1995

Gender Role Versus Work Role: Differing Stresses for Male and Female Psychotherapists?

Julie G. Coplon

Loyola University Chicago

LOYOLA UNIVERSITY CHICAGO

GENDER ROLE VERSUS WORK ROLE:
DIFFERING STRESSES FOR MALE AND FEMALE PSYCHOTHERAPISTS?

A DISSERTATION SUBMITTED TO

THE FACULTY OF THE SCHOOL OF SOCIAL WORK

IN CANDIDACY FOR THE DEGREE OF

DOCTOR OF SOCIAL WORK

BY

JULIE G. COPLON

CHICAGO, ILLINOIS

MAY 1995

ACKNOWLEDGMENTS

I would like to thank my advisor, Dr. Randolph Lucente, for his continued support throughout this project. His good ideas and his good humor helped me to keep going. I would like to thank Dr. Jack Kavanagh for his enormous help with the statistical analysis. I would like to thank Dr. Joseph Walsh and Dr. Sandra Condon for reviewing this project so thoughtfully.

I would like to thank my sister, Bari Attis, for always being there for me. I would like to thank my dear friend and mentor, Judy Bertacchi, for teaching me so much. Dissertation research is a lonely endeavor. I was very lucky to have been able to share the joys and travails of this project with these two women.

Many people provided invaluable help during the course of this project. I would especially like to thank Dr. Wendy Goldberg Gilmore who helped me with the research design. I would like to thank Ellen Kenemore who helped me implement the research design.

I want to thank my friends Randy Barrengos, Karen Benson, Maggie Gibbs and Adina Keesom for allowing me to be unavailable for a very long time.

To Whitman

TABLE OF CONTENTS

LIST OF ILLUSTRATIONS

LIST OF TABLES

Table | Page

CHAPTER 1

THE EMPIRICAL QUESTION

Introduction to the Problem

This study was an exploratory investigation into the impact of a psychotherapist's gender on his or her work as a psychotherapist. How is the process of doing psychotherapy different for male and female therapists? In what way are psychotherapists affected by being male or being female?

Historically, males and females have been socialized to assume different roles in American culture (Solomon 1982).[1] Female socialization, stereotypically, has revolved around the demands of motherhood, and male socialization, stereotypically, has been in preparation for being a "good soldier" (Jordan et al. 1991). These cultural norms, mediated through family structure, lead to somewhat different psychological developmental pathways for boys and girls. Male development is organized around separation and individuation from a different sexed parent, and female development is organized around self-in-relation to a same sexed parent (Chodorow 1978; Jordan et al. 1991).

---

[1] Male and female gender norms are not homogeneous throughout American society, but vary according to class, race, religion and ethnicity. Theory and research typically reflect a white, middle class bias (O'Neil 1982).

Social institutions reinforce these gender arrangements (Miller 1976). The psychological, the cultural, and the political interact with each other to reproduce remarkably stable gender relations regardless of the expansion of female participation into all social institutions.

Thus, women are still the primary caretakers of children even though they may also work. A mother is expected to take care of children and earns the title "working mother" when she is also employed. There is no corresponding title of "caretaking father." As portrayed in the movies, a father who stays home to take care of his children is called "Mr. Mom."

In terms of soldiering, the ban on women in combat positions in this country is still being negotiated. Trained and skilled female pilots have been precluded from flying combat missions. Instead, they have been given the job of training men for the positions that they themselves are not allowed to occupy.

Given that society is highly gendered, gender identity functions as a central, organizing principle of identity (Schachtel 1986; Bernardez 1987; Kaplan 1987). Other aspects of the self are incorporated into the self as male or female. Thus, identity as a psychotherapist is incorporated into the gendered identity of the self as male or female.

The self as psychotherapist has been referred to as the professional self, the second self, and the work ego

(Fliess 1942). The function of psychotherapy, to facilitate growth and development through a uniquely structured relationship, creates tension between the work role and the gender role of the psychotherapist (Schachtel 1986).

Gender role incorporates cultural and personal norms and imperatives regarding how men and women are expected to think, feel, and act. These gender expectations play an organizing function in terms of how identity is consolidated. The role of psychotherapist, however, calls for the suspension of gender role as if it were a component of identity rather than one of the organizing principles of identity.

Changes in the conceptualization of the psychotherapeutic relationship emphasizing psychotherapy as a two-person field (Mitchell 1988) highlight the interplay of work role and gender role in the psychotherapist. The psychotherapist is no longer viewed as the proverbial blank screen but as an active participant using conscious and unconscious processes just as the patient does (Racker 1968). Aspects of relationship and relatedness have assumed a place of importance alongside the more classical emphasis on content interpretations. Empathy becomes understood as central to the therapeutic process (Basch 1983).

Some of the literature has suggested that women are more prepared for the role of psychotherapist than men because of the importance of empathy and nurturance, both in

female development and in doing psychotherapy (Carter 1971). Implicit in this is the assumption that female developmental processes (both psychological and cultural) prepare women to be organized around relationships and caretaking and that these orientations and abilities are useful in doing psychotherapy.

Yet a psychotherapist is not a caretaker, and the imperatives of both jobs differ in important ways. If women are especially suited to doing psychotherapy, are there also ways in which they are particularly stressed by the differences between their gender role of caretaker and the role of psychotherapist? Are there ways in which men are particularly suited to be psychotherapists and ways in which they are particularly stressed by the work?

How do male and female psychotherapists differ in the stress they experience in doing psychotherapy? Does the therapist's gender role make the demand of the work role (doing psychotherapy) different for men and for women? That is the research question posed by this study.

Purpose of the Study

Gender is an important dynamic in all interpersonal relationships, yet little is known concerning its impact on the relationship between psychotherapist and patient. Most studies have focused on the impact of patient gender on diagnosis and treatment, but very few studies have investi-

gated how psychotherapists are affected by their own gender identity.

There are several reasons for this lack. It is hard to isolate the effects of gender because they are typically confounded by the effects of variables such as professional discipline, experience level, practice setting, etc. There are also political constraints to creating dichotomous male/female categories of analysis which historically have seemed to stereotype and stigmatize women.

However, the greatest constraint is the difficulty of identifying the impact of gender in a meaningful way. Professional training and socialization lead to the development of competent professionals who are capable of doing their job regardless of gender. The essential nature and process of doing psychotherapy is likely to be the same for both male and female psychotherapists. This is especially likely to be true for experienced professionals.

Yet common sense tells us that men and women relate in different ways and have differing expectations for themselves based on the imperatives of gender role.[2] This shared cultural understanding of the imperatives of gender role is reflected in Dumb Blonde Jokes and Dumb Men Jokes. "Why is there always a female astronaut? So when the ship

---

[2] Thus, there is a gap between our methodological abilities to identify the impact of gender and our assumptions about gender differences that are based on social observation and lived experience.

is lost in space, someone will ask directions." Everyone knows that men don't ask directions.

How can the impact of gender role on the work role of a psychotherapist be researched? This study will use the concept of stress as a way to investigate the tension between gender role and work role. Stress is conceptualized, in this study, as a therapist's response to uncomfortable feelings evoked in him/her by a clinical interaction. It can be normal and manageable but requires a certain expenditure of energy on the part of the therapist.

Study Rationale: Relevance to Social Work

Research on the impact of gender in the clinical process is relevant to social work because: (1) it contributes to the understanding of the impact of social structure on individual identity; (2) it contributes to the understanding of the complexity of the therapeutic relationship; and (3) it has implications for social work training and supervision.

Social work, as a mental health discipline, has been unique in its recognition of the interconnectedness of intrapsychic, interpersonal, cultural and environmental dynamics. But more is known about these domains categorically than about how they interface. If gender is an organizing dynamic of personality, then gender is inherently a dynamic in all relationships, including professional relationships.

In clinical social work, the professional relationship has always been recognized as central to the therapeutic process (Perlman 1957). Yet very little is known about how a therapist's gender impacts this process. Because of this, gender is not addressed in social work training and supervision. Training and supervision take place as if therapists were not gendered. If this study contributes to the understanding of therapists as gendered human beings, then gender-based countertransference reactions can be more readily identified and ameliorated.[3]

The influence of the Women's Movement of the 1970's and the publication of new theories of female psychological development (Miller 1976; Chodorow 1978; Gilligan 1982) spurred both interest and controversy in social work regarding gender. Attempts were made to understand many aspects of social work using Gilligan's theory.[4] Her theory was used to analyze: the rift between clinical work and research/academia in social work (Davis 1985); ethical judgments of male and female social workers (Dobrin 1989); differences between male and female therapists in making clinical ethical judgments (Johnson and Stone 1989); and the heritage of the social work profession (Rhodes 1985).

---

[3]See Review of the Literature on Women as Therapists for a discussion of Bernadez's (1987) concept of cultural countertransference.

[4]See Review of the Literature on Female Psychological Development for a discussion of Gilligan's research.

The widespread application of Gilligan's theory, often stereotyped as females operating from a mode of responsibilities and males operating from a mode of rights, brought a heated response from feminist social workers (Gould 1988; Fleck-Henderson 1990). Central to their argument was the rejection of dichotomous male-female categories of analysis. These categories were rejected on both analytical grounds (gender was too intertwined with cultural and political factors to be meaningful as an independent variable) and on political grounds (the use of male-female categories served to perpetuate discrimination against women).

Implicit to these arguments were two assumptions: (1) descriptive categories first become accepted as normative, then as prescriptive; and (2) social work's commitment to equality should be reflected in all aspects of the profession and theory should be evaluated according to its political implications.[5]

In social work, the importance of the therapeutic relationship as a process of mutuality has always been recognized as has the need to understand individuals as embodying social as well as intrapsychic dynamics (Perlman

---

[5]Gould (1988), in her article critiquing Gilligan's theory, states, "The discussion is followed by a rationale for considering an alternative vision-a feminist rather than a strictly feminine vision-that can provide a prescriptive rather than a descriptive model for restructuring professional and social reality." By substituting a prescriptive for a descriptive model, theory-building becomes a political act.

1957). With this analytic frame, gender is no longer a variable in the therapeutic process, but the process itself is gendered. Kaplan (1987) elaborates this concept:

> I am suggesting that we think about therapy in a way that we are not accustomed to doing - to think about patients and therapists as being gendered, women or men. This is not to say that there is a direct, one-to-one correspondence between gender and personality. Clearly not all men are alike, nor are all women. But we do live in a highly gendered society, with strong norms about appropriate modes of being for men and women. However, regardless of the extent to which we consciously accept or reject these norms, we act in some relation to them and are experienced by others in relation to them.

In summary, there has been little social work research concerning gender and psychotherapy. As with all social science research, it is difficult to study differences (in this case, the nature and meaning of gender differences in psychotherapy) without running the risk of analytic categories becoming reified. Because any research regarding gender has potential political implications, such research is particularly relevant to social work with its dual identity as a discipline focusing on the individual in relation to society and as a service profession committed to social change.

The Research Question and Operational Hypotheses

This study looked at whether or not certain aspects of the process of psychotherapy were more stressful for male psychotherapists than for female psychotherapists, and vice versa, depending on the fit with gender role.

In the study, stress referred to a specific clinical episode during which a therapist managed uncomfortable feelings evoked in him/her by a client. The stress was neither chronic, nor acute. It was normal and manageable, but the process of managing uncomfortable feelings required a certain expenditure of energy on the part of the therapist.

The Research Question

Is there a difference between the clinical situations that stress male psychotherapists and the clinical situations that stress female psychotherapists?

Conceptualization of the Research Question

The research question was investigated using a quasi-experimental design. Four clinical situations were chosen to be the experimental conditions. Videotaped vignettes were made of actors role-playing clients in each of these four clinical situations. These videotapes were then shown to male and female psychotherapists to measure their reactions to them.

The four different clinical situations making up the experimental conditions around which the research was designed were: (1) an alliance rupture indicated by a client's anger at his/her therapist; (2) when a client, or his/her material, was sexually interesting; (3) when a client seemed very needy and tried to elicit relief from his/her therapist; and (4) when a client was vague or ambig-

uous such that the therapist was unable to discern the meaning of the client's communication.

During an alliance rupture, a client might be angry at the therapist, dislike him/her, not want to talk to him/her. A client might even prematurely walk out of a session. Therapists are trained to tolerate such moments. They typically understand such moments diagnostically, i.e., what they convey about the client's transference, psychopathology and/or phase of treatment. Therapists use clinical judgments to decide how to respond in these moments. However, therapists, as men and women, have their own feelings and conflicts which may be touched in these moments. Being the recipient of someone else's anger may evoke a variety of feelings in the therapist.

There are many different situations whereby a client may be sexually stimulating to a therapist. The client may do this purposely, or it may be unintentional. The client may be conscious of his/her own sexuality, or may not have any awareness that he/she is being sexually stimulating. Some clients are very physically attractive. Therapists may find themselves sexually attracted to these clients even if the clients are not concerned with sexual material or their own sexuality. While sexual feelings toward clients may be natural, the taboos against relating sexually toward clients are such that therapists may not experience these feelings as acceptable.

Sometimes clients turn to their therapists for direct relief from their suffering. Rather than being able to be introspective, a client will want the therapist to do something to make him/her feel better. Clients may exhibit this type of behavior for all sorts of reasons. When clients want their therapists to do or say something to relieve their anxiety and make them feel better, they are trying (actively or passively) to enlist their therapists into relinquishing an interpretative mode. The client's feeling of helplessness raises the question of who (the client or the therapist) will solve the problem at hand.

There are times when a therapist does not know what a client is talking about, or why a client is telling him/her something. The content may be clear while the meaning of the communication is obscure. This is different from situations in which a therapist can readily ask for clarification. In these situations, the client is seemingly involved in what he/she is saying. The therapist would need to abruptly interrupt the client to ask for clarification. A therapist, therefore, is likely to allow the communication to continue while not understanding the point of the communication. Sometimes a therapist is not aware that such a situation is taking place, but, instead, finds him/herself bored or his/her attention drifting. Sometimes a therapist finds himself thinking, "why is he telling me this?" or "what is she talking about?"

The clinical situations depicted in this study are average, expectable clinical situations. The theory literature suggests that the toleration of ambiguity and the preoccupation with maintaining relationships has gender-linked meaning (Gilligan 1982; Jordan et al. 1991). Research investigating therapists' feelings in relation to their patients' feelings has found female therapists most distressed by their patients' dependency feelings and male therapists most distressed when their patients' are experiencing disturbing sexual feelings (Howard, Orlinsky and Hill 1969).

The Operational Hypotheses

1. Male therapists will experience more uncomfortable feelings than female therapists in reaction to a client who is ambiguous.

2. Male therapists will experience more uncomfortable feelings than female therapists in reaction to sexual stimulation from a client.

3. Female therapists will experience more uncomfortable feelings than male therapists in reaction to a client's seeking relief from the therapist.

4. Female therapists will experience more uncomfortable feelings than male therapists in reaction to an alliance rupture in the therapeutic relationship.

