with Eigenvalues $\geq$ 1.

Four factors were generated, accounting for 63.6% of the total variance (see Table 4). All factor loadings of value $\geq$ .35 were considered significant for a particular factor. Factor 1 included the items in order of loadings: identity issues, low self-esteem, fears of "going crazy", problems going on living, feeling low or depressed, getting along with others, rapid mood changes, unusual thoughts

Table 3

Mean Likelihood of Reporting Problems of the PPRS

Problem	Mean	Standard Deviation
1. Isolation/loneliness	2.41	1.80
2. Sexual Problems	3.62	2.18
3. Drug or Alcohol Abuse	3.88	2.65
4. Academic Problems	3.25	2.51
5. Career choice Difficulties	3.03	2.37
6. Physical Problems Related to Anxiety	2.59	2.11
7. Overeating	3.62	2.59
8. Difficulties sleeping, no appetite	2.95	2.37
9. Feeling Anxious	2.27	1.84
10. Feeling Low or Depressed	1.94	1.57
11. Problems being Assertive	2.63	1.98
12. Problems going on Living	3.66	2.46
13. Rigid expectations of sex roles	3.30	2.17
14. Sexual or Physical Abuse	4.36	2.55
15. Problems with Self-Esteem	2.39	1.89
16. Sexual Discrimination	4.15	2.55
17. Difficulties Controlling Temper	3.24	2.30
18. Problems Getting Along with Others	3.29	2.32
19. Unusual thoughts or Feelings	3.54	2.32
20. Fears of "Going Crazy"	3.38	2.35
21. Poor Concentration or Attention	3.11	2.23
22. Identity Issues	3.25	2.40
23. Rapid Mood Changes	3.04	2.27

Table 4

Factor Structure Following Varimax Rotation of the PPRS Factors

Problem	Factor 1	2	3	4
Isolation/Loneliness	.41	.25	.15	.45
Sexual Problems	.21	.04	.56	.18
Drug or Alcohol Abuse	.26	.39	.52	.17
Academic Problems	.13	.60	.21	.41
Career Choice Difficulties	.27	.62	.05	.42
Physical Problems/Anxiety	.19	.31	.25	.63
Overeating	.24	.53	.34	.19
Difficulties Sleeping, No Appetite	.16	.46	.25	.47
Feeling Anxious	.21	.16	.17	.76
Feeling Low or Depressed	.56	.10	.09	.52
Problems Being Assertive	.33	.35	.21	.33
Problems Going on Living	.57	.32	.38	.14
Rigid Expectations of Sex Roles	.34	.11	.58	.17
Sexual or Physical Abuse	.14	.40	.68	.11
Low Self-Esteem	.62	.14	.26	.33
Sexual Discrimination	.19	.46	.56	.21
Difficulties Controlling Temper	.36	.56	.31	.08
Getting Along with Others	.55	.55	.30	.12
Unusual Thoughts or Feelings	.49	.25	.38	.13
Fears of "Going Crazy"	.57	.31	.36	.22
Poor Concentration or Attention	.44	.50	.19	.24
Identity Issues	.62	.34	.27	.28
Rapid Mood Changes	.50	.45	.26	.28
% of Total Variance	47.2	6.5	5.3	4.6
% of Cumulative Variance	47.2	53.7	59	63.6

Factor loadings were considered significant when weights $\geq$ .35

or feelings, poor concentrations or attention, isolation/loneliness, and difficulties controlling temper. Due to higher loadings on the problems of identity issues, and depression, this factor was labelled Identity-Depression. This factor also accounted for 47.2% of the total variance.

Factor 2 included the following items with loadings of .35 or greater, in order: career choice difficulties, academic problems, difficulties controlling temper, getting along with others, overeating, poor concentration or attention, sexual discrimination, difficulties sleeping and no appetite, rapid mood changes, sexual or physical abuse, drug or alcohol abuse, and problems being assertive. The highest loadings on this factor (>.60) were for academic and career problems justifying a label of Career-Academic Role Functioning. This factor accounted for 6.5% of the total variance.

Factor 3 included the following items with significant loadings ($\geq$ .35), in order: sexual or physical abuse (including incest), rigid expectations of sex roles, sexual discrimination, sexual problems, drug or alcohol abuse, problems going on living, unusual thoughts or feelings, and fears of "going crazy". The highest loadings on sexual or physical abuse (.68), rigid expectations of sex roles, and sexual discrimination justified a label for this factor of Gender Related Issues. It accounted for 5.3% of the total variance.

Factor 4 included the following items with significant loadings ($\geq$ .35), in order: feeling anxious, physical problems related to nervousness and anxiety, feeling low or depressed, difficulties sleeping and no appetite, isolation/loneliness, career choice difficulties, and academic problems. This factor was labelled Anxiety and accounted for 4.6% of the total variance.

Scales based upon this factor analysis of the PPRS were constructed by unit weighting and additively combining all items that loaded at least .35 on a factor. These scales were then tested for internal consistency and reliability. Cronbach alphas were .92, .92, .88, and .76 for Factor 1, Factor 2, Factor 3, and Factor 4 respectively, indicating that the factors were sufficiently reliable.

Factor Analysis of the California Personality Inventory-Short Form

The 15 scales of the CPI-short form were factor analyzed for the 216 subjects of the main investigation as well as 60 subjects from a pilot study who were previously recruited at the Psychological Service Centre. The sample of 60 subjects had been asked, while already engaged in psychotherapy to complete only the CPI. These data were combined to provide a sufficiently large sample for a valid factor analysis.

The CPI-short form scales, incorporating the 203 items, were analyzed with a Principal Factors Solution followed by

a varimax rotation on the four factors having Eigenvalues $\geq$ 1. These four factors accounted for 73.9% of the total variance. For all factors, those scales (incorporating specific items scored True or False as Schut et al., 1980 stated) which had factor loadings $\geq$ .35 were considered significantly loaded on a particular factor.

The first factor accounting for 42.8% of the total variance included, in order of loadings: good impression, tolerance, self-control, flexibility, psychological-mindedness, capacity for status,sociability (negatively loaded in relation to other scales), sense of well-being, femininity, and responsibility. This factor was labelled: General Adjustment (see Table 5). The second factor, acounting for 14.8% of the total variance included in order from the highest loading: socialization, dominance, sense of well being, and capacity for status. All scales except capacity for status had factor loadings $\geq$ .60 (see Table 5). This factor was labelled: Mature Socialized Dominance. The third factor, accounting for 9.2% of the total variance included in order: sociability, social presence, and dominance. This factor was named Confident - Outgoing. The fourth factor, accounting for 7.1% of the total variance included: self-acceptance (highest loading), psychological-mindedness, communality, and responsibility.

Table 5

Factor Structure Following Varimax Rotation of the CPI Factors

Scale	$\bar{X}$	(SD)	Factor 1	Factor 2	Factor 3	Factor 4
Dominance	- .5	7.2	-.02	.66	.36	-.18
Capacity for Status	- .4	7.9	.59	.39	-.05	-.02
Sociability	7.2	9.0	-.51	.06	.77	-.08
Social Presence	5.4	8.1	-.14	-.01	.60	.07
Self-Acceptance	3.4	6.2	-.29	.15	.29	-.67
Sense of Well Being	-6.1	15.5	.47	.62	-.13	.23
Responsibility	- .1	6.4	.40	.25	.19	.38
Socialization	- .3	8.7	.13	.81	-.14	.26
Self-Control	-20.8	26.3	.89	.17	-.34	.19
Tolerance	-160.3	19.6	.90	.22	-.26	.09
Good Impression	-12.4	12.9	.91	.12	-.27	.04
Communality	5.4	4.4	-.00	.21	.15	.43
Psychological-Mindedness	-3.5	5.7	.70	.07	.06	.47
Flexibility	-7.3	9.2	.83	-.06	-.20	.12
Femininity	- .8	4.9	.44	.03	-.14	.24
% of Total Variance			42.8	14.8	9.2	7.1
% of Cumulative Variance			42.8	57.6	66.8	73.9

Factor Loadings were considered significant when weights $\geq$ .35.

Self-acceptance was negatively loaded on this factor in relation to the other scales (See Table 5). This factor was labelled: Other Orientation.

The factors including the scales which were unit weighted and summed (if they had loaded at $\geq$ .35) were then tested for internal consistency. Cronbach alphas were .89, .72, .64, and .66 for Factor 1, Factor 2, Factor 3, and Factor 4 respectively, indicating that the factors were satisfactorily reliable.

Primary Analyses

Gender, Sex Role Orientation, Adjustment, and Psychological Problems

Hypothesis 1, that sex-role stereotypic and undifferentiated subjects will report more psychological problems and be less well-adjusted than androgynous and masculine subjects, was tested using two sex (2) x sex-role orientation (4) MANOVAs, one using the CPI factors and the other using the PPRS factors as the dependent variables.

Multivariate analysis of variance of CPI factor scores revealed only a significant main effect of sex-role orientation, $F(12,540.02)=2.54$, p .003, (sex $F(4,204)=2.08$, $p<.085$, sex x sex-role orientation $F(12,540.02)=1.69$, $p<.065$). The univariate F-test for CPI 1 (General Adjustment) in relation to the effect of sex was significant, $F(1,207)=6.13$, $p<.014$ as was the univariate F-

test for CPI 3 (Confident-Outgoing) in relation to the interaction term, $F(3,207)=2.77$, $p<.04$. However, nonsignificant multivariate results preclude the interpretation of univariate Fs (Harris, 1975; Tatsuoka, 1971). This principle relates to all subsequent analyses as well. The post-hoc analyses, therefore, were necessary only for the main effect of sex-role orientation.

Examination of univariate Fs revealed that General Adjustment was significant, $F(3,207)=3.55$, $p < .015$, Mature Socialized Dominance was significant, $F(3,207)=4.60$, $p < .004$, and Confident-Outgoing was significant, $F(3,207)=3.39$, $p < .019$. In addition, canonical correlations between each CPI factor and the set of sex-role variables were significant ($p < .05$) for General Adjustment, -.57; Mature Socialized Dominance, -.70; Confident-Outgoing, -.54; and Other Orientation, -.44. Therefore, pairwise comparisons of group means using Scheffe's post-hoc tests were performed (Hays, 1973, p. 608). The comparisons which were significant ($p < .05$) for General Adjustment were between androgynous subjects and all the other groups. Androgynous subjects, therefore, were significantly better adjusted than undifferentiated, feminine, and masculine subjects (see Table 6). The higher and more positive the score, the higher the level of psychological adjustment.

Scheffe's post-hoc tests were also performed on the group means for Mature Socialized Dominance. Pairwise comparisons

Table 6

Mean California Psychological Inventory Factor Scores According to Sex-Role Orientation

Factor	Sex-Role Orientation			
	Undifferentiated (n=60)	Feminine (n=44)	Masculine (n=43)	Androgynous (n=65)
General Adjustment	-211.51	-218.51	-205.20	-181.58
Mature Socialized Dominance	-13.05	-14.86	-3.86	-.16
Confident-Outgoing	6.61	9.14	17.07	15.39
Other Orientation	3.84	3.53	6.89	7.24

Note: The more positive the mean factor score in value, the higher the level of adjustment.

which were significant at the .05 level occurred with the following groups: undifferentiated and masculine, undifferentiated and androgynous, feminine and masculine, and feminine and androgynous. Across sex, undifferentiated subjects and feminine subjects were significantly less well adjusted on this factor than were masculine and androgynous subjects. However, there were no significant differences within these pairs of groups.

Finally, Scheffe's post-hoc comparisons were performed on the group means for Confident-Outgoing. Significant comparisons ($p < .05$) occurred between the following groups: undifferentiated and masculine, undifferentiated and androgynous, feminine and masculine, and feminine and androgynous. Undifferentiated subjects were significantly less adjusted than were masculine and androgynous subjects. Feminine subjects were slightly better adjusted than were undifferentiated subjects but significantly ($p < .05$) less adjusted than were masculine and androgynous subjects. Although masculine subjects scored higher on the Confident-Outgoing factor than did androgynous subjects, this difference was non-significant (see Table 6).

Multivariate analysis of variance of PPRS factors scores indicated a main effect of sex-role orientation, $F(3,542.67)=2.36$, $p < .006$; no effect of sex, $F(1,205)=.81$, $p < .518$; and no sex x sex-role orientation interaction, $F(3,542.67)=1.16$, $p<.308$. None of the univariate Fs for the

main effect of sex-role orientation was significant precluding the use of Scheffe's post-hoc tests of pairwise comparisons. The univariate Fs were as follows: Identity-Depression, $F(3,208)=2.47$, $p<.063$, Career-Academic Role Functioning, $F(3,208)=.78$, $p<.507$, Gender-Related Issues $F(3,208)=.22$, $p<.884$, and Anxiety, $F(3,208)=1.40$, $p<.244$. The canonical correlations revealed significant (>.30) multivariate relationships between sex-role orientation groups and Identity-Depression(.55) and Anxiety (.41). In the absence of significant univariate ANOVA results, post-hoc multivariate contrasts between the various levels of sex-role orientation were performed. When all PPRS factors were considered simultaneously, undifferentiated subjects were significantly more likely (lower means reflect greater likelihood of reporting problems) to discuss problems in therapy than androgynous subjects ($F(4,205)=4.40$, $p < .002$) or masculine subjects ($F(4,205)=3.47$, $p < .009$), (see Table 7). In addition, feminine subjects were significantly more likely to discuss PPRS problems ($F(4,205)=2.63$, $p < .036$) than masculine subjects. The group means shown in Table 7 indicate that on Identity-Depression, Career-Academic Role Functioning, Gender Related Issues, and Anxiety, there were advantages of masculinity alone as well as of androgyny.

Table 7

Mean Personal Problems Rating Scale Factor Scores According to Sex-Role Orientation

Factor	Sex-Role Orientation			
	Undifferentiated (n=60)	Feminine (n=44)	Masculine (n=43)	Androgynous (n=65)
Identity-Depression	30.28	31.98	36.41	38.64
Career-Academic Role Functioning	40.25	41.95	41.73	45.43
Gender-Related Issues	30.74	30.48	30.61	31.75
Anxiety	18.00	17.75	20.95	20.95

Note: The lower the mean factor score, the greater the likelihood of reporting the problems on a given factor.

Preferred Gender of Therapist and Subject Characteristics

Hypothesis 2a, that sex of subject, sex-role orientation, and attitudes toward women will relate to stated preference or lack of preference for therapist's sex, was tested using a 2(sex) x 4 (sex-role orientation) x 2 (liberal versus conservative sex-role attitudes) ANOVA with the score on the Therapist Preference Form (TPF) being the dependent variable.

Analysis of variance of TPF scores indicated a significant sex-role attitudes x sex-role orientation interaction $F(3,194)=3.48$, $p<.017$. There was no effect of sex, $F(1,194)=1.45$, $p < .230$; no effect of sex-role orientation, $F(3,194)=1.60$, $p < .190$; and no effect of sex-role attitudes, $F(1,194)=1.39$, $p < .240$. Two-way and three-way interactions were also nonsignificant: sex x sex-role attitudes, $F(1,194)=0.28$, $p <.597$; sex x sex-role orientation, $F(3,194)=.46$, $p <.711$; and sex x sex-role attitudes x sex-role orientation, $F(3,194)=0.22$, $p <.883$. A score of 1 to 3 indicates a preference for a male therapist, a score of 4.00 indicates no preference, and a score of 5 to 7 indicates a preference for a female therapist. Figure 1 illustrates the significant sex-role attitudes x sex-role orientation interaction.

A test of simple effects indicated significant differences between the sex-role orientation groups within

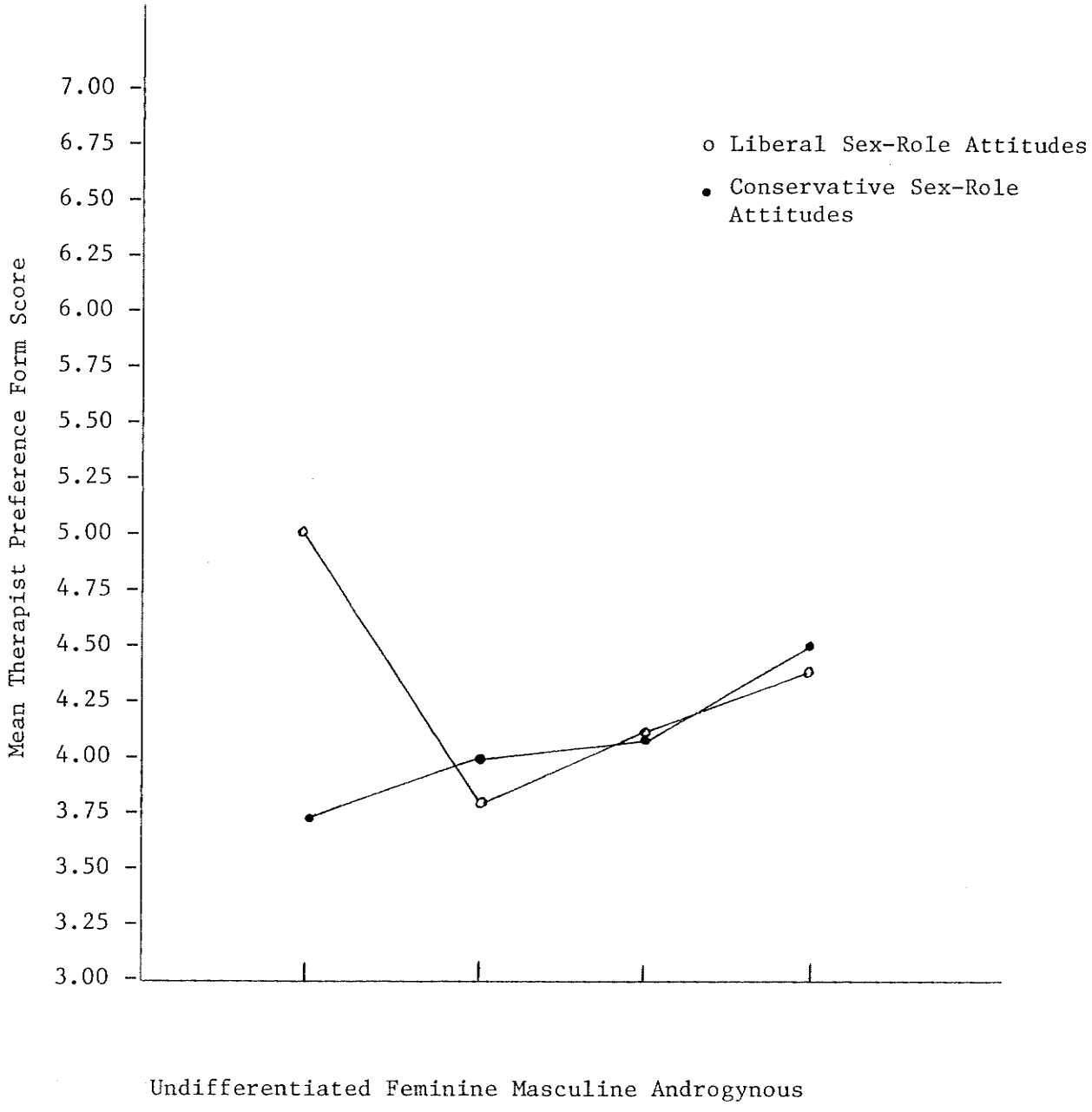

Figure 1. Mean Therapist Preference Form score as a function of sex-role orientation and sex-role attitudes.

the larger group of liberal subjects, $F(3,194)=3.36$, $p < .020$. By examining the mean scores (see Figure 1), it can be seen that liberal, undifferentiated subjects had the strongest preference for female therapists and conservative, undifferentiated subjects had the highest preference for a male therapist (M=3.74). Means for masculine and androgynous subjects who were liberal reflected a marginal preference for a female therapist.