Assumptions

While this was an exploratory study, a quasi-experimental design was chosen for several reasons. The assumption was made that gender role imperatives are organizers of personality, unconscious, and socially adaptive. A therapist is likely to be either unaware of the existence of tension between gender role and work role (resulting in therapeutic blind spots) or be aware of tension and attribute it to psychopathology on the part of the therapist. It was assumed that therapists are therefore unable to volunteer information about the impact of their being male or female on their work as psychotherapists.

Social work is a female-dominated profession. Male clinical social workers are the minority in their profession.[6] It is possible that male clinical social workers, as a self-selected group, differ from the stereotypical male gender role norms. However, it was an assumption of this study that differences between male and female social workers could be investigated despite the broad spectrum of differences within each gender.

A third assumption of this study was that ambiguity, sexual stimulation, dependency, and alliance ruptures have gender-linked meanings. It is possible that the research

---

[6]In 1991, fewer than twenty-three percent of the social workers belonging to the National Association of Social Workers were male (Gibelman and Schervish 1993).

question of this study had merit but was incorrectly operationalized into these particular clinical situations.

While this study is hypothesizing the existence of tension between work role and gender role, it was an assumption of this study that the existence of such a conflict does not impair a social worker's general competence or professional judgment. This study assumed that male and female social workers are competent professionals who abide by the profession's Code of Ethics.[7]

---

[7]The National Federation of Societies for Clinical Social Work states in its Code of Ethics: "Clinical social workers maintain high standards of the profession in all of their professional roles. Clinical social workers value professional competence, objectivity and integrity. They consistently examine, use, and attempt to expand the knowledge upon which practice is based, working to ensure that their services are used appropriately and accepting responsibility for the consequences of their work."

CHAPTER 2

REVIEW OF THE LITERATURE

Literature on Sex and Gender Differences

Attempts to understand sex and gender differences have been made by various disciplines using a variety of research methods. Biology, psychology, sociology and anthropology have each approached the question from a different analytic perspective (Notman and Nadelson 1991). The complexity of the question is beyond the current state of research methodology in each discipline. Hence, finding a meaningful method of investigation within each discipline is still the task at hand. Attempts to understand the interrelationship of the biological, the psychological, the sociological and the cultural have been theoretical and not empirical. Very little of this has been done.

The question of sex and gender differences has often been raised out of political motivations. Special interest groups have looked for a "bedrock" truth that would justify preserving the status quo or would justify changing the status quo (depending on which special interest group was doing the research). Hence, research into sex and gender differences has often been undertaken in support of ideology (be it social, political, religious, or whatever). "Sex-biased assumptions are found in all stages of the research

process: how questions are asked; the ways variables are conceptualized, measured, and labeled; the design and analysis of results; and the interpretation of findings" (Russo 1991). Who did the research, why they did it, and how they did it, must be analyzed as well as the findings of the empirical investigation.[8]

The complexity of the issue is evident. What are valid basic categories of investigation and analysis? The terms "sex" and "gender" are sometimes used interchangeably in discussion, yet "sex" typically refers to the biological (i.e., chromosomal, hormonal, or physiological). "Gender" typically refers to membership in the socially constructed groups of "man" or "woman," i.e., behaviors, characteristics, or identity (West and Zimmerman 1987; Bleier 1991).

While using "sex" and "gender" interchangeably adds to the confusion, separating them resurrects the old debate between nature and nurture. Also, the biological given of sex is not always biologically given, but is, at times, socially constructed. With the condition of testicular feminization, an individual has a male chromosomal pattern and genitalia that appear female. Some of these individuals

---

[8]Nineteenth century scientists looked for measurable differences between the brains of men and the brains of women to prove the inferiority of women. The smaller size of women's brains was then taken as evidence of their intellectual inferiority (Bleier 1991).

have been raised as males, and some of them have been raised as females (Notman and Nadelson 1991).[9]

Increased understanding of the brain's chemistry has led to further confirmation of the artificiality of dichotomously categorizing biological and experiential factors (McEwen 1991; Notman and Nadelson 1991). Both result in biochemical processes taking place in the brain. All mental activity is ultimately organic, regardless of whether the original stimulus was biological (i.e., hormonal) or experiential (i.e., stress). Nerve cell structure and function can be temporarily or permanently altered by experience, as in learning (McEwen 1991). The experiential changes the biological, which then has an effect on the experiential, and on and on and on. Thus, there is always intertwining of endogenous and exogenous factors.

While those seeking to find enduring and fundamental differences between males and females often turned to biology, those seeking to identify the influence of culture on sex and gender differences often turned to anthropology. According to LeVine (1991):

> In the case of institutionalized gender roles, however, only central tendencies among human societies can be related to male and female capacities, and we continue to learn of interesting exceptions, unpredictable from any theoretical premise except one that makes the

---

[9]The individuals raised as males were found to have a predominantly masculine style, and the individuals raised as females were found to have a predominantly feminine style (Notman and Nadelson 1991).

realization of capacities heavily dependent on social and cultural conditions.

In summary, little is definitively known about sex and gender differences. Biology has identified differences in the reproductive capacities of men and women. These start with different chromosomal makeup and different hormonal processes pre- and postnatally, and result in visibly different physiology. Anthropology has identified the existence of gender differentiated norms in most cultures (though these differ from culture to culture), with the mother primarily responsible for care of infants. What research has illuminated is the complexity of the question and the enduring interplay between the biological, the psychological, the social, and the cultural.

Literature on Gender and Psychotherapy

A landmark study relating to gender bias in psychotherapy was done by Broverman et. al. (1970). In this study, male and female clinicians were asked to describe: (1) a healthy adult, sex unspecified; (2) a healthy man; and (3) a healthy woman. As predicted, the description of a healthy adult resembled the description of a healthy man, but differed from the description of a healthy woman. In interpreting these results, the authors speculated that men

and women were raised to fulfill different social roles[10] and that health was judged vis-a-vis the adjustment to society. This became known as the double standard of health.

In a follow-up study, Miller (1974) found no sex bias in clinical diagnosis but a significant sex bias in treatment recommendations. Though passivity was diagnosed as a significant problem using both male and female patient analogues, it was chosen as a focus of treatment only for the male patient. Thus, Miller's results reinforced the Broverman et. al. findings.

However, in a 1976 analogue study, Gomes and Abramowitz (1976) looked at four variables: (1) patient sex; (2) role-appropriateness; (3) therapist sex; and (4) sex-role traditionalism. They found no evidence that any of these four variables were sources of clinical bias. In another analogue study of sex bias (Billingsley 1977), therapists responded to the client's pathology, rather than to the client's sex, in formulating treatment goals. However, the clients' pathologies in this analogue study were severe and clearly defined. Whether therapists' responses to mild and/or vaguely defined pathology would be the same was not known. Billingsley did, however, have an unexplained finding concerning the therapist's gender: male

---

[10]Male and female social roles are not equally valued by society. Female social roles and stereotypic female qualities are those associated with children.

therapists formulated more feminine treatment goals for their clients, and female therapists formulated more masculine treatment goals.

Research following up the issue of sex-role stereotyping found significant stereotyping by social work students in 1967 and in 1973-74, but less sex-role stereotyping in 1976 (Festinger and Bounds 1977). Davenport and Reims (1978) added the variables of theoretical orientation and sex of the therapist to the sex-role stereotyping research. They found no difference in attitudes toward women based on theoretical differences, but a significant difference in attitudes toward women based on sex of the therapist. Male therapists held traditional views of women, and female therapists held contemporary views. A later analogue study (Bernstein and Lecomte 1982) found client gender had no impact on therapists' diagnosis, prognosis and treatment plan. However, therapists' gender, profession, and level of experience all showed significant impact on therapists' judgments.

Replications of studies done over time failed to validate the original Broverman results. However, during that same time period much attention was focused on women's issues. How that influenced the changes in clinicians' judgments and the differences that began to be found in male and female clinicians' attitudes and judgments is not known. What seems clear from the research, however inconclusive the

particular results, is that therapists and patients alike are part of the social fabric and resonate with the social and cultural norms of their times. During periods of social change, these issues are likely to be heightened.

Attempts to use gender as a predictor of outcome have been unsuccessful (Hill 1975; Orlinsky and Howard 1979; Brooks 1981; Jones and Zoppel 1982; Mogul 1982). The therapy relationship is much too complex to look for a single variable as the determinant of treatment success. As Mogul (1982) summed up, "Due to the large number of patient, therapist, and therapy variables with any therapy dyad, numerical research on patient populations regarding the effects of therapist gender has rendered little of definitive or predictive value."

The literature concerning how gender affects transference and/or countertransference approaches the issue in the following ways: (1) should gender affect assignment or referral (Kulish 1984); (2) does gender of the therapist affect the nature of the transference (Felton 1986; Kulish 1989); and (3) does gender of the therapist and/or patient affect the countertransference (Ruderman 1986; Eastwood, Spielvogel and Wile 1990; Lester 1990).

These clinical and research reports used vignettes anecdotally to illustrate the various ways gender impacts on the treatment relationship. Each vignette illustrated a different, and sometimes contradictory, effect of gender.

For example, in Kulish's (1989) interviews with female analysts, some analysts reported paternal transferences were rare; some analysts reported experiencing paternal transferences; and one female analyst felt that labeling transferences as paternal or maternal is misleading since transference is a fluid and dynamic phenomenon.

It seems clear that gender does have an impact, but it cannot be easily categorized. Kulish (1989) concluded her research by stating, "Gender may serve as a basic, unconscious organizing factor around which clinical material is experienced, processed, understood, and interpreted." Reaching similar conclusions, Lester (1990) wrote, "We maintain that gender, being a major organizer in early years, remains a crucial modifier, a key element of patterned form in the continuous processing of perception throughout life."

In summary, attempts to catalogue the impact of gender on psychotherapy process and outcome have led most authors to the same conclusion. It is difficult to understand the impact of gender as an independent variable since the psychotherapeutic process, like all relationships, is itself, gendered.

Literature on Gender and Stress

Stress is best understood as a process, unfolding over time and including biological, psychological and social variables. The experience of stress is also affected by

variables such as resiliency, cognitive coping strategies, and support networks. Each of these variables, however, is too complex to be explanatory within itself. For example, it was assumed that women were somewhat buffered against stress, relative to men, because of their more extensive support networks. Yet recent research has indicated that women are more affected than men by events that happen to those throughout their network (Wethington, McLeod and Kessler 1987). Women are also burdened by providing support to those in their network (Belle 1987). Thus, social networks are both sources of support and sources of stress for women.

Men are assumed to be stressed by their role in the workplace. Research has investigated work as a source of stress but without examining work as a source of gratification or examining the importance of nonwork roles in men's lives (Barnett and Baruch 1987). It was assumed that women would become more stressed as they began entering the work force. Yet research indicates that multiple roles are a source of well-being for both men and women and that women get physiological and psychological benefits from paid work (Barnett and Baruch 1987).

Whether a situation is stressful, and to what degree, seems to depend on the meaning of that experience as well as on the experience itself. That men are more depressed by the strains at work and women are more depressed by marital

problems is explained by the value placed on the two domains for each gender by the culture (Aneshensel and Pearlin 1987). The subjective aspects of stress are thus important to understanding the gender effects. The same role or situation, such as being overweight, may have very different meaning to males and females (Barnett, Beiner and Baruch 1987).

The research on gender and stress is in its infancy and mainly elucidates the complexity of the variables involved and the limitations of current methodology. What is known is that women suffer more from depression and anxiety than do men, and yet women live longer (Barnett, Biener and Baruch 1987). While there is no clear understanding of why women are more depressed yet live longer, one theory is that this seeming paradox reflects the stress of gender roles in this culture. The masculine norm of being strong and stoic precludes emotional expressiveness, which has known physiological consequences. The female norm of being dependent, nonassertive, and concerned with the needs of others leads to a relinquishing of control, which also has known psychological consequences (Barnett, Beiner and Baruch 1987).

Literature on the Stress of Doing Psychotherapy

Burnout has been an important issue in the human services profession. It is a concept referring to a state of personal and professional depletion whereby the stresses

of human service provision have accumulated to a level causing serious impairment of functioning (Farber 1983). Yet most occupational stress for psychotherapists does not reach this dimension. What is the nature of the stress that interferes with optimal functioning? What about stressful aspects of doing psychotherapy that may be mastered, but at a certain personal expenditure of energy?

Recent research and clinical reports addressing the issue of stress have focused on the nature of clinical work itself. Freudenberger and Robbins (1979) used the concept of occupational hazards to describe the stresses inherent in being a psychoanalyst. They described six potential sources of stress: (1) taking care of the needs of others can interfere with responsiveness to friends and family; (2) being the recipient of transference reactions and being involved in the affective life of patients can leave the analyst feeling depleted and/or too full of feelings; (3) the need to contain all reactions and modify them to fit the needs of the patient can lead to loss of self for the analyst; (4) financial pressures can lead to relating to the analytic work strictly in terms of money; (5) personal issues of the analyst can be activated by the transference; and (6) the power of the position can provoke reactions of narcissism, grandiosity and/or omniscience.[11]

---

[11]Presumably, psychotherapists, as well as psychoanalysts, are subject to some or all of these stresses.

In a research study that empirically validated some of Freudenberger and Robbins' observations, Farber and Heifetz (1981) sampled a group of social workers, psychologists and psychiatrists to identify the satisfactions and stresses of psychotherapeutic work. Two of the stressful aspects of the work[12] identified were: (1) the tendency for the role of psychotherapist to extend beyond its proper limits, resulting in the susceptibility of the therapist to physical and emotional depletion, and (2) the difficulty of maintaining equilibrium between involvement and objectivity. These findings were replicated in a study by Hellman, Morrison and Abramowitz (1986).

Central to these stresses of clinical work are the tensions between personal feelings and professional imperatives. Professional work based on an intimate relationship necessitates the maintenance of permeable boundaries between the personal and the professional (Schachtel 1986). This interface is inherently a source of difficulty.

The other area of focus in the literature on stress concerns specific patient behaviors that are difficult for therapists. There have been more replications of studies in this area, and there is more consensus of findings. The patient behaviors identified as stressful by several studies (Farber and Heifetz 1981; Deutsch 1984; Hellman, Morrison,

---

[12]Stressful aspects of patient behaviors are identified separately.

and Abramowitz 1986) include: (1) suicidal statements; (2) expression of aggression or hostility toward the therapist; (3) severe depression; (4) apparent apathy or lack of motivation; and (5) premature termination. Four of these five behaviors are actually communications of particular affective states on the part of patients. None of these studies indicated why a patient's expression of affect caused stress for the therapist.

In the research on the stress of doing psychotherapy, breakdown of results by gender has not been systematic and the differences found have been more confusing than clarifying. In one study, personal depletion was experienced more by females than by males and patient resistances were less stressful for males than for females, but gender was confounded with profession and level of experience (Farber and Heifetz 1981). In a factor analysis study, females indicated more stress in four out of seven categories: (1) frustrations with clients; (2) competency doubts; (3) emotional control; and (4) minimal client involvement (Deutsch 1984). Neither of these studies reported any categories of stress experienced more by male therapists than by females. Deutsch wondered whether her findings indicated that women were actually more stressed by the work or merely more willing to acknowledge their stress (Deutsch 1984).

In a study of therapists' feelings conducted by Howard, Orlinsky and Hill (1969), male and female therapists differed in terms of the frequency of certain feelings experienced during therapy.[13] Male therapists more often felt intimate, attracted, playful, inadequate, preoccupied, detached, withdrawn, bored, angry, discouraged, disappointed, dull, and need to relieve bladder. The authors categorized these feelings as, "unpleasant feelings or feelings particularly responsive to the hetero-sexual composition of the relationship." A factor analysis of the data showed males scoring higher on "uneasy intimacy," "resigned," and "withdrawn." Females scored higher on "involved".

In correlating therapists' feelings with patients' feelings, female therapists seemed to be most distressed by their patients' strong dependency demands, whether expressed passively or intrusively. Female therapists seemed to feel threatened by their patients' dependency demands in a way that male therapists did not.

Male therapists were most distressed by their patients' discomfort with erotic transferences. When female patients were struggling against erotic feelings toward their male therapists, the male therapists were also experiencing sexual feelings. Though sexual feelings were not talked about and were not considered relevant to the treat-

---

[13]This study used only female patients. How patient gender affects the feelings evoked in male and female therapists is not known.

ment relationship, they seemed to be in the room and experienced, with discomfort, by both patient and therapist. Howard et. al. (1969) describe this phenomenon as if both patient and therapist were feeling, "What's wrong with me? I shouldn't be having these thoughts and feelings."

This study did not account for the differences between the situations that evoked the most discomfort in male therapists and the situations that evoked the most discomfort in female therapists. The authors did wonder whether therapists were most uncomfortable when their patients were experiencing feelings that the therapists, themselves, struggled against.

Schachtel (1986) identified the tension between gender role and work role as a major source of stress for psychotherapists. Doing psychotherapy requires therapists: to have permeable self/other boundaries; to enter the world of their patients' feelings; and to tolerate the press of patients' feelings without acting to relieve discomfort. These therapeutic imperatives are different from gender norms which prescribe differing roles for males and females in their responsiveness to the feelings of others. These gender expectations are not merely in psychotherapists but are also in patients, leading patients to have differing reactions to the same behavior by a male and a female psychotherapist.

In summary, there is very little research on the nature of stress experienced by psychotherapists. However, the literature does suggest that: stress relates to the feelings evoked in psychotherapists in reaction to their patients' feelings; the feelings evoked in male psychotherapists are different from the feelings evoked in female psychotherapists; and aspects of the clinical situation that are stressful for male psychotherapists differ from those that are stressful for female psychotherapists.

Literature on Female Psychological Development

Theories of female psychological development that have been put forth during the last twenty years have questioned the validity of classical psychoanalytic developmental theories. Writers such as Miller (1976), Chodorow (1978), and Gilligan (1982) have argued that classical theories were based exclusively on male experience. The use of male experience to explain human development was inadequate for conceptualizing female experience. Both male and female experience must be accounted for in any comprehensive theory of human development.

These more recent theories of female psychological development have posited different developmental paths for girls and for boys. Unlike Freud's theory, in which psychological differences were seen as the inevitable outcome of anatomical differences, these theories focus on the impact

of interpersonal relationships and social structure on psychological development.

Miller's (1976) analysis placed female psychological development in a political context, namely women as the oppressed group in a hierarchically organized society. Many stereotypically female traits are then explained as characteristics of a subordinate group (i.e. race, class). For example, woman's intuition, according to Miller, simply reflects the necessity of the subordinate group being able to read nuances of behavior of the dominant class.

The less valued tasks of society, both public and private, are assigned to subordinates in service to the dominant society. The less valued tasks assigned to women have to do with emotional and physical needs, sexuality, caretaking, etc. However, these are natural aspects of all human experience. Miller contends that by assigning these functions to women, men have alienated themselves from fundamental aspects of their own nature.

For a society to be stable, it must have a way of reproducing itself. Proceeding from this premise, Chodorow (1978) asked the question, "how is it that women come to mother?" Chodorow's analysis placed mothering in a historical, sociological context. The sexual division of labor is a social construct resulting from the industrial revolution. Men were relegated to the public sphere of production

(work) and women were relegated to the private sphere of home (relation to family).

Chodorow used a psychoanalytic object relations point of view to describe psychological development. For girls, relationship to mother was characterized by sameness and diffusion of boundaries. For boys, the relationship to mother was characterized by differences. These object relationships were then reinforced by the family structure and by the larger society. Masculinity was defined as being not feminine and taking one's place in the public, economic domain. Femininity was defined by relatedness to others.

Chodorow was describing how social roles led to gender-linked, intrapsychic organization, which then led boys and girls to the assumption of social roles. Hence, girls grew into mothers not only by social learning, or by simple identification, but because of an internal need for primary relatedness that could only be re-established by becoming a mother.

According to Chodorow's analysis, inequality of the sexes was the result of the economic and social structuring of society which was reflected in the structure of family life. But this inequality was reproduced, not through external coercion and constraints, but through the internalized object relations that resulted from women's mothering. Chodorow contends that inequality between the sexes can

change only if there is a basic change in parenting relationships.[14]

Building upon the work of Miller and Chodorow, Gilligan (1982) approached the question of gender by looking at theories of moral development. Freud theorized that women's moral development was inferior to that of men because women do not have penises. Hence, there is no threat of castration to insure a clear resolution of the oedipal crisis leading to the fixed establishment of the superego. In Kohlberg's studies of moral development, females did not score as high as males. Theories of human development and research methods to study development were based on male development, according to Gilligan. These theories and these studies always found women wanting since the paradigm for understanding women was exclusively male.

Gilligan studied the moral development of girls and boys and posited a two-track sequence of moral development leading to a mode of rights and to a mode of responsibilities. The mode of rights, more typically associated with a masculine emphasis on separation and independence, is based on an ethic of fairness and equality. It is abstract. It reflects the concept that justice is blind. The mode of responsibility, more typically associated with a feminine emphasis on connection and relationships, is based on an

---

[14]Perhaps, this speaks to the reason that women's increased participation in social and economic institutions has not changed the basic gender organization of society.

ethic of care and equity. Justice can only be reached by understanding the context of the situation, by knowing who will be hurt and what will be the repercussions of the actions taken.

Central to these theories of female development were three premises: (1) psychological development and identity formation are gendered processes; (2) female psychological development can be analyzed and understood only in the context of social structure; and (3) the intrapsychic meaning of relationships differs for men and for women because of their differing positions in the larger social structure.

A common theme in classical theories is the value attached to separateness and independence as the hallmark of maturity. Freud, Erikson, and Mahler, in their respective epigenetic theories, all emphasize the discontinuous aspects of development, the need to relinquish early modes of being, thinking and relating. Maturity is described in terms of individualistic tasks and accomplishments.

Current theories of female development emphasize relationships and the continuous aspects of development. These theories do not overvalue independence nor organize development into a maturational hierarchy of accomplishments. Instead, these theories emphasize self in relationship to others (Jordan et. al. 1991).

Literature on the Male Gender Role

The feminist literature positing different developmental tracks for boys and for girls highlighted developmental processes that are specifically male, namely, separation/individuation from a different-sexed parent. Deidentification from mother was seen as the basic, underlying dynamic of male psychological development (Chodorow 1978).

In this regard, the feminist developmental literature is consistent with the classical analytical theories of male development. What is different is the value attached to this process. Whereas classical theory viewed this process as normative, feminist theory views this process as one which leads males to a restricted emotionality and to a denial of basic needs for nurturance, dependency and intimacy.

To be a man means to be in control and to be unlike a woman (Scher 1990). The worst epithets for a little boy to be called are "sissy" and "mamma's boy." Boys are forced to denounce all aspects of themselves that are associated with femininity: emotional expressiveness, nurturance, dependency, and sensuality (Solomon 1982; Taubman 1986). This socialization into a male gender role requires boys to constrain a whole host of feelings (Schachtel 1986).

Masculinity, in this culture, requires strength, invulnerability, successfulness, toughness, self-reliance, aggressiveness, and daring (O'Neil 1990). Men are expected

to be rational, to be competent, and to always know the answer (Solomon 1990). Identity, for men, lies in what they do (Wong 1990), and what they do determines the economic and social status of the family.

In summary, masculinity and femininity are viewed as dichotomous. Masculine characteristics include strength, aggressiveness, rationality, independence, and task orientation. Feminine characteristics include gentleness, passivity, intuitiveness, dependence, and relationship orientation. Psychological and sociological theorists, in general, are agreed on that. Whether these differences are innate or are social constructions, how these gender traits are reproduced, and what value each gender's traits are given in society are all matters of on-going research and debate.

Literature on Women as Therapists

In the literature on why women are especially suited to be therapists (Brown 1990; Carter 1971; Kaplan 1987), much is written about empathy. The claim is that empathy is a core component of the therapeutic relationship and that "women therapists are likely to have in common a greater capacity for empathy..." (Brown 1990). One explanation for this claim cites the importance of empathy in the mother-infant relationship and the internalization of this role by females (Jordan et al. 1991).

Empathy has been defined as the ability to relax one's own ego boundaries to perceive the affective experience of another and the ability to analyze those feelings cognitively (Basch 1983; Raines 1990; Jordan et al. 1991). Writers focusing on women and empathy (Jordan et al. 1991) emphasize the affective component of the empathic process. But Basch (1983) conceptualizes the empathic process as a "circular or helical process" made up of affective and cognitive components and which could be entered into through either path.

The capacity for empathy is not global, however. It can be limited by developmental deprivations or arrests, by intrapsychic conflicts, or by cultural norms (Basch, 1983).

Jordan (1991) explains that the capacity to empathize may exist, but that the specific meaning of affective experiences determine the individual's ability to make use of the capacity for empathy:

> Because self-representations are not global, but cohere around specific affective experiences. . . empathic attunement can be more highly developed with regard to certain experiences than others. . . .Thus empathy cannot be accurately spoken of as a global function.

In taking on the role of psychotherapist, the individual assumes a professional identity which potentially facilitates a shift in these internal relations. Raines (1990) cites Fliess' concept of the analyst's work ego enabling empathy to be based on "a permissive, work-justified, adaptive realignment of the analyst's superego relations with

his or her ego." Sometimes this is possible for a therapist, at other times, not. Mackey and Sheingold (1990) refer to this phenomenon as the therapist's need to "feel relatively at peace with inner feelings that may not be congruent with their expectations of self. . . ."

In social work, the concept of professional values functions in a manner similar to the concept of work ego. Values, as embodied in the National Association of Social Workers' Code of Ethics (1980), "serve as a guide to the everyday conduct" of social workers in their professional relationships.[15]

A therapist's inability to empathize with a patient due to the meaning of the patient's affective material to the therapist is one form of countertransference and is typically viewed as unique to that particular therapist. However, Bernadez (1987), in writing on women as psychotherapists, posits the notion of cultural countertransferences. These differ from the classical countertransferences

> because they are culture-specific and they have unconscious determinants shared in commonality with a large and 'average' group. . . .All these reactions from therapists constitute errors of commission or omission in therapeutic conduct that have as a common denominator shared beliefs about what is expected of a female in this society.

---

[15]In regard to gender, the NASW Code of Ethics (1980) specifically states, "The social worker should not practice, condone, facilitate or collaborate with any form of discrimination on the basis of race, color, sex, sexual orientation. . ."

Hence, these cultural countertransferences can interfere with female therapists' ability to empathize with their female patients. Both female patients and female therapists have been socialized in terms of the culture's expectations and prohibitions vis-a-vis women.

This point of view is in contrast to those who assume that female therapists are more capable of empathizing with clients because of the socialization of females toward motherhood. "Motherhood relies on a careful tuning to the other, a sensitive empathy to the subtle or unarticulated internal states of the infant, and any traits that would enhance these abilities are likely to be developed in females" (Jordan et al. 1991).

Schachtel (1986) links empathy and nurturance as part of female socialization toward motherhood and differentiates that from the role of psychotherapist: "The female gender role authorizes empathy and nurturance. Therefore, a woman behaving in a nonnurturant role may be consistent with her work role but not her gender role." In differentiating gender role from work role, Schachtel (1986) goes on to state,

> Women have been trained to respond by doing something to and for the other person that is different from the analytic role. The female analyst, therefore, is faced with a need to monitor a lifelong gender role if she is to carry a particular other role. . . .The woman analyst is faced with the pressure to 'make it better' - when the task is not that.

In summary, the literature on women as therapists is contradictory and the issue is clearly controversial. Some argue that preparation for motherhood is preparation for the role of psychotherapist. Others argue that preparation for motherhood conflicts with the role of psychotherapist. However, all agree that female socialization in this culture is preparation for motherhood and that that has impact on a female carrying out the role of psychotherapist.

Literature on Men as Psychotherapy Clients and as Therapists

Psychotherapy has historically been a field of male psychotherapists and female clients.[16] When gender issues in the therapy relationship have been raised, the literature has focused on women as psychotherapists and men as clients.

The very male gender role that may cause men intrapsychic or interpersonal suffering makes it difficult for men to become clients in psychotherapy (Scher 1990). Psychoanalytic psychotherapy requires men to be in a dependent position, to acknowledge needing help, to be open and emotionally expressive, and to relinquish a problem-solving mode in exchange for a reflective mode. Hence the prerequisites for being a psychoanalytic psychotherapy client are proscribed by the male gender role.

---

[16]This is not true in social work. It is not known if males who choose a female-dominated discipline such as social work differ from males who choose historically male-dominated disciplines such as psychology and psychiatry.

Therapists are cautioned to understand the impact of male gender role norms on personality development and behavior. Difficulties men might have entering treatment or sustaining a treatment relationship due to the conflict between male gender norms and treatment norms can be easily misdiagnosed as resistance (Osherson and Krugman 1990).[17]

For male psychotherapists, gender role may impact on work role in the form of countertransference reactions. Typical countertransference reactions related to gender role include: competitive struggles; the fear of depletion; discomfort with feelings of vulnerability; discomfort with the feminization of the transference (Osherson and Krugman 1990). Homophobia may be a problem for client and therapist alike (Ipsaro 1986).

Male therapists may hide in the role of psychotherapist and not have full access to their own range of emotional responses to a client (Ipsaro 1986; Schachtel 1986; Freudenberger 1990; Scher 1990). Yet comfort with the role may be an advantage for the male therapist, allowing him to tolerate being the recipient of uncomfortable transference reactions from clients (Schachtel 1986).