The test of simple effects also indicated significant differences between liberal and conservative subjects who had an undifferentiated sex-role orientation, $F(1,194)=12.08$, $p < .001$. Post-hoc analysis of the simple effects of sex-role orientation and sex-role attitudes on therapist preference was done using Scheffe's test (most conservative), the modified least-significant difference test, and the least-significant difference test (most liberal). These are all tests of pairwise comparisons that are exact for unequal Ns. By the Scheffe procedure, no two groups were significantly different at the .05 level. By the modified least-significant difference, only the conservative-undifferentiated and liberal-undifferentiated subjects were significantly different (conservative subjects having a greater tendency to prefer males, liberal subjects having a greater tendency to prefer females). By the least-significant difference test, liberal-undifferentiated subjects had a stronger preference for females than all

subjects except those who were androgynous. Also, conservative-undifferentiated subjects were significantly different from conservative-and liberal-androgynous subjects in having a greater tendency to prefer male therapists.

Reasons for Preferred Sex of Therapist

Hypothesis 2b, that subjects will endorse TPF reasons according to sex, preferred sex of therapist, sex-role orientation, and attitudes toward women, was tested using a 2(sex) x 2 (female preferred therapist, male preferred therapist) x 4 (sex-role orientation) x 2 (sex-role attitudes) ANOVA eight times, once for each reason as the dependent variable. The number of subjects who stated a preference was 96 out of the total sample of 216 subjects. Of these subjects, 58 stated a preference for a female therapist and 32 for a male therapist. Groups by sex included: 13 men who stated a preference for a male therapist, 20 men who stated a preference for a female, 19 women who stated a preference for a male, and 38 women who stated a preference for a female therapist. Due to missing data, 6 subjects with a therapist preference had to be eliminated. All data were dichotomous (0 or 1) for the dependent variable, TPF reason.

For the first two reasons, "I would feel more comfortable in the presence of a person of that sex" and "A person of that sex would be more attractive to me personally" there

were no significant effects of sex, preference, sex-role orientation, sex-role attitudes, or of the two-way interactions (see Tables 8 and 9). Due to empty cells, higher order interactions were suppressed for this and all subsequent analyses.

For the third reason, "I could talk more freely about my problems", there was a main effect of preferred sex of therapist that reached significance (see Table 10). Of the two-interactions, only sex x preference was significant. Since the presence of an interaction typically precludes the interpretation of component main effects, the post-hoc analysis was restricted to further exploration of the sex x preference term. A test of simple effects indicated that there were significant differences between women and men who preferred a male therapist, $F(1,64)=8.59$, $p < .005$ and between women who preferred a female therapist and women who preferred a male therapist, $F(1,64)=10.21$, $p < .002$. Figure 2 illustrates this interaction. Men who preferred a male therapist were significantly more likely than women who preferred a male therapist to endorse this reason. Women who preferred a female therapist were significantly more likely to state this reason than were women who preferred a male therapist. This was a reason that related best to same-sex preferences.

For the fourth reason, "A person of that sex would understand my problems better", only sex x preference was

Table 8

Summary Table of Analysis of Variance of Effects of Sex of Subject, Preferred Sex of Therapist, Sex-Role Orientation, and Sex-Role Attitudes on TPF Reason 1

Source	df	MS	F	p
Main Effects				
Sex	1	0.52	0.58	.45
Preference	1	1.00	1.12	.29
Sex-Role Orientation	3	1.03	1.15	.33
Sex-Role Attitudes	1	2.81	3.13	.08
Two-Way Interactions				
Sex x Preference	1	0.10	0.11	.74
Sex x Sex-Role Orientation	3	0.52	0.58	.63
Sex x Sex-Role Attitudes	1	0.81	0.90	.35
Preference x Sex-Role Oreintation	3	0.56	0.62	.60
Preference x Sex-Role Attitudes	1	0.26	0.28	.60
Sex-Role Orientation x Sex-Role Attitudes	3	0.05	0.06	.98
Error	72	0.90		

Table 9

Summary Table of Analysis of Variance of Effects of Sex of Subject, Preferred Sex of Therapist, Sex-Role Orientation, and Sex-Role Attitude on TPF Reason 2

Source	df	MS	F	p
Main Effects				
Sex	1	0.20	2.41	.13
Preference	1	0.05	0.54	.47
Sex-Role Orientation	3	0.03	0.31	.82
Sex-Role Attitudes	1	0.00	0.00	.95
Two-Way Interactions				
Sex x Preference	1	0.05	0.63	.43
Sex x Sex-Role Orientation	3	0.09	1.07	.37
Sex x Sex-Role Attitudes	1	0.00	0.04	.84
Preference x Sex-Role Orientation	3	0.14	1.68	.18
Preference x Sex-Role Attributes	1	0.00	0.00	1.0
Sex-Role Orientation x Sex-Role Attitudes	3	0.05	0.55	.65
Error	71	0.09		

Table 10

Summary Table of Effects of Sex of Subject, Preferred Sex of Therapist, Sex-Role Orientation, and Sex Role Attitudes on TPF Reason 3

Source	df	MS	F	p
Main Effects				
Sex	1	0.14	0.66	.42
Preference	1	1.20	5.73*	.02
Sex-Role Orientation	3	0.26	1.25	.30
Sex-Role Attitudes	1	0.77	3.67	.06
Two-Way Interactions				
Sex x Preference	1	1.46	6.97*	.01
Sex x Sex-Role Orientation	3	0.30	1.43	.24
Sex x Sex-Role Attitudes	1	0.07	0.33	.57
Preference x Sex-Role Orientation	3	0.22	1.03	.38
Preference x Sex-Role Attitudes	1	0.32	1.54	.22
Sex-Role Orientation x Sex-Role Attitudes	3	0.52	2.49	.07
Error	71	0.210		

* $p < .05$

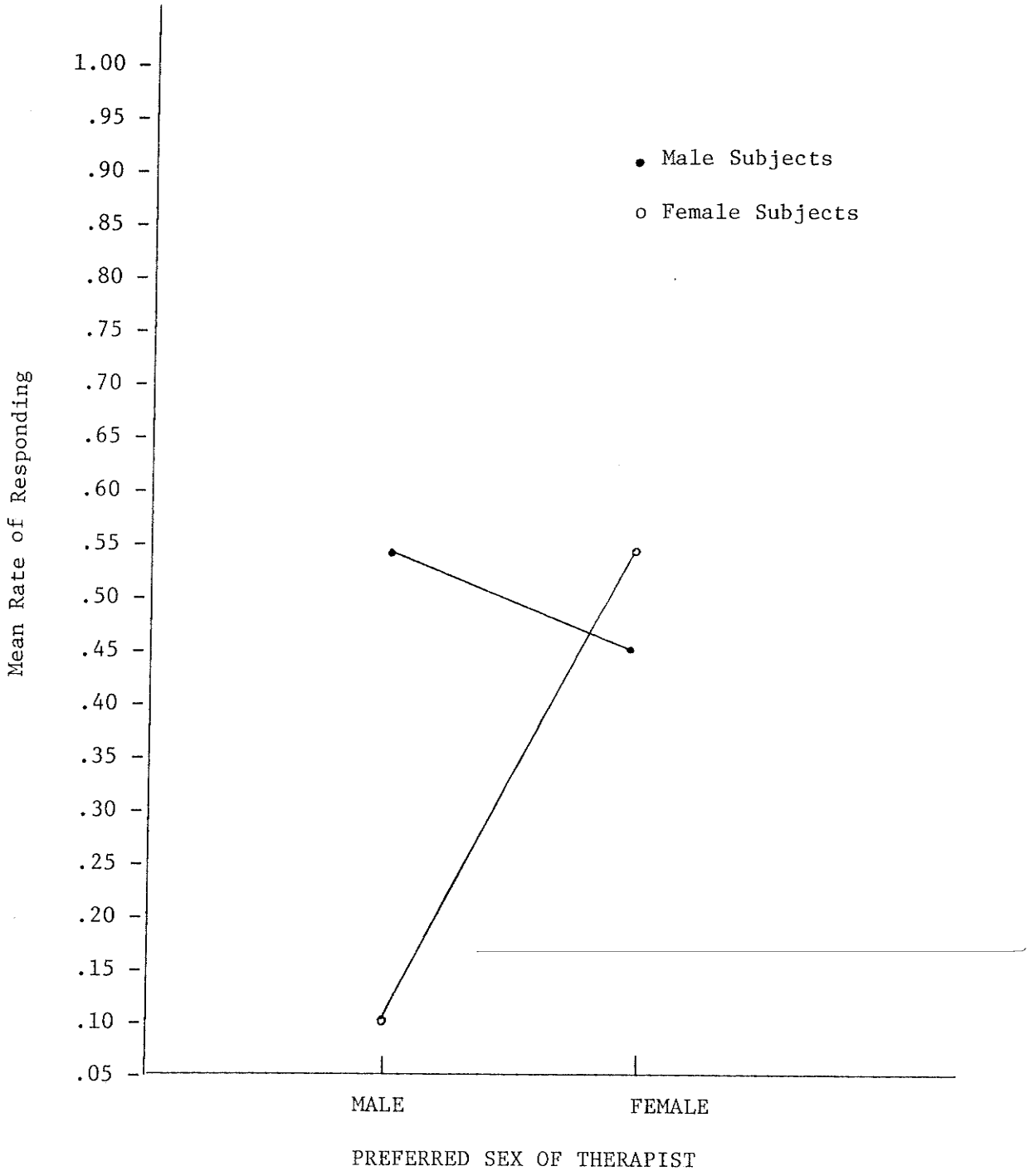

Figure 2. Mean rate of responding to TPF reason 3 as a function of sex of subject and preferred sex of therapist.

significant $F(1,71)=5.86$, $p<.02$ (see Table 11). A test of simple effects indicated that there were significant differences between women and men who preferred a male therapist, $F(1,64)=7.18$, $p<.009$ and between women who preferred a female therapist and women who preferred a male therapist, $F(1,64)=5.51$, $p<.02$ (see Figure 3). Again, as with the third reason listed in the Therapist Preference Form this was a reason more often cited by subjects who stated a same-sex preference for therapist.

For the fifth reason, "A person of that sex would probably be very intelligent," there were no significant effects (see Table 12).

For the sixth reason, "Past experience with professionals of that sex has been satisfactory", there were no significant effects (See Table 13).

For the seventh reason, "I prefer professionals of that sex in general", there was a significant main effect of sex-role attitudes (see Table 14). The preference x sex-role orientation interaction and preference x sex-role attitudes interaction were significant. All other interactions were non-significant (see Table 14 and Figures 4 and 5).

Since the significant main effect of sex-role attitudes was a component of one of the significant interactions (preference x sex-role attitudes), post-hoc analyses were restricted to exploration of the preference x sex-role orientation and preference x sex-role attitudes terms.

Table 11

Analysis of Variance of Effects of Sex of Subject, Preferred Sex of Therapist, Sex-Role Orientation, and Sex-Role Attitudes on TPF Reason 4

Source	df	MS	F	p
Main Effects				
Sex	1	0.08	0.35	.56
Preference	1	0.29	1.33	.25
Sex-Role Orientation	3	0.19	0.84	.48
Sex-Role Attitudes	1	0.11	0.49	.49
Two-way Interactions				
Sex x Preference	1	1.30	5.86*	.02
Sex x Sex-Role Orientation	3	0.27	1.23	.31
Sex x Sex-Role Attitudes	1	0.04	0.20	.66
Preference x Sex-Role Orientation	3	0.22	1.01	.40
Preference x Sex-Role Attitudes	1	0.11	0.47	.49
Sex-Role Orientation x Sex-Role Attitudes	3	0.06	0.28	.84
Error	71	0.22	1.24	

*$p < .05$

Table 12

Analysis of Variance of Effects of Sex of Subject, Preferred Sex of Therapist, Sex-Role Orientation, and Sex-Role Attitudes on TPF Reason 5

Source	df	MS	F	p
Main Effects				
Sex	1	0.08	3.65	.06
Preference	1	0.00	0.10	.75
Sex-Role Orientation	3	0.03	1.29	.29
Sex-Role Attitudes	1	0.04	1.79	.19
Two-way Interactions				
Sex x Preference	1	0.00	0.13	.72
Sex x Sex-Role Orientation	3	0.01	0.23	.88
Sex x Sex-Role Attitudes	1	0.00	0.00	.98
Preference x Sex-Role Orientation	3	0.04	1.64	.19
Preference x Sex-Role Attitudes	1	0.00	0.17	.68
Sex-Role Orientation x Sex-Role Attitudes	3	0.02	0.83	.48
Error	71			

Table 13

Summary Table of Analysis of Variance of Effects of Sex of Subject, Preferred Sex of Therapist, Sex-Role Orientation, and Sex-Role Attitudes on TPF Reason 6

Source	df	MS	F	p
Main Effects				
Sex	1	0.11	0.47	.49
Preference	1	0.71	2.99	.09
Sex-Role Orientation	3	0.14	0.59	.62
Sex-Role Attitudes	1	0.00	0.01	.92
Two-Way Interactions				
Sex x Preference	1	0.34	1.45	.23
Sex x Sex-Role Orientation	3	0.36	1.53	.21
Sex x Sex-Role Attitudes	1	0.07	0.28	.60
Preference x Sex-Role Orientation	3	0.07	0.30	.83
Preference x Sex-Role Attitudes	1	0.01	0.03	.86
Sex-Role Orientation x Sex-Role Attitudes	3	0.42	1.79	.16
Error	71			

Table 14

Analysis of Variance of Effects of Sex of Subject, Preferred Sex of Therapist, Sex-Role Orientation, and Sex-Role Attitudes on TPF Reason 7

Source	df	MS	F	p
Main Effects				
Sex	1	0.02	0.30	.58
Preference	1	0.03	0.36	.55
Sex-Role Orientation	3	0.01	0.07	.97
Sex-Role Attitudes	1	0.50	6.41*	.01
Two-Way Interactions				
Sex x Preference	1	0.22	2.89	.09
Sex x Sex-Role Orientation	3	0.01	0.18	.91
Sex x Sex Role Attitudes	1	0.20	2.54	.12
Preference x Sex-Role Orientation	3	0.44	5.65**	.00
Preference x Sex-Role Attitudes	1	0.34	4.38*	.04
Sex-Role Orientation x Sex-Role Attitudes	3	0.00	0.05	.99
Error	71			

* $p < .05$

** $p < .01$

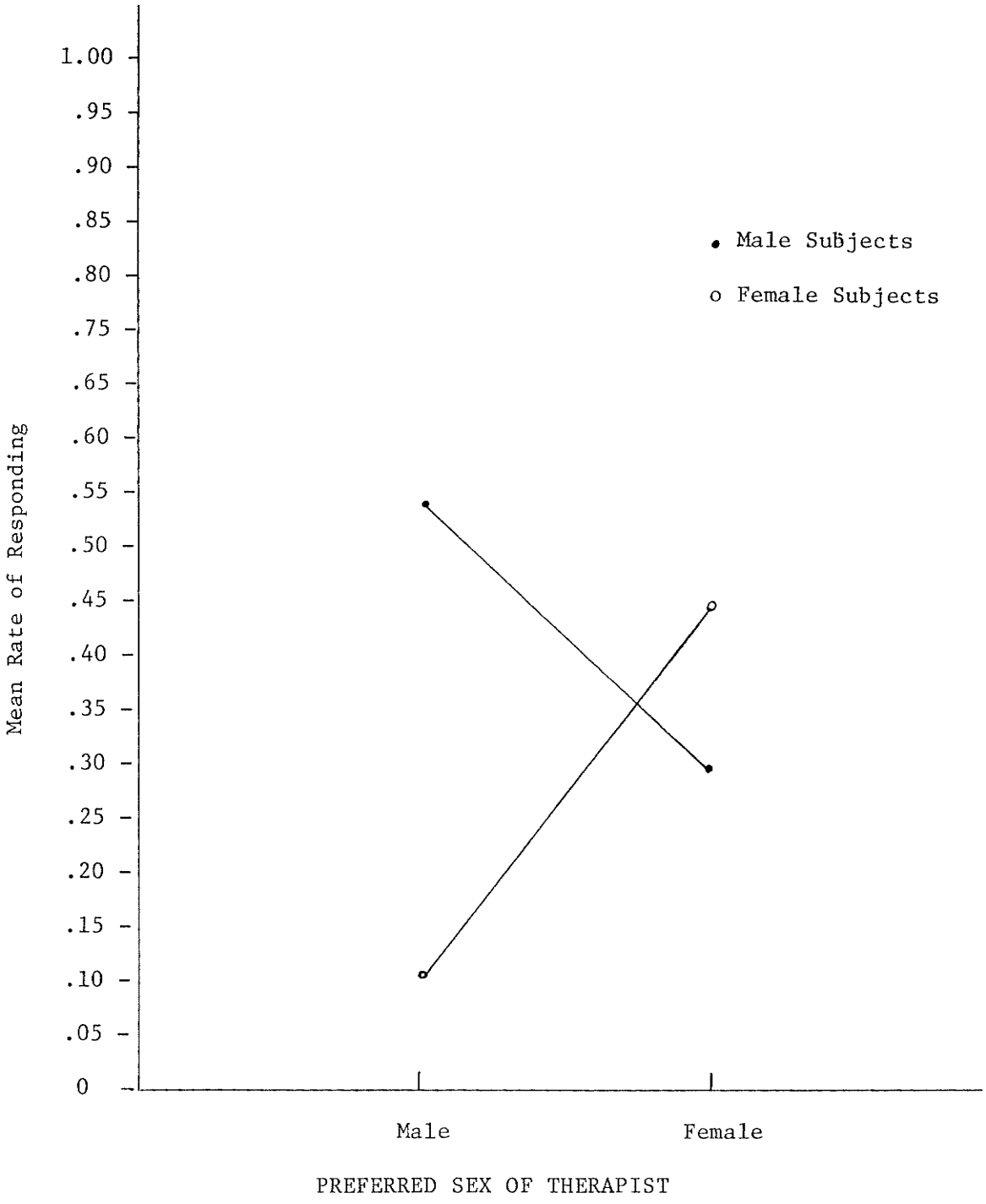

Figure 3. Mean rate of responding to TPF reason 4 as a function of sex of subject and preferred sex of therapist.

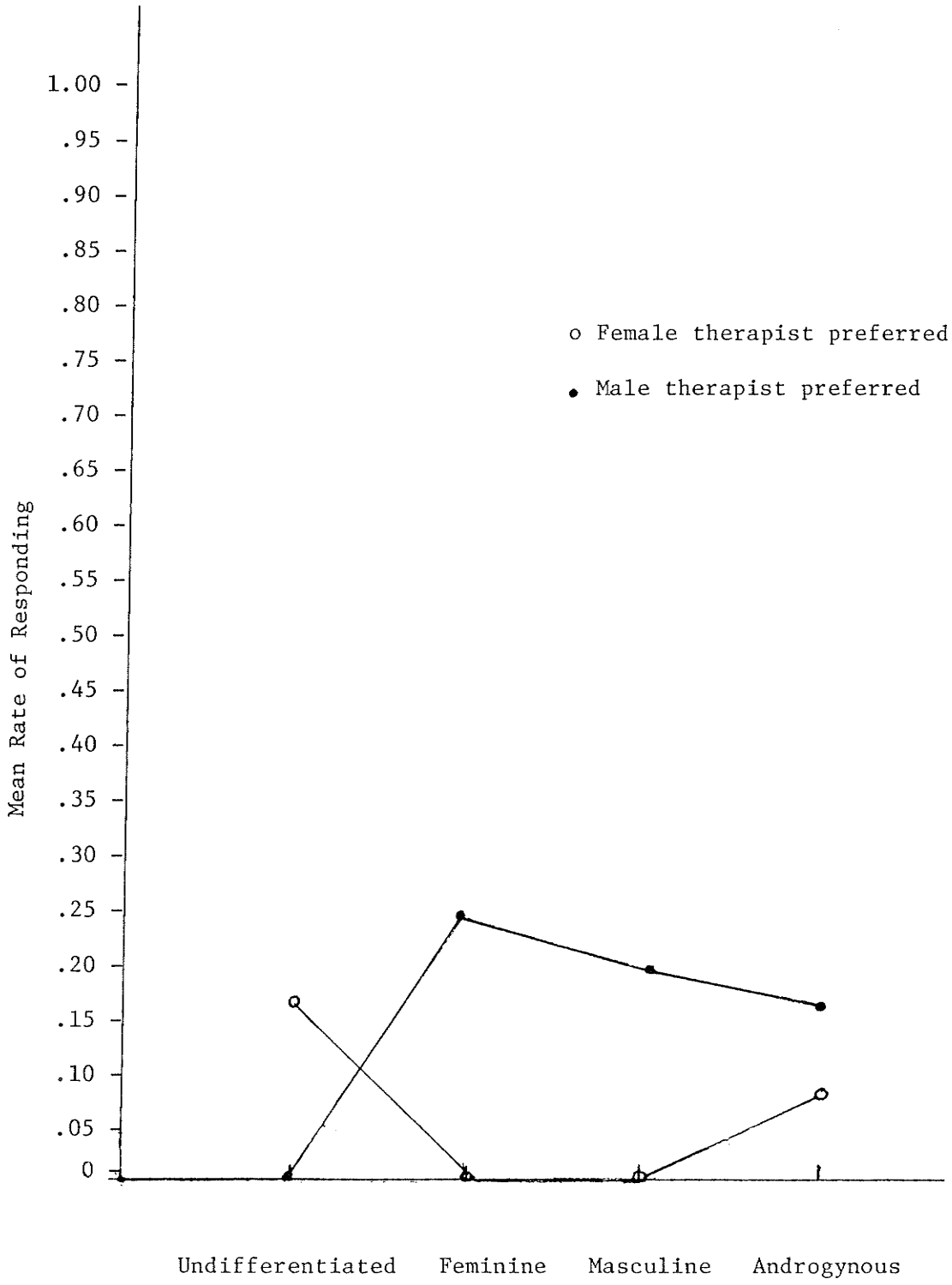

Figure 4. Mean rate of responding to TPF reason 7 as a function of sex-role orientation and preferred sex of therapist.

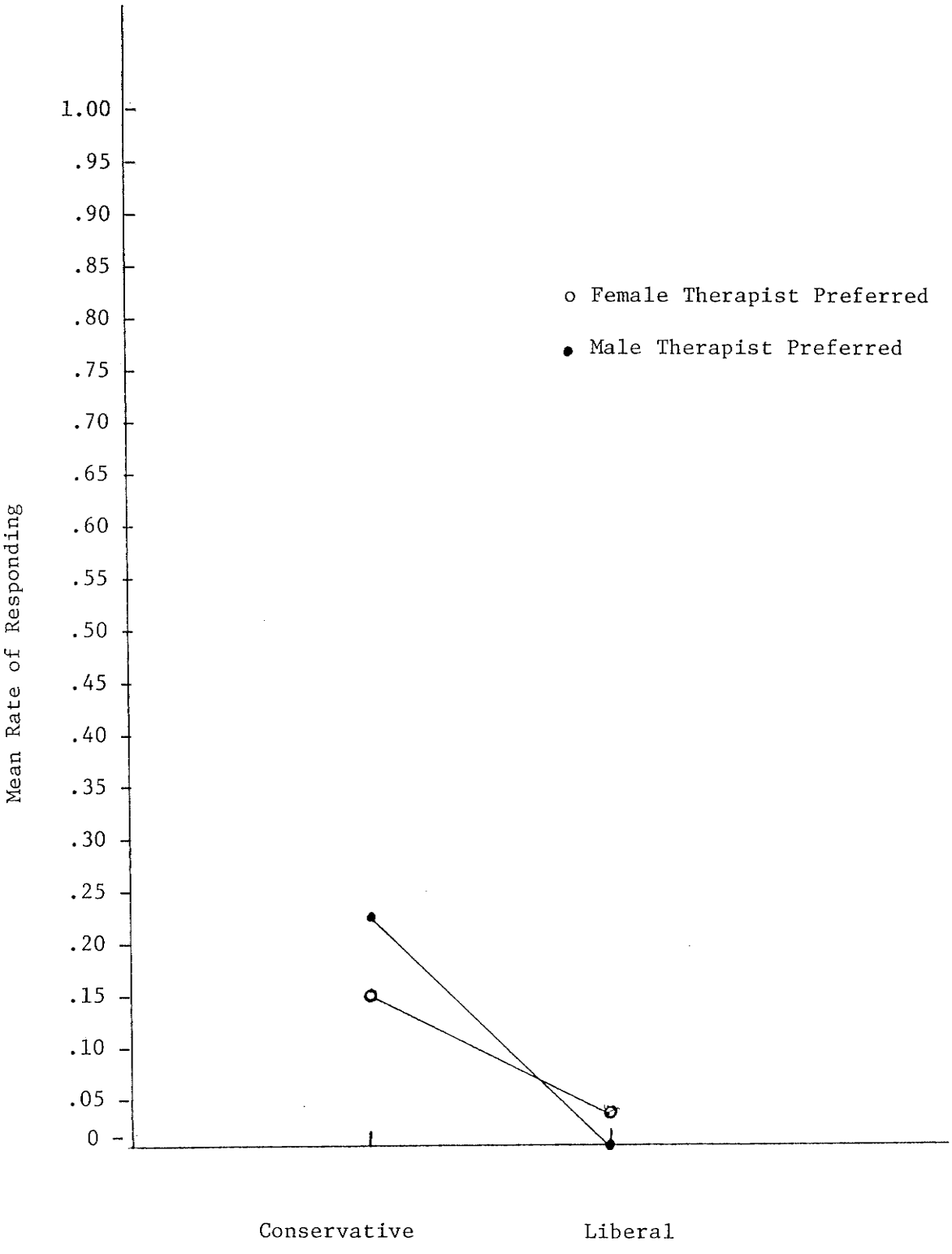

Figure 5. Mean rate of responding to TPF reason 7 as a function of sex-role attitudes and preferred sex of therapist.

A test of simple effects of the preference x sex-role orientation interaction indicated that no groups were significantly different from the others: preference within undifferentiated subjects, $F(1,64)=2.77$, $p<.10$, preference within feminine subjects, $F(1,64)=3.64$, $p<.06$, preference within masculine subjects, $F(1,64)=1.77$, $p<.19$, preference within androgynous subjects, $F(1,64)=.21$, $p<.65$, sex-role orientation within preference for male therapist, $F(3,64)=1.41$, $p<.25$, and sex-role orientation within preference for female therapist, $F(3,64)=.88$, $p<.46$. Although there were no significant differences between groups in this interaction, it is noteworthy that undifferentiated subjects preferring a male as well as feminine and masculine subjects preferring a female therapist did not check this reason at all. Feminine subjects who preferred a male therapist were most likely to cite this reason (see Figure 4).

A test of simple effects of the preference x sex-role attitudes interaction indicated that there were only significant differences between liberal and conservative subjects who preferred a male therapist, $F(1,64)=5.55$, $p<.02$. Liberal subjects who preferred a male therapist never cited this reason, "I prefer professionals of that sex in general" while conservative subjects who preferred a male were most likely of all groups to endorse this reason (see Figure 5).

For the eighth reason, "Past experience with professionals of the other sex has been unsatisfactory", there were no significant effects (see Table 15).

Subjects had an opportunity to add their own reasons for stating a preference for sex of therapist at the end of The Therapist Preference Form. These additional reasons are included in Table 16.

Problems, Adjustment, Sex of Subject, and Therapist Preference

Hypothesis 3a, that the nature of reported problems selected from the Personal Problems Rating Scale will relate to sex of subject and stated preference for sex of therapist or lack of preference; levels of adjustment on the California Personality Inventory will relate to sex of subject and preference or lack of preference for sex of therapist was tested with two 2(sex) x 3 (preference) MANOVAs, one with PPRS factors as dependent variables and the other with CPI factors as dependent variables.

Multivariate analysis of variance of PPRS factor scores indicated only a significant main effect of preference, $F(8,414)=3.46$, $p<.001$, (sex, $F(4,207)=.37$, $p<.827$, and sex x preference, $F(8,414)=1.37$, $p<.21$). The univariate F-tests following the significant multivariate main effect indicated that there was a significant relationship between preference and the Anxiety factor of the PPRS, $F(2,210)=3.91$, $p<.02$,

Table 15

Analysis of Variance of Effects of Sex of Subject, Preferred Sex of Therapist, Sex-Role Orientation, and Sex-Role Attitudes on TPF Reason 8

Source	df	MS	F	p
Main Effects				
Sex	1	0.05	0.44	.51
Preference	1	0.17	1.44	.23
Sex-Role Orientation	3	0.15	1.27	.29
Sex-Role Attitudes	1	0.02	0.14	.71
Two-Way Interactions				
Sex x Preference	1	0.12	1.04	.31
Sex x Sex-Role Oreinationa	3	0.14	1.18	.33
Sex x Sex-Role Attitudes	1	0.01	0.10	.75
Preference x Sex-Role Orientation	3	0.03	0.25	.86
Preference x Sex-Role Attitudes	1	0.14	1.24	.27
Sex-Role Orientation x Sex-Role Attitudes	3	0.04	0.33	.81
Error	71			

Table 16

Reasons Provided by Subjects for Stating Preference for Gender of Therapist

Sex of Subject	Therapist Preference	Reason
Female	2 (Male)	"Slight fear of women (strangers who might not like me)"
Female	6 (Female)	"I would prefer someone my age or somewhat older"
Female	7 (Female)	"Female was recommended for R." (child)
Male	6 (Female)	"more sensitive"
Female	5 (Female)	"I would feel it would be harder to be dishonest with someone of my own sex"
Female	3 (Male)	"male if older, otherwise a female"
Female	3 (Male)	"I haven't had much dealings with the other sex in professional capacities"
Female	1 (Male)	"Since I am here for my own benefit, I would not like to be bothered with any feelings of competitiveness I might have during the course of treatment with a female therapist"
Female	7 (Female)	"Hopefully this preference would put me in touch with a feminist therapist"
Female	2 (Male)	"male therapist would help M. at this stage" (child)
Female	5 (Female)	"I have always seen male psychiatrists and counsellors. A psychiatrist suggested I see a female as she may understand my problems better"

Note: Ratings for therapist preference are on a scale of 1 to 7, with 1 being a strong preference for a male, 4 - no preference, and 7 - strong preference for a female.

(see Table 17 for group means). Scheffe's post-hoc comparisons (Hays, 1973, p. 606) were performed for all pair-wise comparisons on Factor 4. Two comparisons were significant (<.05): between the no-preference group and the male-preferred group, and between the no-preference group and female-preferred group. Subjects who preferred a male therapist or a female therapist were significantly more likely to state a high likelihood of discussing Anxiety (Factor 4) problems. There were no significant differences between the preference groups.

When examining the canonical correlations, it was found that Identity-Depression (as well as Anxiety) was significantly correlated (.433) with therapist preference (or lack of preference). The means (see Table 17) indicated that the preference groups were almost equally likely (Mean for male preference group=30.47, Mean for female preference group=30.84) to report Identity-Depression problems and were more likely to report these problems than subjects who had no preference (Mean=37.47). Therefore, for both Identity-Depression and Anxiety, subjects who reported being more likely to discuss those problems in therapy had a greater preference for a particular gender of therapist.

Multivariate analysis of variance of CPI factor scores indicated a main effect of sex, $\underline{F}(4,206)=3.63$, $\underline{p} < .007$; no effect of therapist preference, $\underline{F}(8,412)=1.66$, $\underline{p} <.11$;

Table 17

Mean Personal Problems Rating Scale Factor Scores According to Preference or Lack of Preference for Therapist's Gender

Factor	Preferred Gender of Therapist		
	Female (n=59)	No Preference (n=120)	Male (n=32)
Identity Depression	30.84	37.47	30.47
Career-Academic Role Functioning	38.47	44.88	41.66
Gender Related Issues	30.11	31.28	31.56
Anxiety	16.52	21.70	17.00

Note: The lower the mean value on a given PPRS factor, the greater the likelihood of reporting that group of problems.

and no sex x preference interaction, $F(8,412)=1.48$, $p<.16$. The univariate F-tests for the main effect of sex indicated that the relationships between sex and General Adjustment was significant, $F(1,209)=11.37$, $p<.001$ and between sex and Confident-Outgoing was significant, $F(1,209)=5.04$ $p<.026$. Canonical correlations between sex and the CPI factors were all significant ($p < .05$): General Adjustment (.88), Mature Socialized Dominance (.51), Confident-Outgoing (-.59), and Other Orientation (.47). Mean scores for males and females on all four CPI factors can be seen in Table 18. Post-hoc interpretations were limited to the effects found in the univariate F-tests. Women were better adjusted than men (General Adjustment factor). Men, however, scored significantly higher than women on the Confident-Outgoing factor (including dominance, social presence, and sociability).

Adjustment and Psychological Problems in Relation to Sex of Subject, Sex-Role Orientation, and Therapist Preference

Hypothesis 3b, that the nature of reported problems and level of adjustment will relate to sex of subject, presence or absence of therapist preference and sex-role orientation, was tested using two 2(sex) x 4(sex-role orientation) x 3 (preference groups) MANOVAs, one with CPI factors as the dependent variables and one with PPRS factors as the dependent variables.

Table 18

Mean California Psychological Inventory Factor Scores According to Sex of Subject

Sex	CPI Factors			
	General Adjustment	Mature Socialized Dominance	Confident-Outgoing	Other Orientation Acceptance
Males (n = 90)	-216.34	-11.37	14.35	4.36
Females (N = 126)	-192.37	- 4.79	10.33	6.24

Note: The higher and more positive the mean factor score, the higher the level of adjustment.

Multivariate analysis of variance of the CPI factors indicated a main effect of sex, $F(4,188)=2.82$, $p < .027$; a main effect of sex-role orientation, $F(12,497.69)=2.00$, $p < .022$; a significant sex x sex-role orientation interaction, $F(12,497.69)=2.34$, $p < .006$; no effect of therapist preference, $F(2,376)=1.33$, $p < .23$; no sex x preference interaction, $F(8,376)=1.49$, $p < .16$; no sex-role orientation x preference interaction, $F(24,657.06)=1.13$, $p < .30$, and no sex x sex-role orientation x preference, $F(24,657.06)=1.18$, $p<.25$.