In summary, the literature on men as clients and men as therapists comes as a result of issues raised by the

---

[17]Using the classical concept of "resistance" frames the difficulty men might have entering and sustaining therapy as idiosyncratic and pathological. Osherson and Krugman are suggesting this (men's discomfort with therapy) is a cultural phenomenon that affects most men.

Women's Movement. Knowledge of the ways in which male gender role impacts on the nature of therapeutic relationships is limited. It seems likely, however, that as the impact of gender role on individuals is better understood, psychotherapy approaches will have to be re-evaluated in terms of their conflict with or congruence with male gender norms.

CHAPTER 3

METHODOLOGY

Overview of the Methodology

Though this study was exploratory, a quasi-experimental research design was used to investigate whether there was a difference between the clinical situations that evoked stressful feelings in male therapists and the clinical situations that evoked stressful feelings in female therapists.

It was an assumption of the study that gender is a fundamental organizer of personality, and that therapists may be unaware of the impact gender has on them and their work. The conceptual framework of tension between work role and gender role posits an unconscious conflict between these two dynamics. A quasi-experimental design seemed to be a feasible way to look for indicators of such a conflict.

Quasi-experimental design is traditionally used to identify the impact of the experimental treatment (Cook and Campbell 1979). The experimental treatment functions as the independent variable and the design is structured such that its effect on the dependent variable can be most clearly recognized and/or confirmed.

In this study, the experimental treatment was a vehicle for illuminating the potential impact of gender, the

independent variable in this quasi-experiment. The looked for effect, stressful feelings, was conceptualized as referring to gender of the subject, rather than to the experimental condition.

The experimental procedure consisted of showing social workers videotapes of actors role-playing clients in session. After each videotape, a feeling scale was administered to measure the feelings evoked in the subject by the clinical vignette.

The research used field testing. The videotaped vignettes were shown at sights convenient for the subjects, either at the researcher's office or the subject's office. There were both individual and group screenings.

A sample of fifty-eight psychodynamically-oriented clinical social workers was drawn, twenty-six male subjects and thirty-two female subjects (see chapter 4). The sample included social workers of various ages, levels of experience, and practice settings. A background questionnaire was given to subjects to identify the professional characteristics of the sample population.

The Experimental Conditions

The four experimental conditions were alliance rupture, sexual stimulation, seeking relief, and ambiguity. They were chosen on the basis of theory and research that suggests a gender-linked response to these situations.

An attempt was made to have comparable male and female vignettes for each experimental condition. However, the experimental conditions were complex. They could be interpreted and enacted in a number of different ways. The personality of each actor gave a distinctive nuance to each role-play even if the interpretations of the experimental condition were similar. In some cases (i.e., ambiguity), very different approaches were taken while still keeping within the parameters of the experimental condition. Some behaviors, i.e., flirting, may seem different when expressed by a male or expressed by a female even if the behaviors are the same. Conceptual descriptions of the experimental conditions and transcripts of the actual videotaped vignettes can be found in Appendix 1.

Experimental Condition One: Alliance Rupture

The vignettes representing an alliance rupture were intended to portray a threat to or disruption of the working relationship between the therapist and the client. Both the male vignette and the female vignette feature the clients' overt expression of negative feelings toward their therapists. According to Safran et. al. (1990), this is the most direct indication of an alliance rupture.

In both of these vignettes, the clients use verbal and non-verbal communication to express their anger. They are critical of their therapists and they withdraw from their therapists. While these vignettes are categorically very

similar, the distinct personalities of the two actors and the specifics of their interpretation, lend a somewhat different feel to each role-play.

Experimental Condition Two: Sexual Stimulation

In these vignettes, the clients are concerned with sexual matters and are drawing attention to their own sexuality. The female client is coquettish. She is discussing whether or not to have phone sex with her boyfriend, though this is never overtly stated. There is a lot of non-verbal communication in this vignette as the female client uses voice, body movement, and facial expressions in a very seductive manner.

In the vignette with the male client, there is less non-verbal communication. The male client speaks very earnestly, and directly, about his own sexuality and what is sexually exciting for him. At times he lowers his voice and at times he gestures with his hands. While what is unspoken with the female client heightens the sexual charge of the vignette, the explicitness of the male client heightens the sexual charge of his vignette.

Both of these vignettes are well within the parameters of the experimental condition (see Appendix 1), but are quite different from each other. For purposes of this study, it was assumed that they were comparable.

Experimental Condition Three: Seeking Relief from the Therapist

These vignettes depict situations where the clients turn to their therapists for direct relief from their suffering. Rather than being able to be introspective, the clients seem to want the therapist to do or say something to make them feel better.

The vignettes are very similar in that both the male and female clients explicitly seek feedback from their therapists about specific situations. The female client wants advice about dealing with her mother. The male client wants help understanding the actions of his female friend. They both use body language, tone of voice, and facial expressions to convey their need for direct help.

Yet, their personalities are quite different. The feel of each vignette is unique, despite their being, categorically, so similar. In this regard, the male and female versions of this experimental condition are similar in comparability to the male and female versions of the first experimental condition.

Experimental Condition Four: Ambiguity

In these vignettes, as in experimental condition two, the male and female presentations are very different. The female client has a spacy, distracted manner and she jumps from one topic to the next. It is difficult to follow what she is actually talking about, though some of her material

conveys the notion of a problem she is struggling with (there are more roommates than closets for them in the apartment). The ambiguity is in the content of the communication.

In contrast, it is relatively clear what the male client is talking about, but it is difficult to understand why he is talking about it. His material is very concrete, simplistic and dull. It is a recitation of seemingly petty activities (i.e., returning a videotape) in a manner devoid of affect. Yet his tone of voice is earnest and involved with what he is saying. The ambiguity is in the meaning of his communication.

Panel of Experts

A panel of three experts was used to establish the content validity of the videotaped vignettes. Each vignette was judged, in its own right, in terms of whether or not it met the criteria for the experimental condition (see Appendix 1). The male and female versions of each experimental condition were not judged vis-a-vis each other for comparability of the vignettes.

The panel of experts consisted of one male social worker and two female social workers. All three were experienced psychotherapists, actively involved in clinical work. One of the experts was exclusively in private practice, one was an administrator in a large social work

agency, and the third was on the faculty of a social work doctoral program in addition to being in private practice.

There was unanimous agreement that each of the eight vignettes validly portrayed the experimental condition it was meant to represent. In addition, there was unanimous agreement that each of the vignettes would be effective in evoking the kinds of feelings that therapists typically experience in clinical situations such as those portrayed.

On the basis of the judgments of the three experts, it was determined that the videotaped vignettes validly operationalized the experimental conditions.

The Videotaped Vignettes

The eight video vignettes, each lasting about two minutes, were made using young adult actors. There were a number of advantages to using all young adults in the vignettes.

Young adults are typically an attractive clinical population to work with, and the use of young adults increased the likelihood of the vignettes engaging the therapist subjects. Young adulthood is a time of identity consolidation during which the experimental conditions may appear in a treatment relationship without necessarily being indicative of a character disorder. In American culture, sexuality is most readily, and least controversially, identified with young adulthood, a time during which courtship is developmentally appropriate.

By using young adults in all the vignettes, client age was controlled as a variable. The young adults used are all Caucasian and without obviously distinguishing characteristics. An exception to this is the actress depicting sexuality, who is extremely attractive.

The young adults used for the role plays are aspiring actors. The researcher used word of mouth to find the actors. The first three actors were found this way. Then two of these actors provided names of other possible actors. The remaining five actors were ultimately located through the actors already used. The actors were paid twenty-five dollars for making the videos, and each taping took about one to one-and-one-half hours to complete.

The young adults used in the video vignettes were informed of the purpose of the videos and the potential audiences to whom it would be shown. They were given release forms to sign (see Appendix 1).

Technical description of making the videotapes

The videotapes were made by the researcher in her office in Evanston. The actors were seated in the office as if they were psychotherapy clients and the researcher sat across from them as if she were the psychotherapist. The actors were taped straight on, looking at and speaking directly to the videocamera.

The researcher used a hand-held Sony Video Recorder, which taped on Video Eight tape. The office had fluorescent

lighting and large windows. On sunny days, this was sufficient lighting for the taping. On cloudy or rainy days, a five hundred watt incandescent bulb was used for additional lighting. At the end of each taping, a thirty-five millimeter Minolta camera was used to take still photographs of each actor.

Both the videotaping and the photographs were framed as mid-shots. Both show each actor sitting in a chair, from the knees up, with the office background visible.

Before beginning the taping, the researcher explained the clinical condition to the actor and showed the actor the conceptual description (see Appendix 1). The researcher explained that the role-play was to be improvised. The actors either thought about what they wanted to do or discussed it with the researcher.

Taping was done in several takes. The actor began the role-play, and the researcher taped for several minutes. How long each take lasted varied from actor to actor and from take to take.

Between takes the researcher gave the actor feedback concerning the role-play. This was the main form of direction. On a few occasions, the researcher gave hand signals during the taping (such as thumbs up to indicate the role-play was proceeding well).

After each taping, the researcher played the Video Eight tape on a nine-inch Magnavox television with built-in

VCR. This required playing the Video Eight tape in the videocamera, which was connected to the television using input and output wires. As the Video Eight tape was playing on the television monitor, it was recorded on VHS tape using the built-in VCR.

The VHS tape was used as a workprint both for convenience and to preserve the Video Eight tape as much as possible. Editing consisted of choosing the best role-play sequence of about two minute duration.

Editing different parts of the tape together was not done for several reasons. First, the researcher did not have the technical capacity to edit videotape. Second, an edited sequence would not be natural, and the researcher thought it would interfere with a therapist's response.

Because the tapes needed to be approximately the same length, about two minutes, this dictated the sequence chosen. Often a very successful role-play sequence would be too short and the material on either side of the sequence would not be good.

Good material met several criteria. It embodied the spirit of the experimental condition. The acting was convincing. The actor said things that were typical of what psychotherapy clients actually say. And the good material lasted for about two minutes.

After the sequence was chosen, the Video Eight tape was again played through the television monitor. This time,

instead of copying the tape on VHS tape, only the chosen sequence was recorded on VHS. Two copies were made so that a backup copy would be available if a videotape broke or failed in some way. Because of the crudeness of this method of editing, some copies varied by a second or two at the beginning and/or end. However, the substance of the tape was the same.

The Experimental Procedure

When subjects were enlisted to participate in the research, they were told that the research concerned feelings evoked in therapists by their clients. They were not told that it concerned uncomfortable feelings, and they were not told that the research question concerned possible differences in the feelings of male therapists and the feelings of female therapists. It was an assumption of this study that the subjects would respond more naturally and less self-consciously without knowledge of the specific research question.

For the most part, subjects were contacted by phone, and the nature of the research was explained to them (see chapter 4). They were told that the experiment would take less than one hour and that it could be done in their office or at the researcher's office. It was explained that their participation would require watching eight brief videotapes of actors role-playing clients and then circling numbers on a feeling scale after each tape.

When the researcher met with the subject, the first step of the experiment was to find a place for the television and arrange a chair for the subject. A nine-inch television with built-in VCR was used to show the tapes. The researcher attempted to set up the television such that viewing the tapes resembled sitting with a client as much as possible. When experiments were conducted at the researcher's office, this step was eliminated since the office was prepared before the subject arrived.

The researcher then reviewed the format of the experiment and gave the subject a clipboard with the research instruments (see Appendix 2). The subject was given a written informed consent to read. This form clearly stated that actors were role-playing clients, making it clear that the subjects would not be viewing actual clients in session. Since there were no known risks associated with participation in the research, no signed consent was required.

Next, the subject was given written instructions to read. The subject was instructed to watch the videotapes as if he/she were the therapist and had been seeing the client for six months. He/She was instructed to note all feelings and their intensity, regardless of how transitory the feelings were. The instructions ended by reminding the subject to circle a number for each feeling even if he/she did not have the feeling (the number "1" indicated "not at all").

If a subject wanted to look at the feeling measurement instrument, he/she was invited to do so.

Any questions the subject had were answered at this point. The researcher then gave verbal instructions to clarify and reiterate what was required of the subject (see Appendix 2). A number of subjects asked whether they should circle feelings as they watched a tape or wait until after the tape was over. The researcher suggested that they wait until the tape was over, but told the subjects that if they were more comfortable circling feelings while watching, they should do so. Most subjects watched a tape then circled feelings, but some subjects circled the feelings while watching a tape.

Altogether, eight videotaped vignettes of actors role-playing clients were shown to the therapists. The tapes were shown in different order for each subject, to control for order effect as a possible variable. Computer-generated random numbers were used to determine the order. Each vignette was on a separate tape cassette so that they could easily be shown in any order. The clients spoke directly to the camera, thereby placing the therapist subject in the position of the therapist. Each tape was approximately two minutes long.

After each videotape was played, the therapist subject filled out a brief measurement instrument on the feelings evoked by the vignette (see Appendix 2). The measurement

instrument listed seventeen feelings. The concept of feelings was used, instead of stress, or discomfort, because of its more neutral connotation. Researchers have suspected that male and female psychotherapists differ in their self-reports of stress (Deutsch 1984).

The list of feelings was partially based on the list of feelings Howard, Orlinsky and Hill (1969) used in their research. However, this list of feelings excluded feelings used by Orlinsky and Hill that were unlikely to be evoked without actual therapist-client interaction (i.e., playful).

A less intense form of a feeling was used when possible. For example, the feeling "irritated" was chosen instead of "angry." The assumption was made that feelings evoked in a therapist watching videotapes would not be as intense as the feelings evoked in the context of a relationship with a client.

The same list of feelings was used following each videotape, but the order in which the feelings were listed was different for each vignette. Computer-generated random numbers were used to determine the order for each of the eight lists of feelings. This was done to control for order of feelings as a possible variable and to limit the likelihood of the subject's getting into a fixed response pattern.

Since the order of feelings changed with each list and the order in which the videotapes were shown changed with each subject, there was no fixed relationship between one of

the experimental conditions and one order of feelings. In other words, the videotape which was shown as "client one" was randomly chosen each time, so the order of feelings on the "client one" feeling list was presumably used with all of the eight vignettes at some point in the data collection.

After all the vignettes were shown, the subjects were asked to choose which client they would most like to work with and which client they would least like to work with. The subjects were asked to briefly state why they had made each choice.

To make the choice, the subjects were given a small photo album with pictures of the clients. The photographs slipped into and out of the sleeves of the album so that the order of the photos could be readily changed for each subject. Before meeting with each subject, the photographs were placed in the album in the order in which the vignettes were to be shown. The clients were numbered accordingly (i.e., the first client shown was numbered "client one").

After that, the subject was asked to fill out a simple, one-page questionnaire, "Background Information on Subjects" (see Appendix 2). This questionnaire concerned the professional activities and orientation of the subjects. Chapter four describes the professional profile of the subjects in the sample.

The entire testing situation took approximately forty-five to sixty minutes, which is similar to the typical

length of a therapy session. It was assumed that the subjects were able to stay emotionally involved for that period of time.