Since the significant main effects of sex and sex-role orientation were components of the significant interaction, sex x sex-role orientation, the post-hoc analysis was restricted to exploration of the sex x sex-role orientation interaction. The univariate F-tests indicated that this interaction was significant for General Adjustment $F(3,191) = 4.15$, $p<.01$ and for Confident-Outgoing, $F(3,191)=3.41$, $p < .02$. Figures 6 and 7 respectively illustrate these interactions. A test of simple effects indicated that of the four sex-role orientation groups, significant differences occurred between women and men who were feminine, $F(4,188)=2.68$, $p<.03$ and between women and men who were undifferentiated, $F(4,188)=3.77$, $p<.01$. For feminine subjects, univariate F-tests indicated that significant differences occurred on General Adjustment, $F(1,191)=9.60$, $p<.002$ and on Mature Socialized Dominance, $F(1,191)=6.20$,

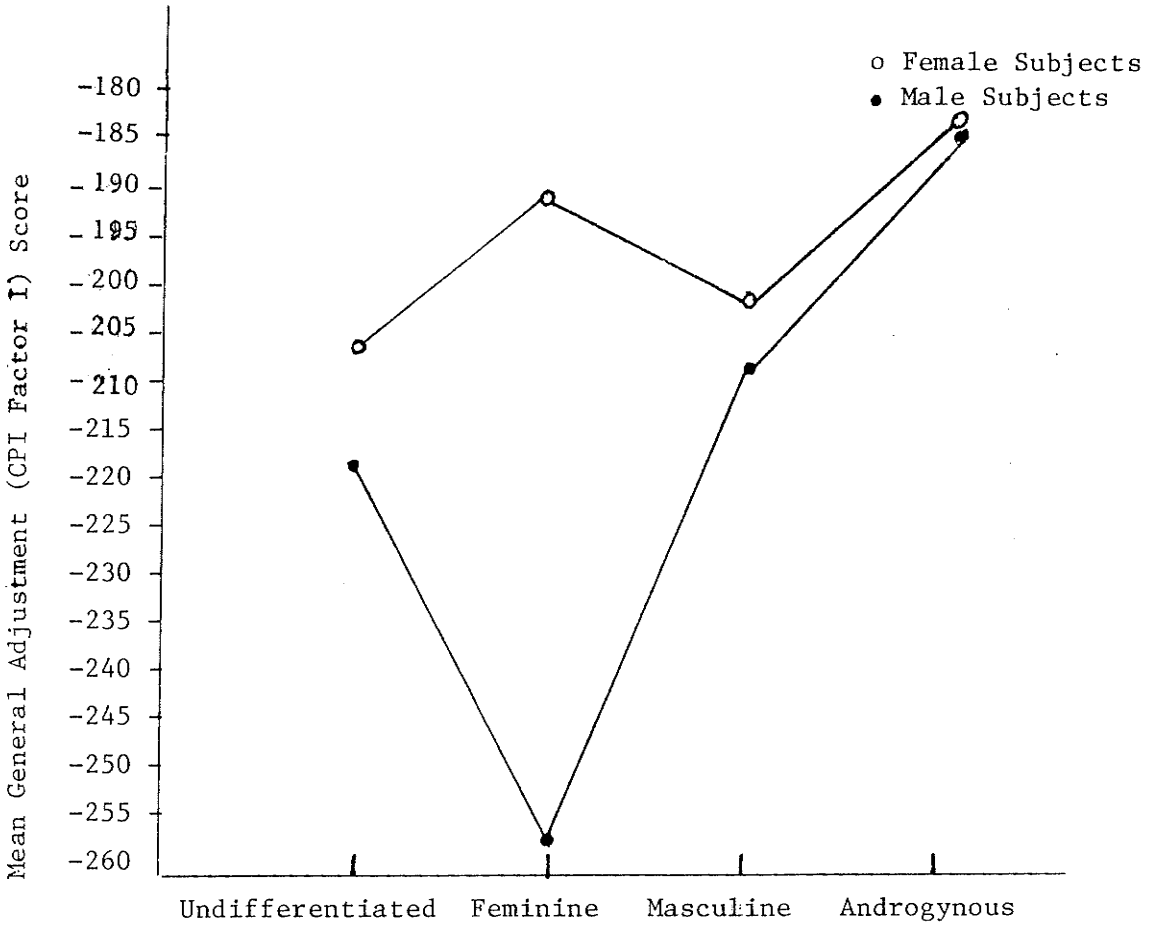

Figure 6. Mean General Adjustment score as a function of sex of subject and sex-role orientation.

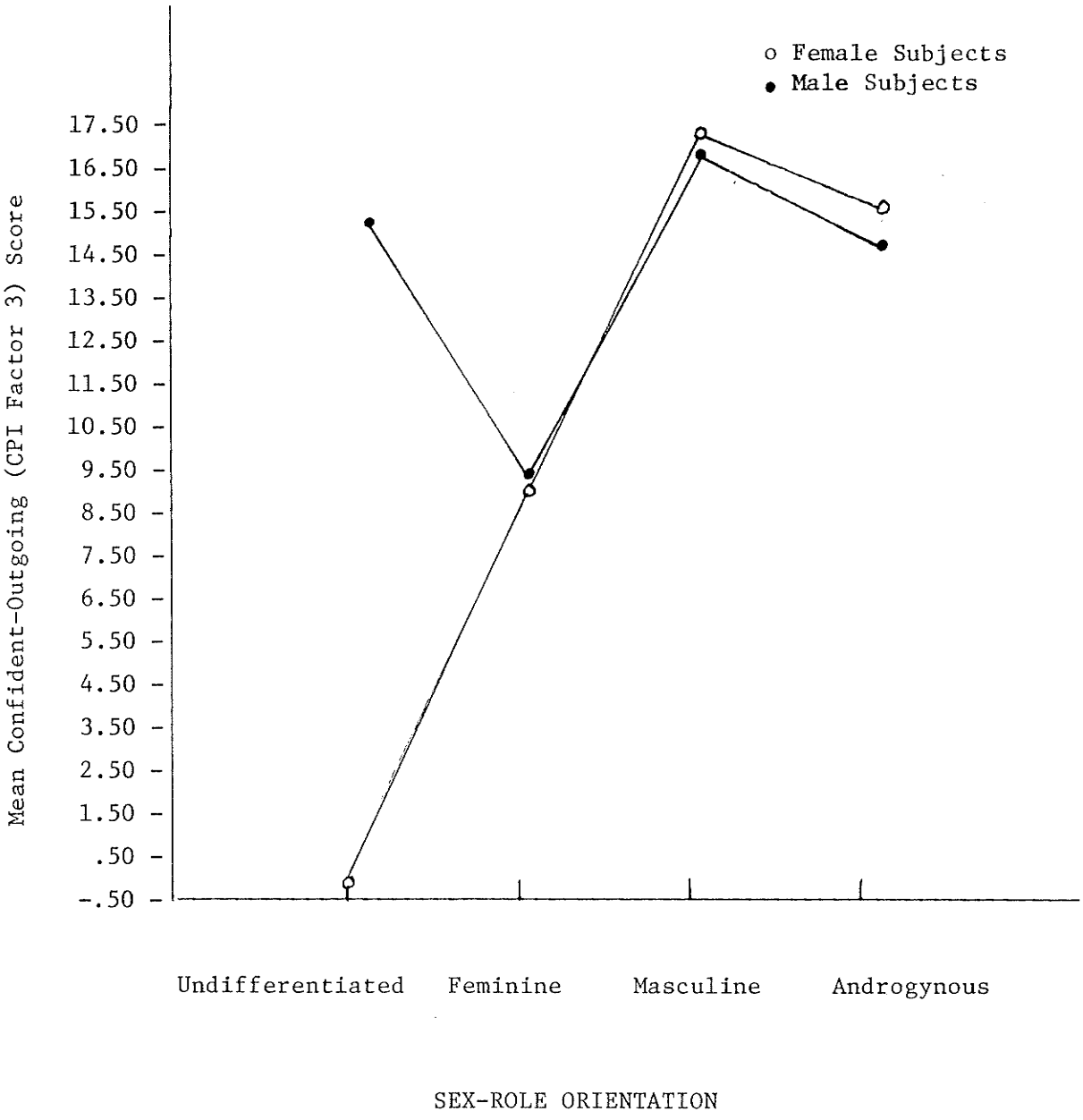

Figure 7. Mean Confident-Outgoing score as a function of sex of subject and sex-role orientation.

$p<.01$. Feminine women scored higher on both these factors than feminine men. For undifferentiated subjects, significant differences occurred between women and men only on Confident-Outgoing, $F(1,191)=13.32$, $p<.000$. Undifferentiated men scored significantly higher than undifferentiated women (see Figure 7).

Multivariate analysis of variance of the PPRS factors indicated a main effect of preference, $F(8,378)=2.60$, $p<.01$; no effect of sex, $F(4,189)=.44$, $p<.78$; no effect of sex-role orientation, $F(12,500.34)=1.63$, $p<.08$; no sex x preference interaction, $F(8,378)=1.29$, $p<.25$; no sex x sex-role orientation interaction, $F(12,500.34)=1.03$, $p<.42$; no preference x sex-role orientation interaction, $F(24,660.55)=.90$, $p<.60$; and no sex x preference x sex-role orientation interaction, $F(24,660.55)=1.02$, $p<.43$.

The univariate F-tests for the significant main effect of preference indicated significant differences between the therapist preference and no preference groups only on the Anxiety factor, $F(2,192)=3.22$, $p<.04$. Canonical correlations between these groups and Identity-Depression, Career-Academic Functioning, and Anxiety were significant at .50, .33, and .56 respectively. The means reported in Table 17 were identical to those resulting from this analysis.

Scheffe's post-hoc comparisons (Hays, 1973, p. 606) were performed on the group means for Anxiety, (the only

significant univariate ANOVA result). Significant differences ($p<.05$) were found between the preference groups and no preference group. As with the results found from testing Hypothesis 3a, both subjects who preferred a male therapist and those who preferred a female therapist, were significantly more likely to discuss Anxiety problems than the nopreference group. No significant difference in the extent of reporting these problems occurred between the two preference groups.

Ideal Therapist Traits in Relation to Subject Characersitics and Therapist Preference

Hypothesis 4a, that sex of subject and stated preference or lack of preference for sex of therapist will relate to perceptions of the "ideal" therapist was tested by a 2(sex) x 3(preference) MANOVA with the three Counsellor Rating Form factors as dependent variables.

Multivariate analysis of variance of the CRF factor scores revealed no effect of sex, $F(3,208)=1.11$, $p <.34$; no effect of preference, $F(6,416)=.80$, $p <.57$; and no sex x preference interaction, $F(6,416)=.59$, $p<.74$.

Hypothesis 4b, that sex of subject, sex-role orientation, and stated preference or no preference for sex of therapist will relate to perceptions of the "ideal" therapist was tested by a 2(sex) x 4(sex-role orientation) x 3(preference) MANOVA with the three CRF factors as dependent variables.

Multivariate analysis of variance of the CRF scores indicated only a significant sex-role orientation x preference interaction, $F(18,537.89)=1.76$, $p<.03$. There was no effect of sex, $F(3,190)=.75$, $p<.52$; no effect of sex-role orientation, $F(9,462.56)=1.65$, $p<.10$; no effect of preference, $F(6,380)=1.41$, $p<.21$; no sex x sex-role orientation interaction, $F(9,462.56)=.81$, $p<.61$; no sex x preference interaction, $F(6,380)=.77$, $p<.59$; and no sex x sex-role orientation x preference interaction, $F(18,537.89)=1.12$, $p<.33$. The univariate F for the sex-role x preference interaction on Agentic Interpersonal Skills (Factor 2) was significant, $F(6,192)=2.16$, $p<.05$. Figure 8 illustrates the interaction for this CRF factor. A test of simple effects on the sex-role orientation x preference term indicated that of the two preference and single no-preference groups, there were significant differences only within the subjects who preferred a male therapist, $F(9,462.56)=1.90$, $p<.05$ for Agentic Interpersonal Skills (according to univariate F-tests), $F(3,192)=3.13$, $p<.03$.

Since higher means reflect a greater endorsement of the Counsellor Rating Form factor, the test of simple effects indicated that of the subjects who preferred a male therapist, those who were feminine rated their "ideal" therapist higher than any other groups on Agentic Interpersonal Skills (i.e., cheerful, clear, dependable,

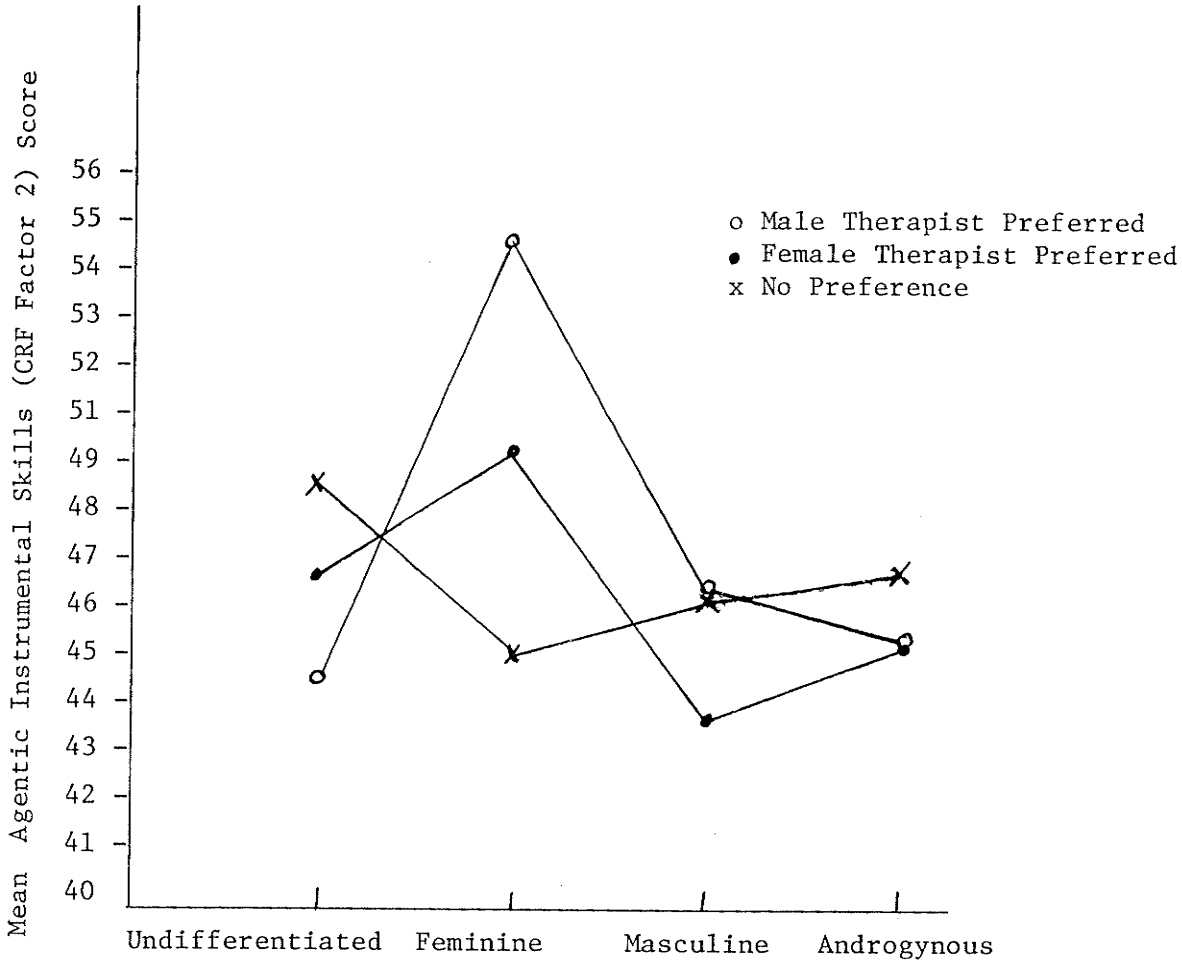

Figure 8. Mean Agentic Instrumental Skills score as a function of sex-role orientation and preferred sex of therapist.

friendly, honest, informed, reliable, respectful, straightforward, and trustworthy).

The test of simple effects also indicated significant differences between the preference and no preference groups who were masculine in sex-role orientation, $F(6,380)=2.51$, $p<.02$. However, none of the univariate F-tests were significant: Professional Competence $F(2,192)=.19$, $p<.83$; Agentic Interpersonal Skills, $F(2,192)=.43$, $p<.65$; and Communal-Expressive Interpersonal Skills $F(2,192)=.14$, $p<.87$. By examining the group means (see Table 19) it can be seen that on Professional Competence and Agentic Interpersonal Skills, masculine subjects who preferred a female therapist rated their "ideal" therapist the lowest of all preference or no preference groups. Masculine subjects who had no preference or preferred a female therapist rated their "ideal" therapist higher on Communal-Expressive Interpersonal Skills than the male-therapist-preferred group. The third factor included the items: appreciative, attractive, close, compatible, believable, friendly, likeable, open, and sociable.

It was considered of interest to include sex-role attitudes in a further multivariate analysis of variance with a 2(sex) x 2 (sex-role attitudes) x 3(preference groups) MANOVA with the three CRF factors as dependent variables. This analysis yielded only nonsignificant

Table 19

Mean Counsellor Rating Form Factor Scores According to Sex-Role Orientation and Therapist Preference

Therapist Preference		Sex-Role Orientation			
		Undifferentiated	Feminine	Masculine	Androgynous
Professional Competence					
Male Therapist Preferred	M	41.92	54.50	41.80	41.00
	n	13	8	5	6
No Preference	M	47.67	41.00	41.90	41.68
	n	27	26	30	37
Female Therapist Preferred	M	43.52	48.60	40.00	40.38
	n	19	10	8	22
Agentic Interpersonal Skills					
Male Therapist Preferred	M	44.77	54.75	46.60	45.67
	n	13	8	5	6
No Preference	M	48.56	45.00	46.27	46.78
	n	27	26	30	37
Female Therapist Preferred	M	46.86	49.40	43.89	45.38
	n	19	10	8	22
Communal-Expressive Interpersonal Skills					
Male Therapist Preferred	M	40.77	49.13	38.60	42.33
	n	13	8	5	6
No Preference	M	45.11	40.69	42.23	42.76
	n	27	26	30	37
Female Therapist Preferred	M	44.14	44.60	42.33	40.50
	n	19	10	8	22

Note: Higher means reflect a greater endorsement of therapist characteristics for a given factor.

results: no effect of sex, $F(3,202)=1.10$, $p<.35$, no effect of sex-role attitudes, $F(3,202)=.49$, $p<.69$, no effect of preference, $F(6,404)=.78$, $p<.59$, no sex x sex-role attitudes interactions, $F(3,202)=1.09$, $p<.35$, no sex x preference interaction, $F(6,404)=.70$, $p<.65$, no sex-role attitudes x preference interaction, $F(6,404)=.65$, $p<.69$, and no sex x sex-role attitudes x preference interaction, $F(6,404)=1.15$, $p<.33$.

Prior Psychotherapeutic Experience, Client Gender, and Preferred Sex of Therapist

Hypothesis 5, that prior psychotherapeutic experience will influence the extent to which subjects prefer a same-sex or opposite-sex therapist, or state no preference at all, was tested with a 2(sex) x 4 (previous therapy status) univariate ANOVA with therapist preference or lack of preference (TPF score) as the dependent variable.

Analysis of variance of Therapist Preference Form scores indicated no effect of sex, $F(1,199)=1.984$, $p<.161$, no effect of previous therapy experience, $F(3,199)=0.98$, $p<.40$, and no sex x previous therapy experience interaction, $F(3,199)=0.56$, $p<.65$. Therefore, whether subjects reported no previous therapy experience or previous experience with a female or male therapist (or both, conjointly) made no significant difference in the extent to which women or men preferred a therapist of a specific gender.

DISCUSSION

The primary purpose of this research was to clarify some of the gender-related variables affecting clients' psychological health and their preferences for psychotherapists as they enter psychotherapy. Previous research, although inconsistent, suggested that clients do have preconceived notions of what they desire in a therapist. The current study was designed to explore the multifaceted relationships between client gender, sex-role orientation, sex-role attitudes, current psychological functioning, attributed characteristics of the "ideal" therapist, and preferred sex of therapist. A more complete understanding of the correlates of client expectations, it is hoped, could further the pursuit of optimal conditions for therapeutic gains.

In addition, this research was designed to study sex differences in psychological adjustment and presenting problems as well as the effects of sex-role orientation on these two dimensions of psychological functioning. The extent to which a subject endorses masculine and feminine traits was studied in relation to several mental health factors and psychological problem areas. A related purpose was to explore the potential of androgyny as a model of mental health for women and men.

Of the subjects in this sample, 44.44% indicated a preference for sex of therapist, supporting the view that asking clients if they prefer a particular gender of therapist may be an important way of meeting clients' needs. The strength of the preference should also be considered, since group means varied within the range of slight preference for males (Conservative-undifferentiated subjects) to slight preference for females (liberal-undifferentiated subjects). There was support for the hypothesis that preference for sex of therapist was affected by a complex interaction of sex-role orientation and sex-role attitudes.

The hypothesis that sex-role orientation would relate to psychological adjustment and self-reported problems was also supported. To varying degrees, masculinity and androgyny were related to both dimensions of psychological functioning, adjustment and presenting problems.

The following discussion will first describe the results pertaining to client preferences (including reasons for these preferences) and perceptions of the "ideal" therapist in relation to previously reported findings in this area of research. Results concerned with the effects of gender and sex-role orientation on factors derived from the two measures of psychological functioning, the CPI and PPRS, will then be discussed. Further analyses regarding the effects of these mental health measures on stated preference for sex of therapist will also be interpreted. The

implications of the finding that prior psychotherapeutic experiences did not appear to affect whether a subject stated a preference for a therapist of specific gender will be discussed. A final section will include a summary of these results as they have contributed to the area of gender-related psychotherapy research and the methodological limitations inherent in the current study. Recommendations for future research will be provided as well as the implications of the current findings to improving future psychotherapy practices.

Preferred Gender of Therapist and Attributes of the Ideal Therapist

The first issue to be addressed was whether clients entered therapy with a particular preference for the therapist's sex. Earlier research (e.g., Engleman, 1974; Jackson, 1972) had reported a preference for a male therapist (or physician). More recent researchers have reported a trend of female therapists becoming increasingly more acceptable and perhaps even preferred by clients (particularly female clients), (Brodsky, 1980; Simons & Helms, 1976; Walker & Stake, 1978). Another finding frequently reported in the analogue research (e.g., Briere & Lanktree, 1983a; Johnson, 1978; Littrell & Littrell, 1982) suggests that when confronted with a choice of therapists, subjects may prefer one of the same sex.

The current research revealed an actual tendency of almost one-half of the subjects (44.44%) to state a preference for the therapist's sex and more of these subjects stated a preference for a female therapist (64.44%) than stated a preference for a male therapist (35.56%). Although more men preferred a female therapist than preferred a male therapist, the sex of therapist difference is accounted for more by the fact that women who stated a preference were twice as likely to state a preference for a female therapist than for a male therapist. These findings support the view stated by Marecek and Johnson (1980) that when viewing such studies chronologically, it becomes quite apparent that the number of clients, especially women, who prefer female therapists is increasing. These writers also stated that the modal client does not have a preference for the gender of his or her therapist. In fact, the current research supports one of the other such studies investigating therapist preferences in clinical subjects (Davidson, 1976) in demonstrating that almost one half the sample (44.44%) did have a preference. The major difference between Davidson's findings and the current findings is that the proportion of preferences for a female was much greater in the current study while the number of subjects preferring a male was much less. Davidson reported that 35% of her total sample preferred male therapists but the present study found that 15.24% of the entire sample preferred a male therapist. In Davidson's study, 15% reported a preference

for a female therapist whereas a female therapist was preferred by 27.62% of the current sample (the remaining 1.58% stating a preference could not be accounted for due to missing data). In any event, over the eight years since Davidson reported her findings with comparable samples (predominantly white, middle income), the preference for male therapists decreased to less than one-half and the preference for a female therapist almost doubled. This finding certainly indicates, as previously suggested (e.g., Brodsky, 1980; Clopton & Haydel, 1982), that female therapists have become much more acceptable to male and female clients, with women expressing a clear preference for female therapists. This preference may also explain why female clients frequently report greater satisfaction and more positive therapy outcome with female therapists (Hill, 1975; Jones & Zoppel, 1982; Kirshner et al., 1978; Rice & Rice, 1973; Schaeffer & Abeles, 1977).

Some of the motives for these preferences will be elaborated subsequently, in reviewing the reasons endorsed by subjects. Also, it appears that subject characteristics, particularly sex-role orientation and sex-role attitudes (rather than simply, subject sex) are integrally related to such preferences.

Subjects of both sexes who had liberal attitudes toward women and were undifferentiated in sex-role orientation had the strongest preference for a female therapist.

Undifferentiated subjects who had conservative attitudes toward women had the strongest preference for a male therapist. Therefore, subjects with profeminist attitudes were more likely to prefer a female therapist, especially if they indicated a low endorsement of instrumental and expressive personality traits on the PAQ. With further post-hoc analyses, it was found that these undifferentiated-liberal subjects had a significantly greater preference for a female therapist than all groups except androgynous subjects, where the difference was non-significant. Androgynous subjects (whether liberal or conservative in their attitudes toward women) preferred a male therapist significantly less than conservative-undifferentiated subjects.

Some researchers have suggested that androgynous individuals incorporate behavioral flexibility (e.g., Bem, 1972, 1974, 1975; Bem & Lenney, 1976; Bem et al., 1976; Kelly & Worell, 1977). The suggestion (e.g., Johnson, 1978) that androgynous subjects may have no preference for therapist gender due to behavioral flexibility was not supported by these findings. Androgynous subjects tended to prefer a female therapist more often than a male therapist. This finding does suggest that androgynous subjects (regardless of their attitudes toward women) may be less critical of female psychotherapists than some other subjects, confirming results reported by Merluzzi and

Merluzzi (1981). The effect of such subject characteristics on perceptions of the "ideal" therapist will be discussed presently.

Subjects were asked to indicate reasons for their stated preference of therapist gender, using the list developed by Davidson (1976). One of the issues raised by her research involved whether attributions of therapist behaviour were related to the therapist's actual behaviour or the client's own sex-role stereotypic attitudes. "Feeling comfortable" and "attractiveness" were not attributes endorsed more by one group or the other (male therapist versus female therapist preferred) in the current study. In contrast, Davidson found that "feeling comfortable" was one of the most frequently checked reasons for preference of either sex of therapist. Davidson's finding that males and females expect to be able to "talk more freely" with a therapist of the same sex was confirmed with the present sample. Subjects expected that a therapist of the same sex would "understand my problems better". Intelligence was not checked significantly more by any group, perhaps because this is an attribute assumed to be present in a therapist. Davidson reported that among clients preferring a female therapist, men were more likely than women to cite the therapist's attractiveness and intelligence as reasons for their choice. Some of the discrepancies between Davidson's findings and those of the current study may be accounted for

by the fact that a female therapist was preferred to a much lesser degree by the earlier study, therefore, undoubtedly affecting the reasons endorsed by subjects.

The writer found that both "satisfactory" and "unsatisfactory" prior experiences with a therapist of a particular sex failed to significantly relate to preferences stated and were infrequently checked by subjects as reasons for their preference. Finally, " I prefer professionals of that sex in general" was differentially checked by subjects in an interesting manner. Undifferentiated subjects preferring a male and feminine or masculine subjects preferring a female therapist did not cite this reason at all. Perhaps feminine and masculine subjects who preferred a female did not feel that they had enough exposure to female professionals to endorse this statement. Feminine subjects who preferred a male therapist were most likely to check this reason. This finding suggests that subjects who perceive themselves as feminine (higher in expressiveness than instrumentality) and prefer a male therapist would support the stereotype that a male therapist is generally more competent.

Attributed characteristics of therapists as they are influenced by the subjects' sex, preferred sex of therapist, sex-role attitudes, sex-role preference, and presenting problems of subjects were explored further using the Counsellor Rating Form (Barak & LaCrosse, 1975). Due to the

controversy surrounding previous factor analyses of this measure and lack of data based on clinical subjects, factor analyses were performed on data provided by the 216 clinical subjects of the present study. Despite reports of three distinct factors: expertness, trustworthiness, and attractiveness (e.g., Barak & LaCrosse, 1975; LaCrosse & Barak, 1976), this factor structure was not supported by the current findings and does suggest that this assumed factor structure should be rejected. The existence of three orthogonal factors allegedly accounting for all the variance should not be applied, particularly to clinical subjects. Initially, a 10-factor solution resulted from the factor analysis. When a 3-factor solution was pursued (consistent with previous research suggesting fewer factors, e.g., Heesacker & Heppner, 1983), the actual factors bore very little resemblance to the supposed factors of "expertness", "trustworthiness", and "attractiveness". The first factor, Professional Competence (e.g., experienced, insightful, intelligent, prepared etc.), accounted for 68.8% of the variance originally accounted for by the 10 factors. These results support Heesacker and Heppner's (1983) findings which led to their conclusion that one major construct operates in the client's perceptions of counsellors. After this first factor, there was little comparability between the present factors and those reported by Barak and LaCrosse (1975).

The second factor, Agentic Instrumental Skills related to the factor of trustworthiness but was not that similar to the factor originally reported by Barak and LaCrosse. This factor also contained traits consistent with cultural norms for masculine behaviour. The third factor, Communal-Expressive Interpersonal Skills had a more feminine (as perceived in our culture) sense to it with high loadings on such traits as appreciative, attractive, close, compatible, believable, friendly, warm, likeable, open, and sociable. These results suggest that the factor structure of the CRF may not be identical with all populations and especially, that clinical subjects will rate their "ideal" therapist differently than college students will rate video tapes of psychotherapists. The method of administering the CRF in the current study (i.e., rating the "ideal" therapist) was quite different to the technique originally used by Barak and LaCrosse (subjects rating videotapes of therapists in an analogue design). However, researchers such as Leung (1984) who also used an analogue design, reported a factor structure quite discrepant from the 3-factor solution described by Barak and LaCrosse.

Further analyses were performed using these factors to determine the relationships of perceptions of therapists to other variables (e.g., preferred sex of therapist, sex-role orientation of subject, etc.). There were no significant relationships between the CRF factors and sex of subject or

preferred sex of therapist (see Hypothesis 4a). However, more complex relationships were tested in Hypothesis 4b, which revealed an interaction of sex-role orientation and preferred sex of therapist in relation to the three factors of "ideal" therapist traits. Feminine subjects who preferred a male therapist rated their "ideal" therapist highest of all groups on Agentic Interpersonal Skills (i.e., reliable, dependable, informed, friendly, honest). It appeared that subjects who were more dependent, submissive, and less instrumental in personality traits (characteristics of the feminine stereotypic role) preferred a male therapist who was "credible" and "competent" (Barak & LaCrosse, 1975; LaCrosse, 1980) yet someone they could depend upon. In contrast, masculine subjects preferring a female therapist (or having no preference) were more inclined to want a therapist high in Communal-Expressive Interpersonal Skills (i.e., appreciative, attractive,close, compatible, warm, sociable etc.). In some respects, these findings agree with those of Feldstein (1979, 1980) and Heilbrun (1976). They reported that men more than women rated their ideal therapist as having female sex-role stereotypic traits while women more than men rated their ideal therapist as having male sex-role sterotypic traits. Since in most cases,men are more likely to be masculine in sex-role orientation than are women, and women are more likely to be feminine, the current findings could be considered to be comparable to those reported by Feldstein. It is interesting, however,

that sex-role orientation was the salient variable here, and not merely gender of the subject as reported by previous researchers (e.g., Subich ,1983).

Both sex role of the client and the preferred gender of therapist should be taken into account when considering the type of therapist a prospective client prefers. Some subjects (depending on their sex-role orientation) have sex-role stereotypic expectations of a therapist determined by the therapist's gender. Although such an effect has been suggested in the literature (e.g., Feldstein, 1979, 1980; Johnson, 1978), studies have tended to be analogue in nature and often overlook the gender of the client and/or therapist, resulting in incomplete comparisons. This effect of stereotypic expectations is mitigated by the sex-role orientation of subjects, with feminine and masculine subjects having more stereotypic expectations than androgynous or undifferentiated subjects.

Certain limitations of this questionnaire should be mentioned at this time. The nature of the items is at times general or ambiguous (e.g., analytic-diffuse) sometimes leading to subjects excluding those items. The resulting factors overlap and, as reported by Corrigan and Schmidt (1983), there is a narrow range of responses on such items as aggreeable-disagreeable, undependable-dependable, inexperienced-experienced, in which one adjective is clearly negative and the other positive.

LaCrosse (1980) wrote that "expertness" may be the most powerful predictor of positive therapeutic outcome. This may well be true to the extent that all subjects to some extent would prefer that their therapist have these characteristics which load highly on the first factor and secondarily, on the second factor. However, masculine subjects who preferred a female therapist rated their "ideal" therapist lower than any other group, on the first two factors, Professional Competence and Agentic Instrumental Skills. So it would seem that individuals entering psychotherapy have different expectations and may not be necessarily looking for a therapist who is instrumental and "expert" in the traditional, masculine manner.

In summary, it was demonstrated that considerable overlap between the factors as well as differences within the factors (as compared to Barak & LaCrosse's 1975 factor structure) preclude an interpretation of the CRF as containing 3 distinct, orthogonal factors: expertness, trustworthiness, and attractiveness. Heesacker and Heppner's (1983) suggestion that these factors may be more distinct in subjects' expectations of therapist behaviour at the beginning of therapy was not supported. In addition, such expectations are affected considerably by an individual's sex-role orientation and the sex of therapist preferred. Perceptions and expectations of therapists have

been shown to be further influenced by factors relating to the individual's problems that s/he brings into the therapy relationship (e.g., Boulware & Holmes, 1970; Lee et al., 1980; Mezzano, 1971; Schneider et al., 1976). This area will be discussed in detail following the interpretation of results related to the adjustment and psychological problems measures.

It was shown in this investigation that subjects do not prefer a therapist who is female or male as a function of their previous experience with a therapist or co-therapist team. It is important to note, however, that more than half (53.70%) of the subjects had not been in therapy previously, so that this analysis was performed on only 100 subjects. Most of these individuals (60) had been involved in therapy with male therapists while only 28 subjects reported having a female therapist; thereby limiting the extent to which valid comparisons could be made with such unequal groups.

Effects of Gender, Sex-Role Orientation and Sex-role Attitudes on Adjustment and Presenting Problems

One of the major purposes of this investigation was to clarify the relationships of gender and sex-role orientation to psychological adjustment and presenting problems. The results in fact do elucidate how sex-role orientation, in particular, is integrally related to mental health and psychological distress. Before discussing these results,

however, it is essential that the results for the individual measures be interpreted.

Sex-Role Orientation and Sex-Role Attitudes

Women have typically scored higher than men on the femininity-expressiveness scale and men typically have scored higher than women on the masculinity-instrumentality scale on both of the most commonly used measures of sex-role orientation: the BSRI and PAQ (Bem, 1974; Spence & Helmreich, 1978). This has held true for "normal" samples of varying ages and socioeconomic status. The extent to which such findings occur among individuals seeking psychological treatment has been somewhat less clear, particularly in relation to actual medians on the subscales (masculinity, femininity) compared for women and men.

The present study found that women, in fact, had a higher median than men on both the masculinity and femininity scales. It was, therefore, not surprising that women were represented in the androgynous group (high femininity, high masculinity) more than in any other sex-role orientation category and that androgynous women outnumbered androgynous men. It was surprising, however, given previous research especially with clinical samples (Antill & Cunningham, 1979; Bernard, 1980; Berzins et al., 1978; Jones et al., 1978; Kelly, 1983; Kelly & Worell, 1977; Locksley & Colten, 1979; Taylor & Hall, 1982), to find that feminine women comprised

the smallest group for women. The largest group of men assigned to a sex-role orientation group occurred with the undifferentiated category (low masculinity-low femininity).

Previous researchers studied membership in sex-role orientation groups in relation to likelihood of seeking treatment in a psychological clinic. LaTorre and Gregoire (1977), for example, found that college students seeking psychotherapy were more androgynous than those students seeking medical treatment. This finding was confirmed for women seeking psychotherapy in the present study. LaTorre and Gregoire interpreted their finding as indicating that "confusion regarding role adoption" was related to subjects having greater psychological difficulties. Obviously, such a statement cannot be made without actually measuring psychological adjustments and presenting problems, as was done in the current investigation. It cannot be assumed that individuals seeking psychological treatment are automatically less well-adjusted or more troubled than those not seeking psychotherapy.