Pilot Study

A pilot study was done before the research was started. Three social workers, one male and two female, volunteered as subjects for the pilot study. The same procedure was followed and the same materials were used as with the research subjects.

Only minor changes were made as a result of the pilot study. The researcher learned to emphasize the need to circle a number for every feeling as this was confusing for one of the subjects in the pilot study. It was suggested by two of the subjects that the researcher sit behind the subjects so as not to be in their line of vision. This was done whenever it was possible during the actual research.

Assumptions and Limitations

This design had several advantages. Videotaped vignettes came closer to capturing the actual feel of sitting with clients than written vignettes could have. Affects were readily communicated using video vignettes. Client gender was more evident using video vignettes. The video vignettes allowed for nonverbal communication, which can have a more powerful effect on a therapist than verbal communication. Since psychotherapists are trained to be

aware of the feelings evoked in them by clients, it was assumed that they were accurate self-reporters.

This design had several limitations. The feelings elicited by a vignette may not have been analogous to feelings elicited in the context of a relationship. Even with the use of videotape, the therapist subject was still an observer and not a participant in the therapeutic interaction. While the experimental conditions provided male and female therapists with the same stimulation, it is possible that clients react differently with male and female therapists.

For therapists who are particularly active in their work with clients, the forced passivity of the experimental condition was not analogous to an actual situation with clients. Some of the feelings evoked in these therapists (i.e., frustration) were in response to the research situation and not to the clinical stimulus.

CHAPTER 4

THE SAMPLE

Introduction

This study used three different types of nonprobability sampling. All of the sampling was purposive. The intent of the sampling was to obtain as subjects a group of experienced, psychodynamically-oriented, male and female social workers currently engaged in clinical work. Within this framework, the researcher used convenience and snowball sampling techniques to find and recruit such social work subjects. As a nonprobability sample, the sample was not representative of all clinical social workers. However, since this was exploratory research a nonrepresentative sample was appropriate for the purpose of the study. The final sample included twenty-six male social workers and thirty-two female social workers.

How the sample was obtained

Using convenience sampling techniques, social work contacts were used to locate social workers who fit the description of the intended sample. Most of the sample (thirty-one subjects) were recruited by cold calling. Seventeen subjects volunteered in response to a subject

recruitment letter written by the researcher and sent out to the students and faculty of The Institute for Clinical Social Work (see Appendix 2). In response to the researcher's cold calling, two agency clinical directors recruited their social work staff for participation in the study. This resulted in two groups of five social workers for a total of ten subjects recruited in this manner.

The process of cold calling started with the researcher's obtaining names of social workers (unknown to the researcher) from social workers known by the researcher. The potential subjects were then called.

The researcher began the conversation by identifying the social worker intermediary who had given the researcher the name. The researcher then identified herself as a Loyola doctoral student looking for subjects for her dissertation research.

If permission was given to describe the study, the researcher explained that it was exploratory research into the types of feelings that clients evoke in their therapists. The researcher explained that it would involve viewing eight brief videotapes and circling numbers on a feeling scale after each tape. It was estimated that the experiment would take less than one hour. If the potential subject agreed to participate, a meeting was arranged.

Snowball sampling techniques were used during the data collection. After the experiment was completed, some sub-

jects asked the researcher about her study and how it was progressing. Other subjects commented that they had enjoyed participating in the experiment. Subjects who engaged the researcher in discussion in this way were then asked if they knew of other social workers who might be willing to participate in the research.

Hence, some of the names of potential subjects were given to the researcher by subjects who had participated in the research themselves. The subjects who had participated in the experiment were asked not to discuss it with the potential subjects.

The second most successful method of recruiting subjects was through a letter, written by the researcher, sent out by the Institute for Clinical Social Work to their faculty and students. This letter contained substantially the same information conveyed in the cold calls to potential subjects. When potential subjects called the researcher to inquire about the research, the same telephone procedure was followed as was used in the cold calls, conveying the same information.

The third method of recruiting subjects was through cold calls to clinical directors of social work agencies. These clinical directors were approached in the same manner as were the individual social workers. Two clinical directors volunteered their staff time and recruited their staff

participation. Both of these clinical directors participated in the research along with their staff members.

Group screenings of the videotapes were arranged for the agency staff. Each group had five staff members. In addition to the two agency group screenings, two of the cold calls resulted in group screenings. One of the groups consisted of four social workers who were in a peer study group together. The other was a group of two social workers.

For the peer study group screening and for one of the agency group screenings, a thirteen inch television monitor was used instead of the nine inch television monitor used for the individual screenings. The second agency provided its own television monitor for the screening. Since the other group screening was for only two social workers, the nine inch television was used.

All potential subjects were given the choice of coming to the researcher's office for the experiment or having the researcher come to their office. Seventeen subjects came to the researcher's office. The other forty-one subjects were seen either in private practice offices or in agency settings. All of the experiments were conducted in professional practice environments.

Subject Demographics

At the end of the experiment, subjects were given a brief (one page) questionnaire to fill out (see Appendix 2).

This form asked for information about professional training, theoretical orientation, nature of clinical practice, practice setting and professional activities. The only personal information requested was sex, age, and whether or not the subject had ever been in therapy.

Professional training

Subjects were asked to identify the discipline of their professional training (see table 1) and their highest professional degree. Of the total sample, 97% were trained as social workers. Out of twenty-six male subjects, twenty-five were trained as social workers, and out of thirty-two female subjects, thirty-one were trained as social workers. The two subjects who were not trained as social workers were both employed as social workers in social work institutions.

Table 1.-The Sample: Professional Training

	Males	Females	Total
Social Work	96%	97%	97%
Psychology	8%	3%	5%
Marriage and Family	8%	0%	3%
Other	8%	3%	5%

These two non-social work subjects had master's degrees in psychology. In addition, one of the subjects

with a master's degree in social work had a doctorate in psychology. Hence, 5% of the total sample had training in psychology.

Two of the subjects, both male, had training in Marriage and Family Counseling. One of the subjects, female, was a Registered Nurse. One of the subjects, male, had a master's degree in Education. And one of the subjects, male, had training in Art Therapy. For these five subjects, this training was in addition to (and sometimes prior to) training as a social worker. (Note that the percentages in the tables do not add up to one hundred percent since subjects may respond positively to more than one category.)

Four subjects, three males and one female, volunteered that they had graduated from the Child and Adolescent Psychotherapy Training program of the Institute for Psychoanalysis. Since this information was not asked for on the background questionnaire, it is possible that other subjects had additional training that they did not write in.

The background questionnaire did not address training in progress (only completed academic training). Since a large number of subjects were recruited through the Institute for Clinical Social Work, it is known that 26% of the sample were involved in or about to begin doctoral work in clinical social work.

The master's degree was the highest earned degree for 91% of the sample. Of the male therapists, 88% had master's

degrees, 12% had doctorates. Of the female therapists, 94% had master's degrees and 6% had doctorates.

Age and professional experience

The researcher's concern was to draw a sample that included experienced practitioners. Inexperienced psychotherapists are often reacting to the newness of a clinical encounter as much as to the specific content of such an encounter. For example, if a psychotherapist has not dealt with many angry clients, the feelings such a clinical situation engenders in the psychotherapist would likely be confounded by the lack of technical expertise in handling those situations.

The method of sampling used produced a very experienced sample population (see table 2). The mean number of years of professional experience for male therapists was sixteen years, with the minimum number of years of experience being one year and the maximum number of years of experience being thirty-five years. The mean number of years of professional experience for female therapists was fifteen years, with the minimum number of years of experience being one year and the maximum number of years of experience being forty-five years.

The mean age of male therapists in the sample was forty-four years old, with a minimum age of twenty-six years and a maximum age of sixty-four years. The mean age of female therapists was forty-five years old, with a minimum

age of twenty-six years and a maximum age of sixty-six years.

Table 2.-The Sample: Age and Experience by Sex

	Age (mean)	Age (min.)	Age (max.)	Yr Exp (mean)	Yr Exp (min.)	Yr Exp (max.)
Male	44	26	64	16	1	35
Female	45	26	66	15	1	45

While no concerted effort was made to obtain a matched sample of male and female social workers, table 2 indicates how closely matched the two groups were in terms of age and experience. Looking at experience in terms of age groupings (see table 3) further delineates similarities between the two groups and also identifies areas of difference in the sample of male social workers and the sample of female social workers.

The age ranges of the male and female subjects were quite similar. There were twice as many female subjects in the fifty to fifty-nine age range, but there were also six more female subjects than male subjects in the study.

In the fifty to fifty-nine age range, there is a difference in experience levels. In terms of mean years of experience, both male subjects and female subjects in the fifty to fifty-nine age group would be considered very

experienced, despite the difference between the two groups. Likewise, both males and females, aged thirty to thirty-nine, would be considered moderately well experienced despite the differences between them. When age is broken into age groups for analysis, each age group is represented by a very small number of subjects which exaggerates any difference between male and female subjects.

Table 3.-The Sample: Years experience by Age Group by Sex

Age	Number Subjects		Years Exp (mean)		Minimum years exp		Maximum years exp	
	M	F	M	F	M	F	M	F
20-29	2	3	2.0	1.3	1	1	3	2
30-39	7	6	5.3	9.2	1	3	8	14
40-49	10	12	18.1	16.4	13	10	23	24
50-59	4	8	26.5	17.9	17	6	32	30
60-69	2	2	32.5	27.5	30	10	35	45

Professional activity

To be included in the study, social workers needed to be involved in clinical practice, so 100% of the subjects listed psychotherapy as a current professional activity.

However, most subjects were involved in two, three or more professional activities (see table 4).

A larger percentage of males than females were employed in each of the other activities specified (supervision, consultation, administration and teaching). The differences between the male subjects and the female subjects approached statistical significance only in the area of teaching. Thus, in terms of professional activities, the male subjects and the female subjects were fundamentally a matched sample.

Table 4.-The Sample: Professional Activity

Professional Activity	Males		Females	
	N	%	N	%
Psychotherapy	26	100%	32	100%
Supervision	17	65%	16	50%
Consultation	13	50%	13	41%
Administration	9	35%	8	25%
Teaching	12	46%	7	22%

Practice setting

The majority of the subjects, both male (77%) and female (72%), saw clients in private practice (see table 5).

Many of them also worked in agencies or hospitals. Given the many professional activities in which the subjects were involved (see table 4), this was not surprising. Again, the female subjects and the male subjects were closely matched.

Table 5.-The Sample: Practice Setting

Practice Setting	Males		Females	
	N	%	N	%
Private Practice	20	77%	23	72%
Agency	10	38%	14	44%
Hospital	4	15%	4	13%
Group Practice	2	8%	2	6%
Other	0	0%	2	6%

Despite the predominance of private practice, the sample included a substantial number of social workers who were working in organizational settings instead of, or in addition to, private practice. Nearly one-fourth of the male subjects (23%) and just over one-fourth of the female subjects (28%) did not see clients in private practice.

Clinical practice

The subjects in the sample were involved in the whole range of clinical activities. Almost every category of

practice was engaged in by over half of the subjects (see table 6). This suggests that the subjects in the sample were experienced not only in depth (number of years of practice), but in breadth (range of practice experience).

Table 6.-The Sample: Clinical Practice

Clinical Practice	Males		Females	
	N	%	N	%
Individuals	26	100%	32	100%
Couples	18	69%	22	69%
Families	14	54%	20	63%
Groups	10	38%	17	53%
Adults	25	96%	32	100%
Adolescents	21	81%	19	59%
Children	20	77%	18	56%

Once again, the male subjects and the female subjects were closely matched. In terms of modalities, the percentages of male subjects and female subjects working with individuals and working with couples was identical. A somewhat higher percentage of female subjects worked with families and with groups, but this difference was not significant.

One male subject did not work with adults as his primary clients, but met with parents adjunctively in his work with children and adolescents. A larger percentage of male subjects than female subjects worked with children and adolescents, but more than half of the female subjects also worked with these two populations. Several of the subjects in the sample had been through the Child and Adolescent Psychotherapy Training Program, and both agencies that participated in the research were youth agencies. That may account for the large percentage of subjects working with children and adolescents.

The hours per week seeing clients was very similar for male subjects and female subjects. The mean number of hours per week seeing clients for male subjects was twenty-four hours. For female subjects, the mean was twenty-three hours. The minimum number of hours per week a male subject saw clients was five hours and the minimum number of hours per week a female subject saw clients was seven hours. The maximum number of hours per week seeing clients was forty-eight hours for a male subject and forty-five hours for a female subject. Once again, the male subjects and the female subjects were closely matched in terms of their clinical practice.

The one aspect of professional experience in which there was a statistically significant difference between male and female subjects was in the use of supervision

and/or consultation. Of the male subjects, 69% received supervision and/or consultation on their clinical work. Of the female subjects, 94% received supervision and/or consultation on their work. Even though the difference between male subjects and female subjects was statistically significant, it should be noted that over two-thirds of the male subjects received supervision and/or consultation. So while the difference between the numbers was statistically significant, it was not necessarily categorically meaningful. A large majority of both male and female subjects received some form of supervision and/or consultation regarding their clinical practice.

Theoretical Orientation

Almost all of the subjects based their clinical practices on a combination of theoretical perspectives (see table 7). Psychodynamic theory was embraced by almost all subjects, and self-psychology informed the work of over two-thirds of the subjects.

For male subjects, family systems theory was the third most subscribed to theoretical orientation, followed by developmental theory. For female subjects, this order was reversed. Sixteen percent of the total sample wrote in other theories than those listed. Jungian theory was the most common other theory to inform clinical practice.

The male subjects and the female subjects were quite similar. In regard to theoretical orientation, there were no significant differences between the two subject groups.

Table 7.-The Sample: Theoretical Orientation

Theoretical Orientation	Males		Females	
	N	%	N	%
Psychodynamic	24	92%	30	94%
Self-psychology	18	69%	25	78%
Family System	16	62%	18	56%
Developmental	13	50%	22	69%
Problem-solving	11	42%	17	53%
Cognitive	11	42%	12	38%
Behavioral	5	19%	7	22%
Other	2	8%	7	22%

Personal experience in therapy

Subjects were asked whether or not they had ever been in therapy. This question was included since the research was investigating uncomfortable feelings evoked in therapists by their clients. The researcher wondered if personal

therapy affected the range of feelings therapists experienced or their awareness of their feelings.

Since the overwhelming majority of the sample (93%) had been in therapy at some time, this was not meaningful as a variable to be analyzed in the sample. Again, there was no significant difference between the male subjects and the female subjects. Of the male subjects, 88% had been in therapy. Of the female subjects, 97% had been in therapy.

Summary

The study used a purposive sample of psychotherapists. There were a total of fifty-eight subjects, twenty-six male subjects and thirty-two female subjects. The background information questionnaire on subjects investigated the professional profile of those who participated in the research. All participants in the study were either social workers by training (97%) or were currently employed as social workers in social work institutions (3%).