In terms of sex-role attitudes, women scored higher (were more profeminist) on the AWS than men, confirming previous findings (e.g., Goldberg et al., 1979; Spence & Helmreich, 1972; Spence et al., 1973). In fact, the means found in this study were comparable to those reported by Gilbert et al. (1979). In the present study, there were also (across both sexes) more conservative subjects (who scored below the

median) than liberal subjects. Although Zeldow and Greenberg (1979) reported that more conservative individuals are less inclined to seek help for psychological problems, 116 of the 216 subjects in the current sample were conservative. The AWS is, therefore, not necessarily a good predictor of who actually seeks help, as was suggested by Zeldow and Greenberg.

Psychological Adjustment and Presenting Problems

Before relating sex-role orientation and sex-role attributes to the measures of psychological functioning, the factors generated from the initial factor analyses will be discussed.

Four and sometimes five factors have been reported in many factor analyses of the California Psychological Inventory (Gynther & Gynther, 1976). Four factors resulted from the present factor analysis. The first factor was similar to the factor of "impulse management and socialization" and "interpersonal effectiveness" previously reported (Gynther & Gynther, 1976). In the present study, this factor was large in accounting for 42.8% of the total variance and was labelled General Adjustment. The second factor (accounting for 14.8% of the total variance) included scales related to "interpersonal effectiveness or even extraversion" (Gynther & Gynther, 1976): dominance, capacity for status, and socialization scales which were typically included on the second factor in previous factor analyses.

This factor, Mature Socialized Dominance, also included a high loading on sense of well-being. Sociability and self-acceptance did not load significantly on this factor as previously reported. The third factor, Confident-Outgoing, did not resemble the third factor of previous factor analyses (achievement via independence and intellectual efficiency were not included in the current investigation) which had also included flexibility and sometimes tolerance. This third factor of the present study included three scales of Gough's (1968) Class I, "measures of poise, ascendency, self-assurance, and interpersonal adequacy": dominance, sociability, and social presence, all somewhat related to the instrumental nature of masculinity. Dominance has been defined as involving "leadership ability"; sociability as an "outgoing, sociable, participative temperament"; and social presence as "poise, spontaneity, and self-confidence in personal and social interaction " (Gough, 1968). The fourth CPI factor, Other Orientation, included communality (also found on the fourth factor of previous factor analyses) relating to "internalization of conventional values" (Gynther & Gynther, 1976), responsibility, psychological-mindedness, and self-acceptance(which was negatively related to the other scales). This factor appears to measure a tendency to please others (to be responsive to others' needs) and to be selfless at the expense of a sense of personal worth and independent thinking or action (see Appendix A).

These factors had internal consistency, were reliable, and distinct from each other. In comparing the current factor analysis to previous factor analyses, it must be reiterated that the majority of previous analyses were based on nonclinical subjects. Further research using the CPI should incorporate factor analyses of data provided by clinical subjects. It is also important to remember that some differences could occur due to previous factor analyses using the full-version CPI scales.

Gender, Sex-Role Orientation, and Psychological Adjustment

Given the current controversy in the research concerning relative benefits of androgyny and masculinity to psychological adjustment, it was predicted that subjects high in masculinity or high in both masculinity and femininity (androgyny) would be better adjusted than subjects low in both masculinity and femininity (undifferentiated) and subjects low in masculinity and high in femininity (feminine). Such effects were expected to hold across sex with the qualification that androgyny could have unique benefits for women and less so, for men. An important finding of the current study which disagreed with much of the previous research (e.g., Gilbert et al., 1981; Jones et al., 1978) was that, on General Adjustment (the first CPI factor), androgynous subjects (male and female) scored significantly higher than all other groups of

subjects including masculine subjects of both sexes. Also, an unexpected finding was that feminine subjects were not significantly less well adjusted than masculine or undifferentiated subjects.

On the second CPI factor, Mature Socialized Dominance, undifferentiated and feminine subjects were significantly less adjusted than androgynous and masculine subjects of either sex, with no significant differences occurring between androgynous and masculine subjects. Although there is a quality of "interpersonal effectiveness" and "extraversion" (Gynther & Gynther, 1976) to this factor, masculine subjects who have been reported to exceed other groups in these areas (Gilbert et al., 1981; Kelly & Worell, 1977; Spence & Helmrich, 1978; Jones et al., 1978; O'Conner et al., 1978), did not rate themselves higher than other groups on this dimension. The current findings are consistent with previous research (Antill & Cunningham, 1979; Kelly et al., 1981; Orlofsky and Windle, 1978); Rodriquez et al., 1980); suggesting that androgynous individuals also have high self-esteem and effective social skills.

The third CPI factor, Confident-Outgoing, was the last factor to demonstrate significant relationships; i.e., significant differences between groups did not occur on Other Orientation. This factor was characterized by traits considered instrumental (masculine) in our culture:

dominance, sociability, and social presence. Relationships between scores on this factor and sex-role orientation groups were similar to those found with the second CPI factor. Feminine and undifferentiated subjects (both sexes) were significantly less adjusted than were androgynous and masculine subjects, again with no significant differences occurring within those pairs of groups.

When subject sex and sex-role orientation were considered together with therapist preference in relation to psychological adjustment as measured by the California Psychological Inventory (see Hypothesis 3b), some interesting relationships resulted. Significant differences occurred between women and men who were undifferentiated and women and men who were feminine. Feminine women were better adjusted than feminine men on the first two CPI factors, General Adjustment and Mature Socialized Dominance. Among undifferentiated subjects, men were significantly better adjusted on the third CPI factor, Confident-Outgoing. It is not surprising that feminine women are better adjusted than feminine men who are not only emitting behaviours that do not typically elicit social rewards (e.g., nurturance, responsivity, emotionality), but also are violating sex-role norms. Despite the low endorsement of sex-role traits by both sexes of undifferentiated subjects, it is possible that undifferentiated males (by virtue of the socialization process related to being male) have incorporated more of the traits of instrumentality inherent in the third CPI factor.

Baucom (1980) reported that masculinity and femininity scales derived from the CPI were differentially related to various CPI adjustment scales. The current results seem to indicate that masculine traits alone or masculinity paired with feminine traits benefit an individual most in terms of psychological adjustment. In the case of the first large factor of adjustment, those individuals who incorporated to a great extent both masculine and feminine traits were most adjusted. This finding confirms Spence et al.'s (1975) assertion that because masculinity and femininity relate positively to self-esteem and psychological adjustment that androgyny contributes a unique potential for general adjustment.

An important issue in this research, however, relates to the actual measurement of androgyny. Since no normative data were available for a large, comparable clinical sample, the medians which resulted from this current study were utilized in assigning subjects to sex-role orientation groups. This method is typical of most, if not all, research using sex-role orientation as an independent variable and obviously presents problems in terms of the generalizability and comparability of the results. There is a very real need for normative data based on large clinical samples using the PAQ so that "androgyny" in one sample is similar to "androgyny" in another.

Another issue relates to the question of why androgynous women were overrepresented in this clinical sample, given that androgyny apparently relates to superior psychological adjustment. To clarify this issue, it is appropriate to refer at this point to results occurring when sex-role orientation was not used as an independent variable (see Hypothesis 3a). These results indicated that when sex-role orientation was not taken into account, there were sex differences. Women scored significantly higher than men on General Adjustment and Other Orientation. This latter factor (communality, responsibility, psychological-mindedness, and self-acceptance which was negatively related) seemed to measure, as was earlier stated: a tendency to please others and to be responsive to others' needs which has been considered to be more typical of women in our culture (Baucom, 1980; Bem, 1974, 1975; Gilbert, 1981; Spence & Helmreich, 1978; 1980). Men were better adjusted on the Confident-Outgoing factor.

These findings appear to suggest that in terms of psychological adjustment, women in this sample entering psychotherapy were better adjusted than the men seeking treatment. To some extent, this difference can be explained by the medians that were found: i.e., women were higher on both masculinity and femininity than men, therefore making it more likely for women to be classified as androgynous. The fact that men had lower masculinity (an unusual finding)

also suggests that this sample of men is at higher risk for psychological problems, given the high value in a patriarchial culture placed on instrumental traits (e.g., Block, 1973; Gilbert, 1981; Gilbert et al., 1981; Jones et al., 1978) which they appear to be lacking to some extent. In addition, as was previously discussed, men who are feminine in personality orientation in the absence of masculine traits will also be at risk for psychological difficulties.

Several interpretations for these differences with respect to more adjusted women entering psychotherapy than men may apply to these results. Women who are not playing the traditional female role may be labelled as disordered (Boverman et al., 1970; Chesler, 1972; Kaplan, 1983; Sherman, 1980). They may also experience greater behavioural conflict (Kelly & Worell, 1977) with traditional sex-role standards continuing to be enforced. A response bias may prevail in our society, where women are expected to be more emotional than men and it is less stigmatizing for women to discuss emotional problems so that they are more willing to articulate such problems (Nathanson, 1975; Phillips & Segal, 1969). The view that has often been stated (Franks & Rothblum, 1983; Gove & Tudor, 1980) regarding the demands of traditional sex roles being more maladaptive for women than for men, and women having less control over their lives does not seem to apply particularly to the present sample.

However, women did have a higher degree of other orientation and lower degree of self-acceptance regardless of sex-role orientation, which could precipitate help-seeking behaviour. Sex-role orientation must be considered, nevertheless, in such theorizing.

It would seem that previous findings regarding the earlier entry of women into psychotherapy as compared to men have been supported by the current research. Kirshner et al. (1978) found that female college students sought help from the counselling service at an earlier stage of distress than did men. Kessler et al. (1981) found with extensive surveys that women were considerably more likely than men to recognize emotional problems thereby causing women to outnumber men in mental health facilities. They concluded that similar feelings of depression or distress are more likely to lead women to perceive themselves as having a psychological problem. It is possible that with a less acute sensitivity to emotional distress, men enter therapy only when they experience more severe problems.

Gender, Sex-Role Orientation, and Presenting Problems

With the relationships found in this study between gender, sex-role orientation, and adjustment, it is now necessary to turn to the effects of gender and sex-role orientation on presenting problems. First, the actual factors of the Personal Problems Rating Scale will be discussed.

Depression (both the individual item and depression-related symptoms on the first factor) was the most commonly reported problem while sexual and physical abuse was the least often reported problem area. Although subjects were informed several times that this research was confidential and anonymity of their responses would be maintained, it is quite likely that subjects did not wish to acknowledge a less socially acceptable problem area which they also may never have acknowledged to themselves (e.g., the code of secrecy related to incest), (Herman, 1981; Rush, 1980). The items included on this questionnaire were general in nature (rather than specifically focused on the symptoms related to a problem like sexual or physical abuse) and sampled several areas of psychological distress. Nevertheless, a significant finding was that a factor with high loadings of sexual/physical abuse and sex-role related issues emerged.

Generally, the PPRS separated through factor analysis into four relatively distinct factors involving clusters of problems focused in these areas: Identity-Depression, Career-Academic Role Functioning, Gender Related Issues, and Anxiety. Again (as with the adjustment analyses) when sex-role orientation was included in the analyses, no differences occurred in relation to just subject sex but instead, the results related to membership in sex-role orientation groups. Undifferentiated subjects were significantly more likely than masculine and androgynous

subjects to report having the problems found on the PPRS. Feminine subjects were also more likely to report these problems, in general, than were masculine subjects. This finding further supported the mental health advantages of androgyny, but also, instrumentality(masculinity) alone, especially in contrast to communality-expressivity (femininity) alone. No differences appeared in relation to Gender Related Issues or Career-Academic Role Functioning, as expected, so that relationships between sex-role orientation and problems in these areas were not distinguished. It is not entirely clear why this research failed to reveal such relationships. For example, masculine subjects (especially males) did not rate themselves as being more likely to discuss in therapy the more instrumental problems of Career-Academic Role Functioning (e.g., Kelly, 1983: Kelly & Worell, 1977). This could be explained by the high proportion of males in this sample who were not masculine-stereotyped.

While one cannot disregard the higher prevalence of such problems as depression in women (18 to 23% of all females versus 8 to 11% of all males as indicated in the DSM-III; American Psychiatric Association, 1980), many researchers (Jones et al.,1978; Kelly, 1983; Rosenfield, 1980) have reported sex-role orientation to be a much more salient factor than gender in the development of psychological problems. The current research also supports previous

analogue research (e.g., Baucom & Danker-Brown, 1979; Briere & Lanktree, 1983b) in which depression was related to sex-role orientation rather than sex, per se Furthermore, when gender was considered in isolation (without considering sex-role orientation) as recommended by researchers such as Kelly (1983), no gender effects were found in relation to self-reported psychological problems (see Hypothesis 3a).

The few studies which, thus far, have attempted to examine such effects (including gender and sex-role orientation) with clinical samples, have either failed to include both genders of subjects (Thomas & Reznikoff, 1984) or excluded a sex-role orientation group (e.g, masculine females in a study completed by Burchardt & Serbin, 1982) thereby limiting the comparisons that can be made to other empirical research. In any event, it would appear that androgynous and masculine subjects consistently report feeling less troubled with psychological problems than do undifferentiated and feminine subjects. It is also interesting that subjects of both sexes within a given sex-role orientation group were more alike than dissimilar. Baucom (1980) also reported that CPI profiles of women and men within each sex role were remarkable similar, although he assigned subjects to sex-role orientation groups using the masculinity and femininity scales derived from the CPI.

Briere and Lanktree (1983b) reported that masculine women (as well as undifferentiated and feminine women) were more

depressed on the Beck Depression Inventory than were androgynous women, whereas masculinity benefitted men in terms of reducing the risk of depression. Such sex differences were not found in the current investigation, perhaps because this was not a sample comprised only of college students, but included subjects from a range of age, educational, and socioeconomic backgrounds.

In summary, this research exploring the relationships of sex and sex-role orientation to psychological functioning provides empirical evidence for a strong relationship between sex-role orientation, adjustment, and risk of developing psychological problems. Androgyny provided similar benefits for men and women, in terms of greater psychological adjustment, social competence, and fewer psychological problems. In other instances, masculine and androgynous subjects of both sexes were equally better adjusted and less troubled than were undifferentiated and feminine subjects. Undifferentiated subjects were significantly more troubled, in many respects, than were both masculine and androgynous subjects. Subjects lacking in culturally sanctioned behaviours of either sex role may, in fact, be the most disordered group (Kelly et al., 1981) because "undifferentiated orientation ... should be related to ineffective handling of situations, since the individual is endorsing few desirable attributes of either kind" (Kelly, 1983, p. 16) culminating in their social incompetence (Burchardt & Serbin, 1982; Kelly, 1983).

These findings contrast with the common view that stereotypically feminine sex-role behaviour is particularly related to greater risk for psychological problems (Hare-Mustin, 1983; Kelly, 1983; Taylor & Hall, 1982). In summary, these results support the perspective that androgyny may provide benefits for both women and men in terms of psychological well-being. Nevertheless, caution must be exercised in interpreting these results beyond the definition of androgyny supported by Bem (1977), Berzins et al. (1978), Kelly and Worell (1976), Spence et al. (1974, 1975, 1979), Strahan (1975), and Worell (1978), i.e., high levels of both masculinity and femininity as measured by Spence and Helmreich's (1975) Personal Attributes Questionnaire.

Psychological Problems and Adjustment in Relation to Therapist Preferences

As was stated earlier, the type of presenting problem has been demonstrated extensively to influence preferences for a particular gender and type of therapist (e.g., Boulware & Holmes, 1970; Fuller, 1974; Haviland et al., 1983; Lee et al., 1980; Vice, 1975). Much of this previous research, however, was based on analogue studies with college students, was retrospective in nature, or included only women clients.

The present research explored this issue with clinical subjects using naturalistic means, by asking subjects prior to therapeutic contact, their preference for sex of therapist. These subjects stated therapist preferences differentially as a function of the type of problems they wished to discuss and not in relation to the level of psychological adjustment they experienced prior to therapy. When gender of subject and stated preference or lack of preference for sex of therapist were considered in relation to psychological problems reported, gender of subject was not important (see Hypothesis 3a). However, there was a main effect of preference for sex of therapist in relation to self-reported problems. The results were not in the expected direction; i.e., same-sex preferences for more personal problems versus no preference or preference for a male therapist for vocational/career-type problems (Fuller, 1964; Haviland et al., 1983; Lee et al., 1980; Vice, 1975). The current findings revealed that subjects who were likely to discuss Anxiety (PPRS factor 4) problems and Identity-Depression (PPRS factor 1) problems in therapy, stated a preference for therapist gender with no significant differences between a female or male therapist. In other words, subjects who were depressed and anxious stated a preference for the therapist's gender but the particular gender was nonsignificant. This could mean that when individuals are in greater distress, they have more specific needs with respect to the type of therapist they

prefer. So, for example, not only was it shown that feminine subjects preferring a male therapist wanted a therapist especially high in Agentic Instrumental Skills but that feminine subjects who were more anxious and depressed had a stronger preference for a male therapist. Therefore, sex-role orientation and type(s) of presenting problem(s) affected the preferred therapist of prospective clients. In comparing the current research to previous studies, the present study demonstrated that clients who stated a higher likelihood of discussing problems in therapy expressed a stronger preference for the sex of therapist while there was no relationship between type of problem and specific gender of therapist preferred by the client.

It was also surprising that there was no relationship between Gender Related Issues (sexual or physical abuse, sexual discrimination, rigidity of expectations of sex roles, etc.) and preferred sex of therapist. Previous research has found that women not only report these problems but often prefer a female therapist (Franks & Rothblum, 1983; Marecek & Johnson, 1980; Orlinsky & Howard, 1975, 1976; Simons & Helms, 1976). However, it was shown that sex-role orientation rather than gender per se is directly related to the development of certain problems. Perhaps more important in terms of this factor, the questionnaire included general items in the area of women's issues and might have produced some significant differences if the

items had been more specific to issues of wife battering, incest, sexual assault, etc. It is also likely that the Gender Related Issues that were included on this questionnaire were under-reported due to the tendency for clients to be less willing to discuss more sensitive issues as opposed to the "socially-acceptable" problems of anxiety and depression.

Summary of Primary Findings and Conclusions

It was found that, where such comparisons could be made (i.e., CRF, CPI), clinical subjects completed such forms differently than did nonclinical subjects. The current results, particularly with the Counsellor Rating Form, call into question previously held assumptions that this measure assesses ratings on three distinct, orthogonal dimensions: expertness, trustworthiness, and attractiveness. It was suggested that further research be directed at using such measures to assess clinical subjects' expectations and perceptions rather than generalizing from college students who are quite different in age, background, and investment in clinically-related issues. Furthermore, it was shown that responses on the PAQ provided by a clinical sample of individuals varying on age, education, and occupational factors (but more comparable to the general population) were quite different than those provided by college student samples. Previously, it was reported that the largest

proportion of women were feminine-typed and most males masculine-typed (e.g., Bem, 1974; Berzins et al., 1978; Spence & Helmreich, 1978). The present study did not support these findings, in that the largest group of women were androgynous and the largest group of men were undifferentiated.

As expected, more women than men participated in this study, reflecting the sex ratio of individuals seeking psychological services in most clinical settings. However, entry into treatment did not reflect greater dysfunction in women, as they exceeded men on a General Adjustment factor and a factor involving responsivity to others, although at the expense of self-acceptance. Also, a relationship was found between androgyny (which occurred more often in women) and better adjustment, as well as lower ratings on self-reported psychological problems (with some advantage of instrumentality alone occurring). These findings suggest, as Kirshner et al. (1978) reported, that women are more likely to seek psychological treatment at an earlier stage of distress than are men. It is also possible that as Broverman et al. (1970); Chesler (1972); and Kaplan (1983) have asserted, women who refuse to play the traditional female role may be labelled as disordered and may, therefore, seek treatment.

It is possible that the benefits of androgyny found in this research relate only to a certain group of people but

this is a much broader group than was previously studied (e.g., college student samples, upper middle-class subjects). The subjects in this study had a mean age of 32.5 years, almost half were married, and 58.80% had finished high school or had completed some college, suggesting that this was a fairly average, lower-middle-class to middle class population. As Baucom (1980), Kaplan (1976, 1979), and others have proposed, a changing culture may become gradually more accepting of instrumental and expressive behaviours in both sexes so that freedom from sex-role stereotypes may become the model of mental health for the future. In 1984, we may be experiencing, finally, a period of transition where such behaviour can become the ideal.

A third major area of findings is that, in contrast to previous findings usually based on analogue research, major differences in preferred sex of therapist did not occur principally in relation to the subject's gender. Preferred sex of therapist is a much more complex issue involving the interaction of several factors; sex-role orientation and presenting problems significantly affected the preferences that subjects expressed. Masculine subjects preferring a female therapist perceived their ideal therapist as communal and expressive while feminine subjects preferring a male therapist perceived their ideal therapist as agentic and instrumental. High levels of anxiety and depression also

were related to a greater preference for the sex of therapist. These findings do support the view (Bem, 1974; Brodsky & Hare-Mustin, 1980; Kelly, 1983; Marecek, 1979; Worell, 1978) suggesting the potential of sex-role orientation as a predictor of preferences and stated reasons for those preferences.

Androgyny also related to preferred sex of therapist in terms of a greater preference for a female therapist being expressed than generally across other groups, regardless of sex-role attitudes (liberal versus. conservative). Not only were androgynous subjects more accepting of women in a male-dominated profession (with liberal-undifferentiated subjects being the exception) but they also did not express extreme preferences, perhaps suggesting the behavioural flexibility that some researchers have described (e.g., Motowidle, 1982; Spence, 1979; Spence & Helmreich, 1979, 1980).

Preferences were also affected by the particular distress reported with subjects who reported greater anxiety or depression being more likely to state a preference for sex of therapist. Overall, these findings pointed to an increase in the tendency for clients (especially women) to prefer a female therapist. Also, this research confirms previous findings (e.g., Walker & Stake, 1978) that a significant proportion of clients entering therapy have a preference for the therapist's gender.

Despite the methodological limitations of this study, which will be elaborated below, expectancies of therapist behaviour and the existence of distinctive client preferences were found as well as some of the sex-role orientation factors related to psychological health. These findings were based on a large sample of subjects more representative of the general population at large (except on racial, socioeconomic factors) than was the case in previous research. Therefore, it is hoped that these findings indicate some important trends in individuals seeking psychotherapy.

Methodological Considerations of Present Investigation and Recommendations for Future Research

One of the most obvious considerations relates to the measures used in this research. The Counsellor Rating Form is not the sensitive measure of therapist behaviour that it has been purported to be. The Personal Problems Rating Scale proved to be an instrument which distinguished psychological problems into four distinctive, internally consistent areas. However, future research could extend the questionnaire in adding more specific items, particularly in relation to gender issues, when studying the effects of sex-role orientation. As mentioned previously, generalizations from these findings regarding the effects of sex-role orientation are further limited by this data's definition of androgyny. Future research should attempt to increase the base of normative data with clinical subjects.

Another issue which cannot be overlooked relates to the self-report nature of these measures. Although subjects' self-perceptions and perceptions/preferences of therapists are very important, more behavioual measures, particularly of sex-role orientation are required (Kelly, 1983). Perhaps, therapists' observations of clients could be used to validate these self-ratings in the future. Spence and Helmreich (1980) stressed that abilities, interests, attitudes, values, external pressures, relationships to significant others as well as expectations and behaviours of others must also be considered when assessing sex-role behaviours and preferences. Future research should attempt to assess the effects of these factors.

It is also important to recognize that the perceptions and effects reported in this study were relevant to a particular time for the client, prior to the actual psychotherapeutic process. Certainly, more information is needed regarding the expectancies with which clients enter psychotherapy, and more research is required to assess the relationship of such expectancies to process and outcome of therapy. The study of psychotherapy can be divided into three parts: 1) "the functional impacts to therapy, i.e., potential determinants of therapeutic process and the potential predictors of therapeutic outcome"; 2) the unfolding sequence of events and experiences that constitute psychotherapy as a systematic phenomenon"; 3) "future life and personal condition of the patient, ... the possible

consequences or effects of therapeutic process" (Orlinsky & Howard, 1980, p. 5). The current research has attempted to sample expectations and subjects characteristics at the particular point of time when a subject enters therapy. Obviously, whether these expectations are confirmed or disconfirmed will affect the process and outcome of therapy and warrants follow-up studies which can study such factors, including sex-role stereotyping (Brodsky & Hare-Mustin, 1980). Further, as suggested by Deaux (1984), such resarch could consider the choices subjects make as well as the process of interaction and sequences of expectancy confirmation within the therapeutic relationship. Observations of clients and therapists in interaction with each other could be made more directly with particular attention to the effects of gender, sex-role interaction, and race on these interactions.

As stated previously, sex-role and androgyny literature has relied upon "normal" college student samples using analogue adjustment paradigms. "An important goal for the 1980's may be to integrate more directly sex-role 'personality' research with research on clinical disorders" (Kelly, 1983, p. 24).

Implications and Recommendations for Mental Health Services

This research has clearly demonstrated that many clients do enter psychotherapy relationships with specific preferences concerning what they desire in a therapist. There may be benefits to soliciting such information from clients to reduce the tendency for professionals to view the client as a passive participant and to enhance the optimal conditions for therapeutic change. As clinical practice incorporates the use of such information provided by the client, research should observe the changes in these perceptions in relation to client-therapist interactions as well as the effects of such perceptions and preferences on therapeutic process and outcome. It is also important to keep in mind that in this sample, almost one half of the subjects stated a preference for the sex of therapist. There was no evidence of an anti-female bias but there was a strong indication of an emerging preference for a female therapist by both genders. However, most therapists are male and such preferences cannot be met with current resources. Therefore, greater efforts should be made to both encourage women into these helping professions but also to support them through their training with more female role models and attention to women's issues (as recommended by the American Psychological Association Task Force, 1975) so that this male-dominated profession will become less male-dominated.

Finally, clear evidence has been presented in

support of the benefits of incorporating expressive and instrumental personality traits for greater psychological adjustment and reduced risk of experiencing personal problems. This evidence, in contrast to insufficient evidence from previous research, does support androgyny as a potential model of mental health for both women and men. However, in a traditional culture, sex-role violations can reduce an individual's chances of receiving rewards (Kelly, 1983). Clients should be enlightened regarding the beneficial effects of androgyny over sex-typing, as well as the conflicts that they may encounter. Gilbert (1981) stressed the importance of discovering for oneself what behaviour is appropriate rather than being aware only of stereotypic socially appropriate behaviours one has been taught. It is imperative that therapists also evaluate the effects of cultural norms on their own behaviour as individuals, as well as therapists. A continuing goal for mental health practitioners should involve the pursuit of a conceptual base for integrating psychological androgyny and effective personal functioning rather than genderizing such human characteristics as expressiveness and instrumentality. In conclusion, as other researchers have stated (e.g., Gilbert, 1979; Kenworthy, 1979), androgyny is important in understanding effective personal functioning but is not a solution to institutional sexism and discrimination against women.

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Appendix A

California Psychological Inventory Scales and Purposes

Scale	Purpose
Class I. Measures of Poise, Ascendancy, Self-Assurance, and Interpersonal Adequacy	
Do (dominance)	To assess factors of leadership ability, dominance, persistence, and social initiative
Cs(capacity for status)	To serve as an index of an individual's capacity for status (not actual or achieved status). The scale attempts to measure the personal qualities and attributes which underlie and lead to status.
Sy (sociability)	To identify persons of outgoing, sociable, participative temperament.
Sp (social presence)	To assess factors such as poise, spontaneity, and self-confidence in personal and social interaction.
Sa (self-acceptance)	To assess factors such as sense of personal worth, self-acceptance, and capacity for independent thinking and action.
Wb (sense of well-being)	To identify persons who minimize their worries and complaints, and who are relatively free from self-doubt and disillusionment.
Class II. Measures of Socialization, Maturity, Responsibility and Intra-personal Structuring of Values	
Re (responsibility)	To identify persons of conscientious, responsible, and dependable disposition and temperament.
So (socialization)	To indicate the degree of social maturity, integrity, and rectitude which the individual has attained.
Sc (self-control)	To assess the degree and adequacy of self-regulation and self-control and freedom from impulsivity and self-centredness.
To (tolerance)	To identify persons with permissive, accepting, and non-judgemental social beliefs and attitude.

California Psychological Inventory Scales and Purposes

Scale	Purpose
Gi (good impression)	To identify persons capable of creating a favourable impression, and who are concerned about how others react to them.
Cm (Communality)	To indicate the degree to which an individual's reactions and responses correspond to the modal ("common") pattern established for the inventory.
Class III. Measures of Achievement Potential and Intellectual Efficency	
Ac (achievement via conformance)	To identify those factors of interest and motivation which facilitate achievement in any setting where conformance is a positive behaviour.
Ai (achievement via independence)	To identify those factors of interest and motivation which facilitate achievement in any setting where autonomy and independence are positive behaviours.
Ie (intellectual efficiency)	To indicate the degree of personal and intellectual efficiency which the individual has attained
Class IV. Measures of Intellectual and Interest Modes	
Py (psychological-mindedness)	To measure the degree to which the individual is interested in, and responsive to, the inner needs, motives, and experiences of others.
Fx (flexibility)	To indicate the degree of flexibility and adaptability of a person's thinking and social behaviour.
Fe (femininity)	To assess the masculinity or femininity of interests. (High scores indicate more feminine interests, low scores more masculine).

Appendix B

Demographic Information

You will be involved in a research project including several questionnaires. Only general results will be of interest and your identity will remain anonymous. All of your responses will be kept strictly confidential. For the purpose of relating your answers to general background information, please complete this form.

Sex: M _____ F _____

Age: _____

Marital Status: _____

Education: _____

Occupation: _____

Have you ever, at any time, been in psychotherapy? Yes _____ No _____

What sort of therapy was it? academic/vocational _____

individual psychotherapy _____

marital psychotherapy _____

family psychotherapy _____

other psychotherapy _____

If you have been in therapy, what was the sex of your last psychotherapist?

Male _____ Female _____

Both a male and a female therapist

Appendix C

Personal Attributes Questionnaire

The items below inquire about what kind of person you think you are. Each item consists of a pair of characteristics, with the letters A-E in between. For example: Not at all Artistic A....B....C....D....E Very Artistic

Each pair describes contradictory characteristics--that is, you cannot be both at the same time, such as very artistic and not at all artistic.

The letters form a scale between the two extremes. You are to choose a letter which describes where you fall on the scale. For example, if you think you have no artistic ability, you would choose A, if you think you are pretty good, you might choose D, and if you are only medium, you might choose C, and so forth. Please circle your answers.

1.	Not at all aggressive	A..B..C..D..E	Very aggressive
2.	Not at all independent	A..B..C..D..E	Very independent
3.	Not at all emotional	A..B..C..D..E	Very emotional
4.	Very submissive	A..B..C..D..E	Very dominant
5.	Not at all excitable in a major crisis	A..B..C..D..E	Very excitable in a major crisis
6.	Very passive	A..B..C..D..E	Very active
7.	Not at all able to devote self completely to others	A..B..C..D..E	Able to devote self completely to others
8.	Very rough	A..B..C..D..E	Very gentle
9.	Not at all helpful to others	A..B..C..D..E	Very helpful to others
10.	Not at all competitve	A..B..C..D..E	Very competitive
11.	Very home oriented	A..B..C..D..E	Very worldly
12.	Not at all kind	A..B..C..D..E	Very kind
13.	Indifferent to others' approval	A..B..C..D..E	Highly needful of others' approval
14.	Feelings not easily hurt	A..B..C..D..E	Feelings easily hurt
15.	Not at all aware of feelings of others	A..B..C..D..E	Very aware of feelings of others
16.	Can make decisions easily	A..B..C..D..E	Has difficulty making decisions
17.	Gives up very easily	A..B..C..D..E	Never gives up easily
18.	Never cries	A..B..C..D..E	Cries very easily
19.	Not at all self-confident	A..B..C..D..E	Very self-confident
20.	Feels very inferior	A..B..C..D..E	Feels very superior
21.	Not at all understanding of others	A..B..C..D..E	Very understanding of others
22.	Very cold in relations with others	A..B..C..D..E	Very warm in relations with others
23.	Very little need for security	A..B..C..D..E	Very strong need for security
24.	Goes to pieces under pressure	A..B..C..D..E	Stands up well under pressure

The Attitudes Toward Women Scale -Short Form

The statements listed below describe atttitudes toward the roles of women in society which different people have. There are no right or wrong answers, only opinions. You are asked to express your feeling about each statement by indicating whether you (A) agree strongly, (B) agree mildly, (C) disagree mildly, or (D) disagree strongly. (Circle the letter that best describes your feeling.)

1. Swearing and obscenity are more repulsive in the speech of a woman than a man.

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

2. Women should take increasing responsibility for leadership in solving the intellectual and social problems of the day.

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

3. Both husband and wife should be allowed the same grounds for divorce.

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

4. Telling dirty jokes should be mostly a masculine perogative.

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

5. Intoxication among women is worse than intoxication among men.

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

6. 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.

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

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

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

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

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

9. A woman should be as free as a man to propose marriage.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

17. Women should be encouraged not to become sexually intimate with anyone before marriage, even their fiance.

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

18. The husband should not be favoured by law over the wife in the disposal of family property or income.

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

19. Women should be concerned with their duties of childbearing and house tending, rather than with desires for professional and business careers.

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

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

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

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

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

22. On the average, women should be regarded as less capable of contributing to economic production than are men.

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

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

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

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

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

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

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

Appendix E

The Personal Problems Rating Scale

For each of the following problems, indicate whether this would be a problem that you would discuss with a therapist if you were ever in therapy. Place an X in the space which corresponds to how likely you feel it would be for you to talk about that problem.

1. Isolation/loneliness

Very likely ____ ____ ____ ____ ____ ____ ____ Not at all likely

2. Sexual problems

Very likely ____ ____ ____ ____ ____ ____ ____ Not at all likely

3. Drug or alcohol abuse

Very likely ____ ____ ____ ____ ____ ____ ____ Not at all likely

4. Academic problems (such as test anxiety, studying problems)

Very likely ____ ____ ____ ____ ____ ____ ____ Not at all likely

5. Difficulties making career choices

Very likely ____ ____ ____ ____ ____ ____ ____ Not at all likely

6. Physical problems related to nervousness, anxiety

Very likely ____ ____ ____ ____ ____ ____ ____ Not at all likely

7. Overeating, keeping weight down

Very likely ____ ____ ____ ____ ____ ____ ____ Not at all likely

8. Difficulties sleeping and having some appetite for food

Very likely ____ ____ ____ ____ ____ ____ ____ Not at all likely

9. Feeling anxious

Very likely ____ ____ ____ ____ ____ ____ ____ Not at all likely

10. Feeling low or depressed

Very likely ____ ____ ____ ____ ____ ____ ____ Not at all likely

11. Problems being assertive around other people, and expressing myself

Very likely ____ ____ ____ ____ ____ ____ ____ Not at all likely

12. Problems going on with living; feeling like I want to end it all

Very likely ____ ____ ____ ____ ____ ____ ____ Not at all likely

13. Rigid expectations of what a man or woman should be (particularly in relationships)

Very likely ____ ____ ____ ____ ____ ____ ____ Not at all likely

14. Sexual or physical abuse (including incest)

Very likely ____ ____ ____ ____ ____ ____ ____ Not at all likely

15. Problems with self-esteem and feeling insecure

Very likely ____ ____ ____ ____ ____ ____ ____ Not at all likely

16. Sexual discrimination; problems involving sexism (particularly at work or at school)

Very likely ____ ____ ____ ____ ____ ____ ____ Not at all likely

17. Difficulties controlling my temper

Very likely ____ ____ ____ ____ ____ ____ ____ Not at all likely

18. Problems getting along with others

Very likely ____ ____ ____ ____ ____ ____ ____ Not at all likely

19. Unusual thoughts or feelings

Very likely ____ ____ ____ ____ ____ ____ ____ Not at all likely

20. Fears of "going crazy"

Very likely ____ ____ ____ ____ ____ ____ ____ Not at all likely

21. Poor concentration or attention

Very likely ____ ____ ____ ____ ____ ____ ____ Not at all likely

22. Identity issues--"Who am I?"

Very likely ____ ____ ____ ____ ____ ____ ____ Not at all likely

23. Rapid mood changes

Very likely ____ ____ ____ ____ ____ ____ ____ Not at all likely

Appendix F

California Psychology Inventory

Directions: This booklet contains a series of statements. Read each one, decide how you feel about it, and then mark your answer on the special IBM answer sheet. Make no marks on the test booklet. If you agree with a statement, or feel that it is true about you, answer TRUE. If you disagree with a statement, or feel that it is not true about you, answer FALSE.