As a group, the subjects were mature both personally and professionally. The mean age of subjects was forty-five years old. The mean years of professional experience was fifteen years. All subjects worked as psychotherapists, but more than half of the sample were also involved in supervision, administration, consultation and/or teaching.

Almost three-fourths of the sample (74%) saw clients in private practice, but many of them also worked in agencies or hospitals. A majority of the sample saw

individuals, couples and families. For the majority, individual work involved working with children, adolescents, and adults.

Psychoanalytic theory strongly influenced the theoretical orientation of the subjects in the sample. Psychodynamic theory was embraced by an overwhelming majority of the subjects (93%), followed by self-psychology (74%).

As a group, the sample was mature, experienced, involved in a variety of practice settings and a variety of professional activities. They worked with adults, adolescents and children using several different clinical modalities.

While the sample was not necessarily representative of clinical social workers, it was well-suited for the purposes of exploratory research. Using an experienced sample, involved in a range of professional activities and working with a varied practice, increased the likelihood that the subjects were reacting to the experimental stimulus and not to limitations in their own professional repertoire.

While the sampling process did not include a concerted plan for obtaining a matched group of male subjects and female subjects, analysis of the demographic data suggested that a matched group was actually obtained. Use of supervision and/or consultation was the only question on the entire questionnaire in which there was a statistically significant

difference between male and female subjects. In all other areas, there was a startling similarity between the two groups of subjects.

The similarity of the professional demographics of the two groups served as a control in the experiment. It strengthened the likelihood that any differences found in reaction to the experimental stimulus would be correlated with gender differences rather than with professional differences.

CHAPTER 5

DATA ANALYSIS

Introduction to the Data Analysis

The data analysis was based on the data collected on the feeling list measurement instrument (see Appendix 2). This measurement instrument, administered after each videotaped vignette was shown, contained a list of seventeen feelings. The subjects were instructed to rate the feelings evoked in them by the vignettes using a seven-point Likert scale. The subjects were to circle a number from one to seven for each feeling on the list, indicating the extent to which they experienced that feeling while watching the vignette.

On the scale, "1" was labeled "not at all," four ("4") was labeled "somewhat" and "7" was labeled "very." Though technically an ordinal-level measurement scale, the data was treated as interval-level data for several reasons. First, it is standard practice in the social sciences to assume that Likert scales represent continuous data with equal class intervals (DiLeonardi and Curtis 1988). This assumption enables a greater range of statistical procedures to be used. Second, since this research was exploratory, some

exactitude could be sacrificed for better indicators as to whether or not this line of inquiry should be pursued.

Factor scaling was the first step in the data analysis. The research was presented to subjects as concerning feelings, and it was kept hidden from subjects that the real focus of the investigation was stressful feelings. Therefore, the feeling list contained a variety of feelings, including several that were not necessarily stress-inducing (i.e., interested). A factor analysis was done to create scales of feelings. Three scales were created which measured three different types of feeling responses: a distress scale, a caring scale, and an uninvolved scale.

The second step in the data analysis was to analyze the scales for reliability using Cronbach's alpha. Each scale was rated for its inter-item reliability. The scales were also analyzed for inter-case reliability. The one feeling (attracted) that was not included on any scale was analyzed for its inter-case reliability only. Since the scales had good reliability ratings, they were each treated as a unit (variable) in the subsequent data analyses.

The final step was to analyze the data using a repeated measures analysis of variance. Three ANOVA's were run, one each using each of the three scales. The fourth ANOVA was run on "attracted," the feeling that was not included in any of the scales.

These were two by four by two repeated measures analyses of variance. The sex of the therapist (male or female) was a between factor and the vignette (four different experimental conditions) and the sex of client (each condition enacted twice, once with a male client and once with a female client) were the within group repeated factors. The results of these statistical procedures served as the basis for addressing the research questions.

The Factor Analysis

A factor analysis was used to create scales from the data. Factor scaling is appropriate when the data items are thought to contain underlying dimensions (Bailey 1987), each of which can be viewed as a hypothetical variable. The seventeen-item feeling list was constructed to include several different types of feelings, hence a factor analysis was chosen to identify which feelings shared a common dimension. By creating scales to represent each of the feeling dimensions, the subsequent data analyses were more meaningful since the point of the investigation concerned the category of stressful feelings, not the individual feelings per se.

The first step in the factor analysis was to find the correlations among all pairs of variables (feelings) to be analyzed. A table showing all of these pairs of correlations was then constructed (see table 8 for the correlation matrix).

Table 8.-Correlation Matrix

	ANX	ATTR	BOR	CONC	CONF	DEF	DET	EMP
ANXIOUS	1.00							
ATTRACTD	.19	1.00						
BORED	-.09	-.29	1.00					
CONCERND	.37	.20	-.27	1.00				
CONFUSED	.18	-.13	.33	.03	1.00			
DEFENSVE	.61	.20	-.15	.35	.02	1.00		
DETACHED	-.04	-.26	.62	-.24	.31	-.08	1.00	
EMPATHIC	.22	.38	-.40	.60	-.23	.24	-.41	1.00
GUILTY	.50	.15	-.06	.26	.05	.56	-.05	.22
IMPATINT	.11	-.21	.57	-.18	.43	.10	.48	-.33
INTERSTD	.19	.52	-.64	.47	-.26	.17	-.62	.63
INVOLVED	.22	.51	-.61	.46	-.24	.24	-.59	.59
IRRITATD	.26	-.18	.39	-.04	.30	.31	.38	-.21
SYMPTHTC	.24	.38	-.32	.59	-.10	.26	-.36	.74
TENSE	.73	.11	-.10	.32	.15	.62	-.04	.19
THGHTFUL	.25	.30	-.41	.50	-.04	.24	-.35	.52
UNCOMF	.71	.14	-.05	.28	.17	.60	-.01	.12

Table 8.-Correlation Matrix (Continued)

	GUIL	IMPA	INT	INV	IRR	SYMP	TENS
GUILTY	1.00						
IMPATINT	.05	1.00					
INTERSTD	.12	-.44	1.00				
INVOLVED	.18	-.44	.76	1.00			
IRRITATD	.18	.60	-.37	-.31	1.00		
SYMPTHTC	.22	-.26	.56	.55	-.22	1.00	
TENSE	.44	.13	.15	.19	.35	.19	1.00
THGHTFUL	.15	-.26	.56	.54	-.17	.50	.24
UNCOMF	.43	.17	.10	.15	.35	.14	.76

Table 8.-Continued

	THGHFUL	UNCOMF
THGHTFUL	1.00	
UNCOMFORTBL	.17	1.00

On the basis of the correlation matrix, a principle component analysis was done. Only seven iterations were required for this analysis. Three significant factors were identified. Together, these three factors accounted for over 63% of the variability (see table 9).

Table 9.-Principle Component Analysis

FACTOR	EIGENVALUE	PCT OF VAR	CUM PCT
1	5.81706	34.2	34.2
2	3.75619	22.1	56.3
3	1.23913	7.3	63.6

From this principle component analysis, three significant factors were identified as having eigenvalues greater than one. A principle axis factor analysis was conducted and a three-factor solution resulted which accounted for 56.6% of the variability. These factors were rotated using a varimax rotation (see table 10).

The three factors were named "distress" (factor one), "caring" (factor two), and "uninvolved" (factor three). These three factors accounted for sixteen of the seventeen feelings on the feeling measurement instrument. A value of .4 or more was considered high enough to qualify a feeling to be associated with a factor (Bailey 1987).

Table 10.-Rotated Factor Matrix

	FACTOR 1	FACTOR 2	FACTOR 3
ANXIOUS	.80521	.20272	.04360
ATTRACTED	.14339	.36745	-.30943
BORED	-.11541	-.23401	.77234
CONCERNED	.28155	.67262	-.07734
CONFUSED	.15330	-.03192	.45865
DEFENSIVE	.73428	.20459	.00262
DETACHED	-.03703	-.27882	.67451
EMPATHIC	.10636	.79041	-.27790
GUILTY	.54643	.18422	.02425
IMPATIENT	.17216	-.17416	.70054
INTERESTED	.11603	.59104	-.61974
INVOLVED	.18769	.55541	-.59901
IRRITATED	.39596	-.15367	.55727
SYMPATHETIC	.10862	.81006	-.17509
TENSE	.84656	.12597	.04402
THOUGHTFUL	.19186	.56358	-.28198
UNCOMFORTBL	.84038	.06741	.06742

The feeling "attracted" did not significantly correlate with any of the factors and was treated as a variable in itself in subsequent analyses. Two feelings, "involved" and "interested," were negatively correlated with factor three. They were not included in the scale as a negative correlation, but led to naming the scale "uninvolved."

On the basis of the three factors, three scales were created (see table 11). Factor one produced the distress scale. Factor two produced the caring scale. Factor three produced the uninvolved scale. Each of these scales was treated as a single variable in subsequent analyses.

Table 11.-The Three Scales with Factor Loadings

DISTRESS (Factor 1)		**CARING** (Factor 2)		**UNINVOLVED** (Factor 3)	
anxious	.81	concerned	.67	bored	.77
defensive	.73	empathic	.79	confused	.46
guilty	.55	interested	.59	detached	.67
tense	.85	involved	.56	impatient	.70
uncomfrtbl	.84	sympathetic	.81	irritated	.56
		thoughtful	.56		

Reliability

The three scales were analyzed for inter-item reliability using Cronbach's alpha. This test measured the average correlation for all items. It is a conservative test of internal consistency (DiLeonardi and Curtis 1988). An alpha of .8 or higher is considered adequate.

The three scales were also analyzed for inter-case reliability across the eight vignettes. The variable "attractive" was only analyzed for inter-case reliability across vignettes. Since it was a single-item variable, inter-item analysis did not apply.

The distress scale was made up of five items (see table 11). The Cronbach's alpha for this scale ranged from .80 to .84. The caring scale was made up of six items (see table 11). The Cronbach's alpha for this scale ranged from .73 to .77. The uninvolved scale was made up of five items (see table 11). The Cronbach's alpha for this scale ranged from .74 to .78.

Table 12.-Inter-item Reliability using Cronbach's Alpha

SCALE	CRONBACH'S ALPHA
DISTRESS	.80 to .84
CARING	.73 to .77
UNINVOLVED	.74 to .78

Inter-case reliability was analyzed using Cronbach's alpha to assess the reliability of each scale across the eight vignettes. Cronbach's alpha for the distress scale ranged from .80 to .84. Cronbach's alpha for the caring scale ranged from .73 to .77. Cronbach's alpha for the uninvolved scale ranged from .74 to .78. The single-item variable "attracted" was also assessed to see how consistently it was used across the eight vignettes. Cronbach's alpha for attracted ranged from .81 to .85.

Table 13.-Inter-case Reliability using Cronbach's Alpha

SCALE/VARIABLE	**CRONBACH'S ALPHA**
DISTRESS	.80 to .84
CARING	.73 to .77
UNINVOLVED	.74 to .78
ATTRACTED	.81 to .85

Cronbach's alpha is sensitive to the number of items being analyzed, increasing as the number of items increases (DiLeonardi and Curtis 1988). Given the small number of items and cases involved in this research, these can be considered strong reliability ratings.

Repeated Measures Analyses of Variance

The establishment of the four variables, the three scales and the single-item variable, readied the data for further analysis. The research question concerned the difference between stressful feelings evoked in male subjects by the vignettes and stressful feelings evoked in female subjects by the vignettes.

A two by four by two repeated measures analysis of variance was chosen to investigate differences between the two subject groups. A repeated measures ANOVA was necessary since the same subject responded to eight different vignettes. Hence, these measurements were not independent of one another, but were repeated measures of the same subject under different circumstances. Though there were eight vignettes, they represented only four experimental conditions. Each experimental condition was enacted twice, once using a female client and once using a male client. The analysis of variance assessed differences in subjects (male and female) by differences in vignettes (four experimental conditions) by differences in clients (male and female). The four different repeated measures ANOVA's that were run analyzed differences in relation to the four different dependent variables: distress; caring; uninvolved; and attracted.

Analysis of Variance: Distress Scale

In analyzing the differences between male subjects and female subjects in their distressed responses, no significant differences were found (see table 14). This was the focus of the research question.

Table 14.-Repeated Measures ANOVA: Distress Scale

SV	df	SS	MS	F	Sig F*
SubSex(SS)	1	4.89	4.89	.03	.864
Within	51	8417.90	165.06		
Vignette	3	4130.88	1376.96	44.97	.000*
SS x Vign	3	60.27	20.09	.66	.580
Within	153	4685.28	30.62		
ClSex (CS)	1	181.62	181.62	10.87	.002*
SS x CS	1	24.94	24.94	1.49	.227
Within	51	851.77	16.70		
VignxCS	3	204.66	68.22	2.90	.037*
SSxCSxVign	3	83.75	27.92	1.19	.317
Within	153	3600.44	23.53		

*This column indicates the probability that the F statistic is significantly different than zero. The starred numbers (*) are statistically significant at the .05 level.

Significant differences (p=.000) were found in the distressed responses of the subjects to the four different experimental conditions. Given that the four experimental conditions were constructed to provide four very different types of stimulation, this finding was expected (see table 15).

Table 15.-Experimental Conditions

VIGNETTE	EXPERIMENTAL CONDITION	CALLED
1	Alliance Rupture	Angry
2	Sexual Stimulation	Sexy
3	Seeking Relief from Therapist	Needy
4	Ambiguity	Vague

However, the research hypotheses speculated that the distress evoked by the different experimental conditions would differ according to the gender of the therapist. There was a differing degree of distress evoked by the different conditions, but male and female therapists agreed on which conditions were more or less distressing.

Significant differences (p=.002) were found in the subjects' distressed reactions to the male and female clients.

This meant that male and female subjects, alike, on occasion responded with significantly differing degrees of distress to male and female clients enacting the same experimental condition. The use of male and female clients was intended to control for the effect of client sex as a possible variable and did not directly impact on the research question itself. Hence, this was an unexpected finding.

In addition to the main effect differences in response to vignette and to client sex, there was a significant interaction effect (p=.037) of vignette with client sex (see table 16 and figure 1). This interaction was disordinal, which meant that any inference regarding the main effect findings were confounded. Hence, the responses to the vignettes (experimental conditions) were confounded by the sex of the client; and the responses to the sex of the client were confounded by the experimental condition.

Table 16.-Distress Mean Scores:
Experimental Condition (Vignette) by Client Sex

EXPERIMENTAL CONDITION		CLIENT MALE	CLIENT FEMALE
VIGNETTE 1	ANGRY	18.8	19.4
VIGNETTE 2	SEXY	12.8	12.4
VIGNETTE 3	NEEDY	11.6	15.1
VIGNETTE 4	VAGUE	9.9	11.3

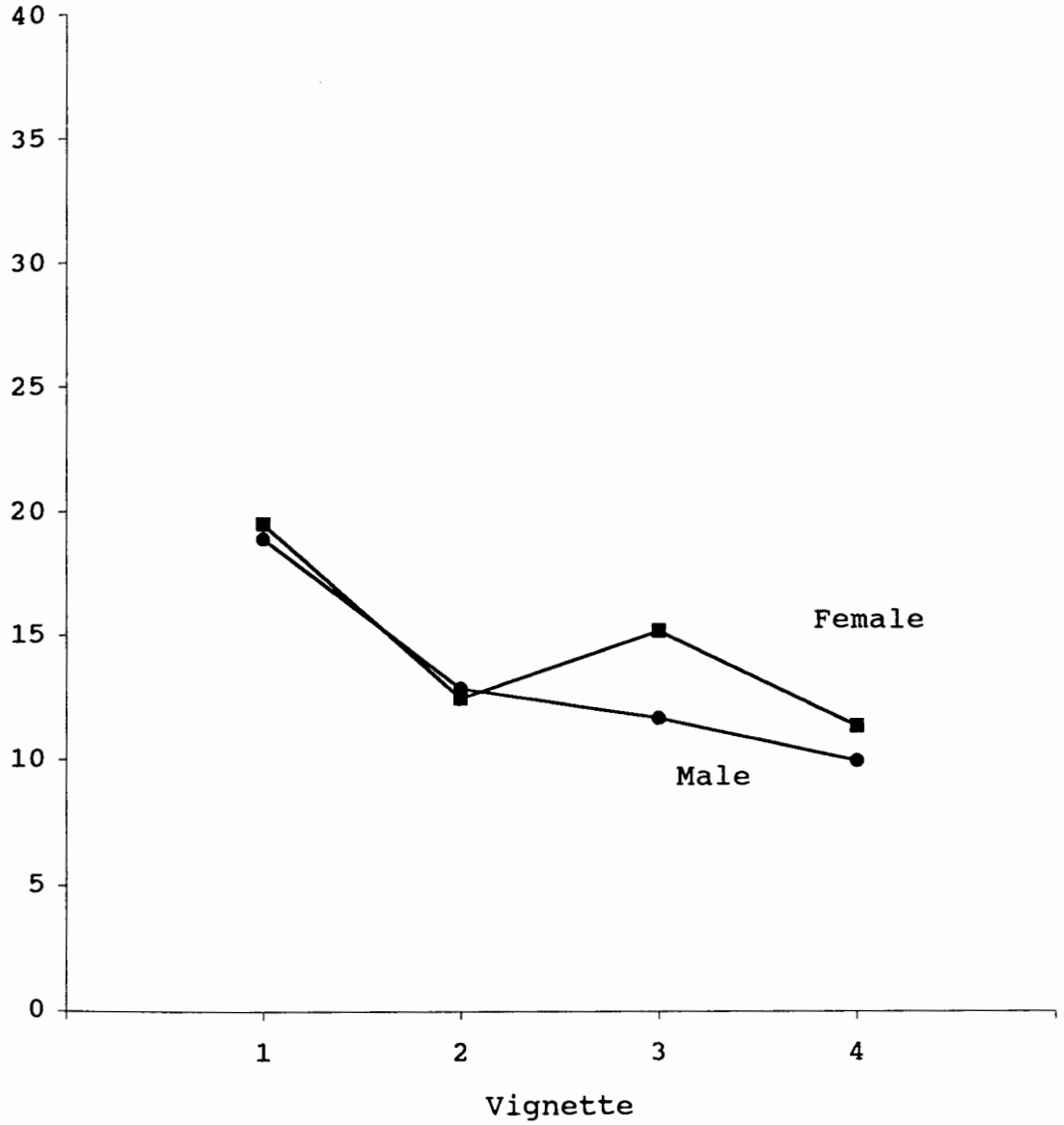

Figure 1.-Repeated Measures Analysis of Variance of Distress Scale: Interaction of Vignette by Client Sex

In response to the angry, needy and vague experimental conditions (vignettes 1, 3 and 4), subjects were more distressed by the female client than by the male client. In response to the sexy experimental condition (vignette 2), subjects were more distressed by the male client than by the female client, though the responses were very close.

In response to male clients, the subjects were most distressed by the angry male client, then by the male talking about his sexuality, then by the male who was needy. Subjects were least distressed by the male who was vague.

In response to female clients, subjects were most distressed by the angry female, then by the needy female, then by the female talking about sex. Subjects were least distressed by the female who was vague.

Hence, the angry clients, male or female, evoked the most distress in subjects, though the female client evoked more distress than the male (though not by much). The next most distressed reaction was to the needy female. This was followed by distress evoked by the sexy male, then the sexy female. The needy male evoked noticeably less distress than the sexy male, the sexy female and especially less than the needy female. The vague clients evoked the least distress in subjects, though the female client evoked more distressed responses than the male. The meaning of these findings will be interpreted in conjunction with the findings from the other analyses of variance.

It should be noted that while there were significant differences between some of these scores, they were all on the lower half of the distress scale. A hypothetical score of twenty, indicating "somewhat," would be in the middle of the scale.

Analysis of Variance: Caring Scale

There were no significant differences between the male therapists and the female therapists in their responses on the caring scale (see table 17). As with the distress scale, there were significant main effect differences in the subjects' caring responses to the different vignettes ($p=.000$), significant main effect differences in the subjects' caring responses to client sex ($p=.000$) and a significant interaction between vignette and client sex.

The interaction between vignette and client sex was disordinal (see table 18 and figure 2). Thus, inferences regarding the differences in response to the vignettes were confounded by client sex and inferences regarding differences in response to client sex were confounded by vignette.

Most of the caring scores were in or near the upper half of the caring scale (a hypothetical score of twenty-four would be in the middle of the scale, indicating "somewhat"). The vague experimental condition (vignette 4), both with the male client and the female client, evoked caring scores in the lower half of the scale.

Table 17.-Repeated Measures ANOVA: Caring Scale

SV	df	SS	MS	F	Sig F*
SubSex	1	355.44	355.44	2.45	.124
Within	51	7393.96	144.98		
Vignette	3	8724.24	2908.08	68.41	.000*
SS x Vign	3	20.73	6.91	.16	.921
Within	153	6503.72	42.51		
ClSex (CS)	1	510.82	510.82	19.80	.000*
SS x CS	1	6.02	6.02	.23	.631
Within	51	1315.58	25.80		
VignxCS	3	1511.97	503.99	19.73	.000*
SSxCSxVign	3	11.41	3.80	.15	.930
Within	153	3907.64	25.54		

*This column indicates the probability that the F statistic is significantly different than zero. The starred numbers (*) are statistically significant at the .05 level.

The angry and needy experimental conditions evoked the most caring responses, followed by the sexy experimental condition (see table 18). The least caring response was evoked by the vague experimental condition. The impact of client sex varied.

It is not apparent why the male client in the angry experimental condition and the male client in the sexy experimental condition evoked more caring responses than the female clients. Nor is it apparent why the female client in the needy experimental condition and the female client in the vague experimental condition evoked more caring responses than the male clients. However, male and female subjects both responded in like fashion to the different condition/client sex combinations. It seems noteworthy that male and female subjects responded so much alike when the different condition/client sex combinations evoked such variation in the caring responses.

Table 18.-Caring Mean Scores:
Experimental Condition (Vignette) by Client Sex

EXPERIMENTAL CONDITION		CLIENT MALE	CLIENT FEMALE
VIGNETTE 1	ANGRY	31.9	29.9
VIGNETTE 2	SEXY	24.6	23.5
VIGNETTE 3	NEEDY	25.8	31.5
VIGNETTE 4	VAGUE	15.9	22.2

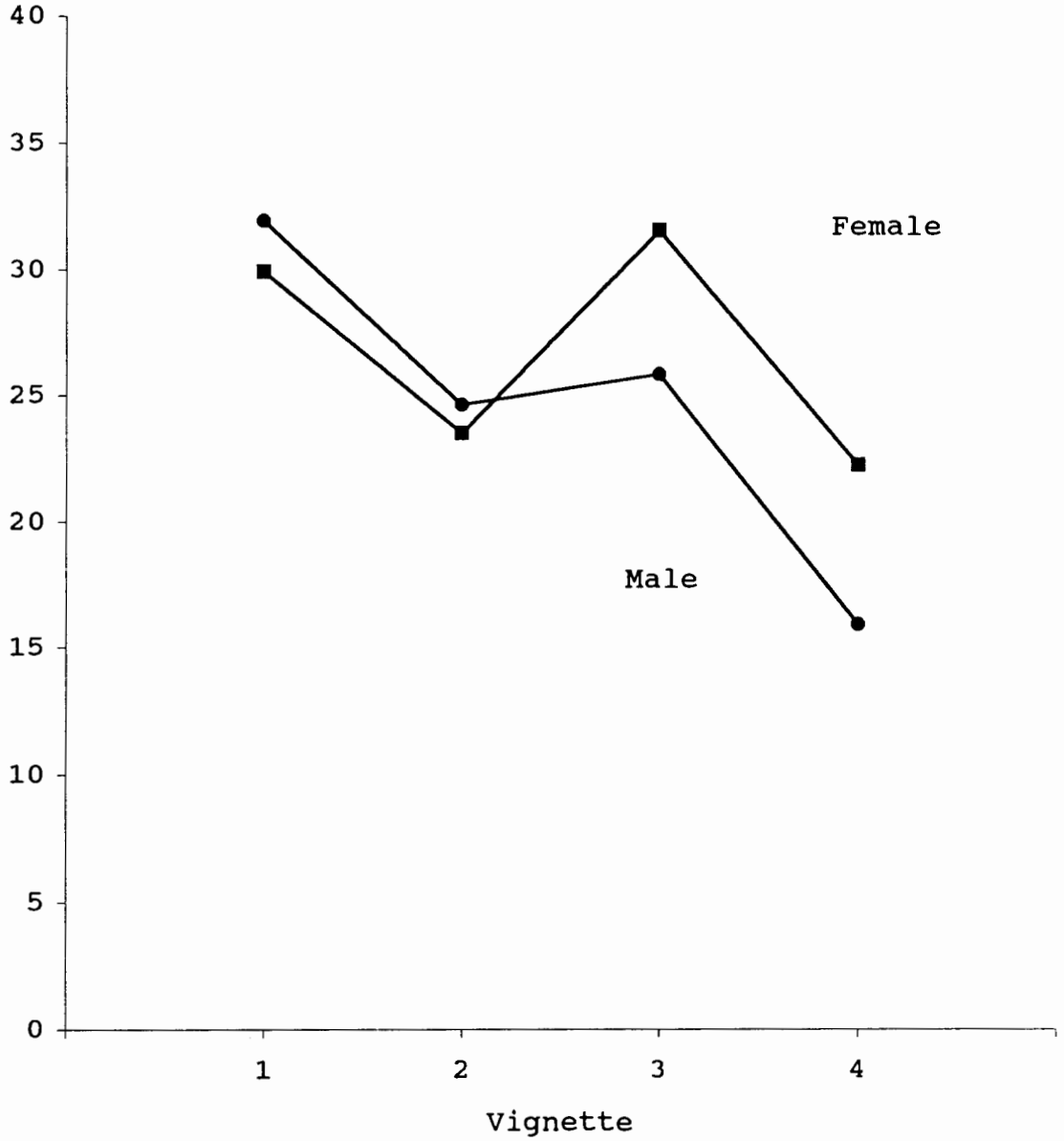

Figure 2.-Repeated Measures Analysis of Variance of Caring Scale: Interaction of Vignette by Client Sex

Analysis of Variance: Uninvolved Scale

There were no significant differences between the responses of male therapists and the responses of female therapists on the uninvolved scale (see table 19). The only main effect difference of significance found was in regard

Table 19.-Repeated Measures ANOVA: Uninvolved Scale

SV	df	SS	MS	F	Sig F*
SubSex	1	8.63	8.63	.07	.795
Within	51	6428.46	126.05		
Vignette	3	5031.51	1677.17	48.93	.000*
SS x Vign	3	15.28	5.09	.15	.930
Within	153	5244.44	34.28		
ClSex (CS)	1	.62	.62	.02	.878
SS x CS	1	3.56	3.56	.14	.712
Within	51	1314.23	25.77		
VignxCS	3	511.76	170.59	7.68	.000*
SSxCSxVign	3	22.17	7.39	.33	.802
Within	153	3400.32	22.22		

*This column indicates the probability that the F statistic is significantly different than zero. The starred numbers (*) are statistically significant at the .05 level.

to the vignettes (p=.000). However, responses to vignettes were confounded by client sex (p=.000) as shown in figure 3.

When the vignettes showed male clients, the uninvolved scores were the lowest for the angry experimental condition (vignette 1), the next lowest for the sexy experimental condition (vignette 2), the next lowest for the needy experimental condition (vignette 3) and the highest for the vague experimental condition (vignette 4). When the vignettes showed female clients, the lowest uninvolved score was for the needy experimental condition (vignette 3), the next lowest for the angry experimental condition (vignette 1), the next lowest for the sexy experimental condition (vignette 2), and the highest for the vague experimental condition (vignette 4).