If you find a few questions which you cannot or prefer not to answer, they may be omitted. However, in marking your answers on the answer sheet, make sure that the number of the statement is the same as the number on the answer sheet.

1. I enjoy social gatherings just to be with people.
2. The only interesting part of the newspaper is the "funnies".
3. A person needs to "show off" a little now and then.
4. Our thinking would be a lot better off if we would just forget about words like "probably", "approximately", and "perhaps".
5. Some people exaggerate their troubles in order to get sympathy.
6. I often feel that I made a wrong choice in my occupation.
7. I always follow the rule: business before pleasure.
8. I would like to be a journalist.
9. I think I would like the work of a building contractor.
10. I have had very peculiar and strange experiences.
11. My daily life is full of things that keep me interested.
12. It makes me feel like a failure when I hear of the success of someone I know well.
13. I gossip a little at times.
14. I tend to be on my guard with people who are somewhat more friendly than I had expected.
15. When I was going to school I played hooky quite often.
16. It is hard for me to start a conversation with strangers.
17. For most questions there is just one right answer, once a person is able to get all the facts.

18. I sometimes pretend to know more than I really do.

19. Sometimes I feel like smashing things.

20. Women should not be allowed to drink in cocktail bars.

21. When someone does me a wrong I feel I should pay him back if I can, just for the principle of the thing.

22. I seem to be about as capable and smart as most others around me.

23. I find it hard to keep my mind on a task or job.

24. The trouble with many people is that they don't take things seriously enough.

25. I have often met people who were supposed to be experts who were no better than I.

26. I liked school.

27. I think Lincoln was greater than Washington.

28. A windstorm terrifies me.

29. Sometimes I feel like swearing.

30. I am embarrassed by dirty stories.

31. Sometimes I cross the street just to avoid meeting someone.

32. I used to keep a diary.

33. When I get bored I like to stir up some excitement.

34. I like to boast about my achievements every now and then.

35. Most of the arguments or quarrels I get into are over matters of principle.

36. Once a week or oftener I feel suddenly hot all over, without apparent cause.

37. Sometimes I think of things too bad to talk about.

38. I would do almost anything on a dare.

39. With things going as they are, it's pretty hard to keep up hope of amounting to something.

40. I cannot keep my mind on one thing.

41. I must admit that I often do as little work as I can get by with.

42. I like to be the centre of attention.

43. I like to listen to symphony orchestra concerts on the radio.

44. I can be friendly with people who do things which I consider wrong.

45. I have no dread of going into a room by myself where other people have already gathered and are talking.

46. When in a group of people I have trouble thinking of the right things to talk about.

47. I set a high standard for myself and I feel others should do the same.

48. School teachers complain a lot about their pay, but it seems to me that they get as much as they deserve.

49. At times I feel like picking a fist fight with someone.

50. Sometimes I have the same dream over and over.

51. It is annoying to listen to a lecturer who cannot seem to make up his mind as to what he really believes.

52. I don't blame anyone for trying to grab all he can get in this world.

53. I believe we are made better by the trials and hardships of life.

54. I do not always tell the truth.

55. I was a slow learner in school.

56. I like poetry.

57. I think I am stricter about right and wrong than most people.

58. I am likely not to speak to people until they speak to me.

59. It takes a lot of argument to convince most people of the truth.

60. I feel as good now as I ever have.

61. It makes me uncomfortable to put on a stunt at a party even when others are doing the same sort of thing.

62. Most people make friends because friends are likely to be useful to them.

63. I wish I were not bothered by thoughts about sex.

64. I seldom or never have dizzy spells.

65. It is all right to get around the law if you don't actually break it.

66. Most people will use somewhat unfair means to gain profit or an advantage rather than to lose it.

67. I like to be with a crowd who play jokes on one another.

68. I am somewhat afraid of the dark.

69. I have a tendency to give up easily when I meet difficult problems.

70. I would like to wear expensive clothes.

71. I believe women should have as much sexual freedom as men.

72. Criticism or scolding makes me very uncomfortable.

73. I have strange and peculiar thoughts.

74. If I am not feeling well I am somewhat cross and grouchy.

75. I frequently notice my hand shakes when I try to do something.

76. Every citizen should take the time to find out about national affairs, even if it means giving up some personal pleasures.

77. I like parties and socials.

78. My parents have often disapproved of my friends.

79. I should like to belong to several clubs or lodges.

80. My home life was always happy.

81. I often act on the spur of the moment without stopping to think.

82. I do not have a great fear of snakes.

83. My way of doing things is apt to be misunderstood by others.

84. I never make judgements about people until I am sure of the facts.

85. I commonly wonder what hidden reason another person may have for doing something nice for me.

86. I am certainly lacking in self-confidence.

87. When I work on a committee I like to take charge of things.

88. Sometimes I feel as if I must injure either myself or someone else.

89. I have had more than my share of things to worry about.

90. I often do whatever makes me feel cheerful here and now, even at the cost of some distant goal.

91. I am inclined to take things hard.

92. I am quite often not in on the gossip and talk of the group I belong to.

93. I can remember "playing sick" to get out of something.

94. Once in a while I laugh at a dirty joke.

95. Before I do something I try to consider how my friends will react to it.

96. I would like to be a soldier.

97. In a group of people I would not be embarrassed to be called upon to start a discussion or give an opinion about something I know well.

98. If given the chance I would make a good leader of people.

99. I enjoy a race or game better when I bet on it.

100. I have often found people jealous of my good ideas, just because they had not thought of them first.

101. Sometimes at elections I vote for men about whom I know very little.

102. I like to go to parties and other affairs where there is lots of loud fun.

103. Most people are honest chiefly through fear of being caught.

104. I very much like hunting.

105. I have frequently found myself, when alone, pondering such abstract problems as freewill, evil, etc.

106. I have never been in trouble with the law.

107. In school I was sometimes sent to the principal for cutting up.

108. I think I would like the work of a librarian.

109. I love to go to dances.

110. Most people inwardly dislike putting themselves out to help other people.

111. I feel uneasy indoors.

112. I usually expect to succeed in things I do.

113. Most people worry too much about sex.

114. It is hard for me to find anything to talk about when I meet a new person.

115. I like to read about history.

116. I am apt to show off in some way if I get the chance.

117. A person does not need to worry about other people if only he looks after himself.

118. We ought to pay our elected officials better than we do.

119. I can honestly say that I do not really mind paying my taxes because I feel that's one of the things I can do for what I get from the community.

120. I am so touchy on some subjects that I can't talk about them.

121. The future is too uncertain for a person to make serious plans.

122. I would like to be a nurse.

123. The man who provides temptation by leaving valuable property unprotected is about as much to blame for its theft as the one who steals it.

124. I am a good mixer.

125. I am often bothered by useless thoughts which keep running through my mind.

126. If I were a reporter I would like very much to report news of the theater.

127. Most of the time I feel happy.

128. I like mechanics magazines.

129. I like large, noisy parties.

130. I often feel as though I have done something wrong or wicked.

131. In school I found it very hard to talk before the class.

132. I usually feel that life is worthwhile.

133. I think most people would lie to get ahead.

134. I am a better talker than a listener.

135. I like science.

136. I am bothered by people outside, on streetcars, in stores, etc., watching me.

137. Sometimes I rather enjoy going against the rules and doing things I'm not supposed to.

138. I have very few quarrels with members of my family.

139. If I get too much change in a store, I always give it back.

140. I enjoy many different kinds of play and recreation.

141. I like to read about science.

142. It is hard for me to act natural when I am with new people.

143. I refuse to play some games because I am not good at them.

144. I have never done anything dangerous for the thrill of it.

145. As a youngster I was suspended from school one or more times for cutting up.

146. I used to like it very much when one of my papers was read to the class in school.

147. I feel that I have often been punished without cause.

148. I would like to be an actor on the stage or in the movies.

149. At times I have a strong urge to do something harmful or shocking.

150. I often get feelings like crawling, burning, tingling, or "going to sleep" in different parts of my body.

151. I don't seem to care what happens to me.

152. Police cars should be especially marked so that you can always see them coming.

153. When the community makes a decision, it is up to a person to help carry it out even if he had been against it.

154. I have nightmares every few nights.

155. If I am driving a car, I try to keep others from passing me.

156. I have a great deal of stomach trouble.

157. I have been afraid of things or people that I knew could not hurt me.

158. I would rather have people dislike me than look down on me.

159. Any man who is able and willing to work hard has a good chance of succeeding.

160. I hardly ever feel pain in the back of the neck.

161. My parents wanted me to "make good" in the world.

162. I almost never go to sleep.

163. Voting is nothing but a nuisance.

164. Everything tastes the same.

165. I often start things I never finish.

166. Education is more important than most people think.

167. Sometimes I used to feel that I would like to leave home.

168. Much of the time my head seems to hurt all over.

169. I never worry about my looks.

170. My people treat me more like a child than a grown-up.

171. In school most teachers treated me fairly and honestly.

172. I usually try to do what is expected of me, and to avoid criticism.

173. A person should not be expected to do anything for his community unless he is paid for it.

174. Some of my family have habits that bother and annoy me very much.

175. No one seems to understand me.

176. I dream frequently about things that are best kept to myself.

177. I think I am usually a leader in my group.

178. I seem to do things that I regret more often than other people do.

179. I have reason for feeling jealous of one or more members of my family.

180. My table manners are not quite as good at home as when I am out in company.

181. I would never go out of my way to help another person if it meant giving up some personal pleasure.

182. I doubt if anyone is really happy.

183. I am known as a hard and steady worker.

184. I usually have to stop and think before I act even in trifling matters.

185. It is pretty easy for people to win arguments with me.

186. I know who is responsible for most of my troubles.

187. I get pretty discouraged with the law when a smart lawyer gets a criminal free.

188. I have not lived the right kind of life.

189. I have used alcohol excessively.

190. Life usually hands me a pretty raw deal.

191. Most young people get too much education.

192. I regard the right to speak my mind as very important.

193. I am bothered by acid stomach several times a week.

194. I get all the sympathy I should.

195. The things some of my family have done have frightened me.

196. I am troubled by attacks of nausea and vomiting.

197. If I saw some children hurting another child, I am sure I would try to make them stop.

198. Almost every day something happens to frighten me.

199. My family has objected to the kind of work I do, or plan to do.

200. There seems to be a lump in my throat much of the time.

201. I have more trouble concentrating than others seem to have.

202. A person is better off if he doesn't trust anyone.

203. People who seem unsure and uncertain about things make me feel uncomfortable.

Appendix G

This is a research form. You do not have to fill it in, but your cooperation would be appreciated.

Therapist Preference Form

Imagine that you are going to a therapist to talk about yourself, think about how you would feel about the sex of the therapist. Please answer the following questions. Circle the black dot that best corresponds to your feeling.

If I were seeing a therapist, my preference as far as the sex of the therapist would be:

Male Therapist			No Preference			Female Therapist
(-3)	(-2)	(-1)	(0)	(+1)	(+2)	(+3)
strong preference	moderate preference	slight preference		slight preference	moderate preference	strong preference

If you indicated any preference at all, please check those reasons that influenced your choice.

_____ 1. I would feel more comfortable in the presence of a person of that sex.

_____ 2. A person of that sex would be more attractive to me personally.

_____ 3. I could talk more freely about my problems.

_____ 4. A person of that sex would understand my problems better.

_____ 5. A person of that sex would probably be very intelligent.

_____ 6. Past experience with professionals of that sex has been satisfactory.

_____ 7. I prefer professionals of that sex in general.

_____ 8. Past experience with professionals of the other sex has been unsatisfactory.

_____ 9. Other _____

Appendix H

Counsellor Rating Form for the "Ideal" Therapist

Listed below are several scales which contain word pairs at either end of the scale and seven spaces between the pairs. Please rate the way the "ideal" counsellor would be for you (disregarding theoretical orientation).

If you feel that the "ideal" counsellor very closely resembles the word at one end of the scale, place a check mark as follows:

fair ___: ___: ___: ___: ___:___: ___: _X_ unfair

OR

fair _X_: ___: ___: ___: ___: ___: ___: ___ unfair

If you think that one end of the scale quite closely describes the "ideal" therapist then make your check mark as follows:

rough ___: _X_: ___: ___: ___: ___: ___: ___ smooth

OR

rough ___: ___: ___: ___: ___: _X_: ___: ___ smooth

If you feel that one end of the scale only slightly describes the "ideal" therapist, then check the scale as follows:

active ___: ___: _X_: ___: ___: ___: ___: ___ passive

OR

active ___: ___: ___: ___: ___: _X_: ___: ___ passive

If both sides of the scale seem equally associated with your feelings of the way the "ideal" therapist is or if the scale is irrelevant, then place a check mark in the middle space:

hard ___: ___: ___: _X_: ___: ___: ___: ___ soft

Your first impression is the best answer.

PLEASE NOTE: PLACE CHECK MARKS IN THE MIDDLE OF THE SPACES

agreeable ___: ___: ___: ___: ___: ___: ___ disagreeable

unalert ___: ___: ___: ___: ___: ___: ___ alert

analytic ___: ___: ___: ___: ___: ___: ___ diffuse

unappreciative ___: ___: ___: ___: ___: ___: ___ appreciative

attractive ___: ___: ___: ___: ___: ___: ___ unattractive

casual ___: ___: ___: ___: ___: ___: ___ formal

cheerful ___: ___: ___: ___: ___: ___: ___ depressed

vague ___: ___: ___: ___: ___: ___: ___ clear

distant ___: ___: ___: ___: ___: ___: ___ close

compatible ___: ___: ___: ___: ___: ___: ___ incompatible

unsure ___: ___: ___: ___: ___: ___: ___ confident

suspicious ___: ___: ___: ___: ___: ___: ___ believable

undependable ___: ___: ___: ___: ___: ___: ___ dependable

indifferent ___: ___: ___: ___: ___: ___: ___ enthusiastic

inexperienced ___: ___: ___: ___: ___: ___: ___ experienced

inexpert ___: ___: ___: ___: ___: ___: ___ expert

unfriendly ___: ___: ___: ___: ___: ___: ___ friendly

honest ___: ___: ___: ___: ___: ___: ___ dishonest

informed ___: ___: ___: ___: ___: ___: ___ ignorant

insightful ___: ___: ___: ___: ___: ___: ___ insightless

stupid ___: ___: ___: ___: ___: ___: ___ intelligent

unlikeable ___: ___: ___: ___: ___: ___: ___ likeable

logical ___: ___: ___: ___: ___: ___: ___ illogical

open ___: ___: ___: ___: ___: ___: ___ closed

prepared ___: ___: ___: ___: ___: ___: ___ unprepared

unreliable ___: ___: ___: ___: ___: ___: ___ reliable

disrespectful ___: ___: ___: ___: ___: ___: ___ respectful

irresponsible ___: ___: ___: ___: ___: ___: ___ responsible

selfless ___: ___: ___: ___: ___: ___: ___ selfish

sincere ___: ___: ___: ___: ___: ___: ___ insincere

skillful ___: ___: ___: ___: ___: ___: ___ unskillful

sociable ___: ___: ___: ___: ___: ___: ___ unsociable

deceitful ___: ___: ___: ___: ___: ___: ___ straightforward

trustworthy ___: ___: ___: ___: ___: ___: ___ untrustworthy

genuine ___: ___: ___: ___: ___: ___: ___ phony

warm ___: ___: ___: ___: ___: ___: ___ cold

Appendix I

Description of Research and Request for Participation

Hello, my name is _____. I am assisting a graduate student in Clinical Psychology, in her dissertation research which she is doing with people like yourself who are being seen at the Psychological Service Centre.

What we would like for you to do is to take this package of questionnaires home and fill them out in relation to your feelings and impressions. Your responses will be kept strictly confidential and separate from your therapy (or any contacts) at the P.S.C. In no way will your answers affect the treatment that you receive. However, we hope that this research will benefit future clients at the P.S.C. in the treatment that they receive.

It is important that you participate in this research, if at all possible. If you do decide to participate and return all the forms with your responses, we will provide you with a small token of our appreciation ($3). This will in no way entirely compensate for your time and effort but in a small way will represent our gratitude for your participation.

I will be phoning you in the next week at which time I will answer any questions you might have. You can return the package to the P.S.C. when you have your next scheduled session or mail it in with the enclosed stamped envelope. It is very important that we receive your complete questionnaires at your earliest convenience.

Thank you very much for your co-operation.

Appendix J

Cover Letter to Subjects

Dear P.S.C. Client:

As a graduate student in clinical psychology, I am requesting that you participate in a research project I am engaged in for my doctoral dissertation. Although this research will not directly affect your present therapy, it is our hope that the information gathered from this research will benefit people who are treated in the future at the P.S.C. and elsewhere. Participation is entirely voluntary but your time and effort in completing these questionnaires will be very much appreciated.

The package includes questionnaires consisting of checklists and statements which you will answer in terms of how they relate to yourself. Instructions are included with each questionnaire. Please complete all the forms. While we certainly do not have enough funds to pay you adequately for your time, we would like to give you 3 dollars as a token of our appreciation for completing the forms. All your responses will be kept completely confidential. We are not interested in the individual's responses but rather, how people generally answer such questionnaires. Only general results of this research will be available. If you would like to receive such feedback, please indicate below:

_____ Yes, I would like to receive general results of this research.

Could you take some time now to answer the questionnaires? An addressed envelope is enclosed in which you can return the questionnaire to the Psychological Service Centre.

Thank you very much for your co-operation.

Cheryl B. Lanktree, M.A.
Clinical Psychology Ph.D. Student

John R. Schallow, Ph.D., Research Advisor
Director of Clinical Training
Associate Professor, Dept. of Psychology
University of Manitoba