Table 20.-Uninvolved Mean Scores:
Experimental Condition (Vignette) by Client Sex

EXPERIMENTAL CONDITION		CLIENT MALE	CLIENT FEMALE
VIGNETTE 1	ANGRY	11.7	13.3
VIGNETTE 2	SEXY	13.3	16.0
VIGNETTE 3	NEEDY	15.3	12.3
VIGNETTE 4	VAGUE	22.0	20.9

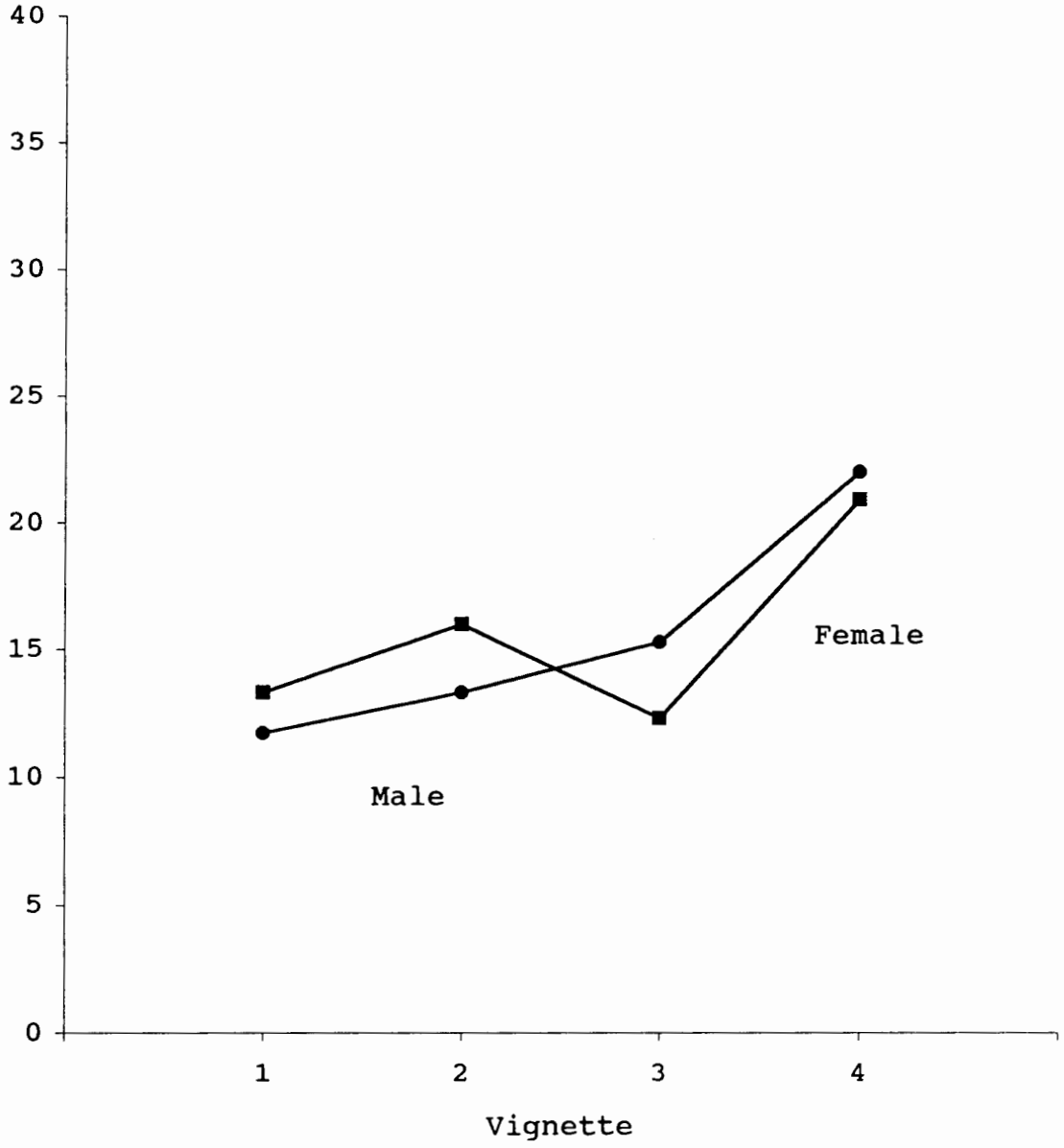

Figure 3.-Repeated Measures Analysis of Variance of Uninvolved Scale: Interaction of Vignette by Client Sex

Summary of Findings on the Three Scales

The research question concerned differences in the stress experienced by male therapists and by female therapists in regard to specific clinical situations. There were no significant differences found in the responses of the male therapist subjects and the responses of the female therapist subjects on any of the three scales. The three scales measured three dimensions of feeling responses in therapists: distress; caring; and lack of involvement.

On all three scales, there were significant differences found in response to the four different experimental conditions (vignettes). These four conditions were: (1) alliance rupture (angry); (2) sexual stimulation (sexy); (3) seeking relief from the therapist (needy); and (4) ambiguity (vague).

The vignettes were constructed to evoke different feeling responses. However, the hypothesized differences in response to the vignettes according to subject gender were not found. Instead, male and female subjects responded in similar fashion to the four vignettes, but their reactions to the vignettes were confounded by client sex.

On two of the scales, the distress scale and the caring scale, significant differences were found in regard to the sex of the client. Inferences regarding these differences were confounded by a significant interaction effect with vignette.

The mean scores of the client/condition configurations on each of the scales have been ranked for comparison (see table 21). The scores on the distress scale and the caring scale have been ranked from highest (1) to lowest (8). This has been inverted for the uninvolved scale whose scores have been ranked from lowest (1) to highest (8).

There is consistency across the three scales when the rankings are divided into three sections. The top three rankings on each scale include the angry male and the angry female, and the needy female. The top three rankings for the caring scale and the uninvolved scale are the same. However in evoking distress, the angry female client is ranked first, rather than third as on the other two scales.

The bottom two rankings are identical across all three scales. The vague male evoked the least distress, the least caring and the highest level of uninvolvement. Next up in the rankings (seventh), on all three scales, was the vague female.

There was consistency across scales in that the middle three rankings (fourth, fifth, and sixth) of each scale included the sexy male, the sexy female, and the needy male. However, their order within the midsection varied from scale to scale with no discernible pattern.

Table 21.-Rankings of Client/Condition on Scales*

RANK	DISTRESS	CARING	UNINVOLVED
1	Angry Female	Angry Male	Angry Male
2	Angry Male	Needy Female	Needy Female
3	Needy Female	Angry Female	Angry Female**
4	Sexy Male	Needy Male	Sexy Male**
5	Sexy Female	Sexy Male	Needy Male
6	Needy Male	Sexy Female	Sexy Female
7	Vague Female	Vague Female	Vague Female
8	Vague Male	Vague Male	Vague Male

*Ranked highest (1) to lowest (8) on Distress Scale
Ranked highest (1) to lowest (8) on Caring Scale
Ranked lowest (1) to highest (8) on Uninvolved Scale

**The angry female and the sexy male tied for third place with identical scores on the Uninvolved Scale

Analysis of Variance: Attracted

The feeling attracted was analyzed as a variable within itself as it did not correlate with any of the three scales. Table 22 shows that significant main effect differences were found between male and female therapist subjects in their attracted responses (p=.010). Significant main effect differences were also found in regard to client sex (p=.011) and in regard to the vignettes (p=.000).

Table 22.-Repeated Measures ANOVA: Attracted

SV	df	SS	MS	F	Sig F*
SubSex	1	66.05	66.05	7.07	.010*
Within	55	513.73	9.34		
Vignette	3	151.80	50.60	26.96	.000*
SS x Vign	3	.41	.14	.07	.974
Within	165	309.65	1.88		
ClSex (CS)	1	8.28	8.28	6.98	.011*
SS x CS	1	12.71	12.71	10.70	.002*
Within	55	65.29	1.19		
VignxCS	3	36.99	12.33	8.57	.000*
SSxCSxVign	3	2.26	.75	.52	.667
Within	165	237.28	1.44		

*This column indicates the probability that the F statistic is significantly different than zero. The starred numbers (*) are statistically significant at the .05 level.

Table 23.-Attracted Mean Scores:
Subject Sex by Client Sex

		SUBJECT SEX	
		MALE	FEMALE
CLIENT SEX	MALE	3.26	2.83
	FEMALE	3.87	2.77

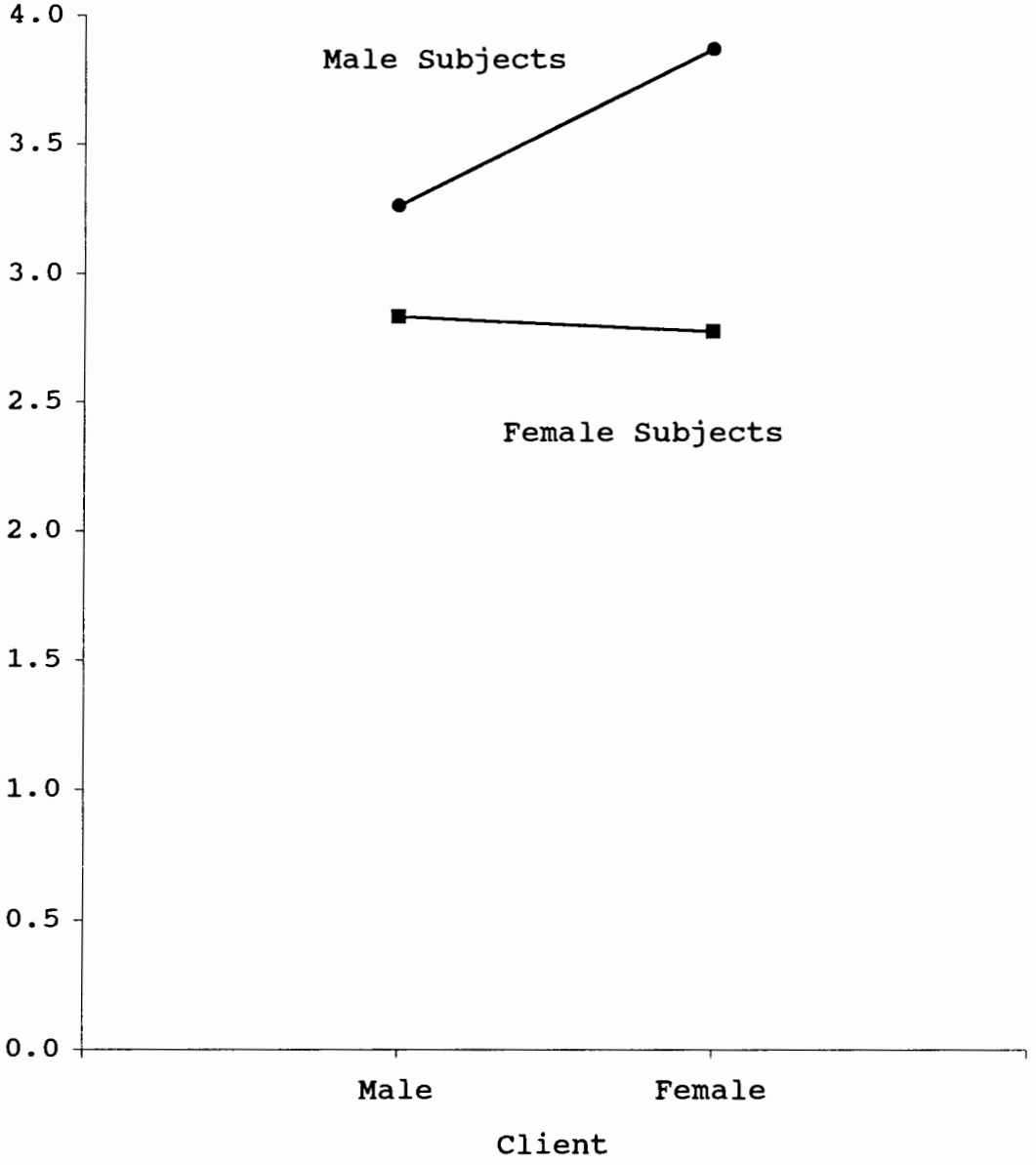

Figure 4.-Repeated Measures Analysis of Variance of Attracted: Interaction of Subject Sex by Client Sex

However, there were also significant interaction effects found between subject sex and client sex ($p=.002$) and significant interaction effects between vignette and client sex ($p=.000$).

The interaction between subject sex and client sex was ordinal (see table 23 and figure 4). Male subjects were more attracted to the clients, both male clients and female clients, than were female subjects. However, male subjects were more attracted to female clients than to male clients, and female subjects were more attracted to male clients than to female clients.

While attracted was the only dependent variable in which there was a significant difference between male subjects and female subjects, it was not a particularly meaningful finding. All of the mean ratings for attracted (see table 23) were less than four which would indicate "somewhat" on the feeling scale. Hence, attracted did not dominate the feeling response for male or female subjects.

Most/Least Favored Clients

In addition to responding to the feeling measurement instrument, subjects were asked to choose which client they would least like to work with and which client they would most like to work with. Subjects were also asked why they made that choice.

The angry male client was chosen most often by male subjects as the most desirable client to work with. The

needy female client was the second most popular client with male subjects. These two choices accounted for two-thirds of the male subjects' choices (see table 24). The needy female client was the most popular client with female subjects, followed by the angry female client and then the angry male client. These three choices accounted for three-fourths of the female subjects' choices (see table 24).

Table 24.-Ranking of Most Favored Clients by Subject Sex

Rank	MALE SUBJECT CHOICE		FEMALE SUBJECT CHOICE	
	CLIENT	%	CLIENT	%
1	Angry Male	38%	Needy Female	38%
2	Needy Female	31%	Angry Female	22%
3	Sexy Female	12%	Angry Male	16%
4	Sexy Male	8%	Needy Male	13%
5	Angry Female*	4%	Sexy Female	6%
6	Vague Female*	4%	Sexy Male**	3%
7	Vague Male*	4%	Vague Female**	3%
8	Needy Male	0%	Vague Male	0%

*These three clients tied for fifth place.
**These two clients tied for sixth place.

The reasons most often given to explain why a subject would most like to work with a particular client were: (1) The client seemed to be engaged, seemed to be asking for help. (2) The subjects liked that type of client or were reminded of a client of their own that they had liked. (3) The client seemed to be in touch with feelings. (4) The client would be challenging to work with.

When asked which client they would least like to work with, male subjects chose the vague male client, followed by the vague female client. The vague clients accounted for 61% of the choices made by male subjects (see table 25). The vague clients accounted for 62% of the female subjects' choices, with the votes split evenly between the vague male and the vague female (see table 25).

The reasons most often given to explain why a client was chosen by subjects as the one they would least like to work with were: (1) They felt no connection to the client; the client didn't seem engaged. (2) The subjects disliked that type of client or doing the kind of treatment required by that type of client. (3) The client was boring. (4) The subjects were made uncomfortable by that type of client.

In general, subjects liked to work with the needy female or the same-sexed angry client. These three clients were the ones that ranked highest on the distress scale and the caring scale and with whom the subjects were the least uninvolved. The least liked clients, the vague male and

female, were ranked lowest on the distress scale and the caring scale. They were the clients with whom the subjects were the most uninvolved.

Table 25.-Ranking of Least Favored Clients by Subject Sex*

Rank	MALE SUBJECT CHOICE		FEMALE SUBJECT CHOICE	
	CLIENT	%	CLIENT	%
1	Vague Male	42%	Vague Male**	31%
2	Vague Female	19%	Vague Female**	31%
3	Angry Female	15%	Sexy Male	16%
4	Sexy Female	12%	Sexy Female	13%
5	Sexy Male	8%	Angry Female	6%
6	Angry Male	4%	Needy Female	3%
7	Needy Female***	0%	Angry Male***	0%
8	Needy Male***	0%	Needy Male***	0%

*Rank of "1" indicates client most often chosen as least favored.
**Tied for first place.
***Tied for seventh place.

The findings based on this measure are in keeping with the findings based on the feeling measurement instrument. However, the meaning of these findings is still unclear.

CHAPTER 6

DISCUSSION

The Research Question and Operational Hypotheses

This study investigated whether male psychotherapists and female psychotherapists were stressed by different aspects of the clinical process. To investigate this question, four clinical situations were chosen as the experimental conditions. These four situations were chosen based on theory and research that suggested they might have gender-linked meaning.

The experimental conditions represented: (1) an alliance rupture indicated by a client's anger at the therapist; (2) sexual stimulation in the client's material or physical presentation; (3) seeking relief of anxiety from the therapist; and (4) ambiguity in the meaning of the material presented by a client.

These four situations were role-played by young adult actors and these role-plays were videotaped. Each situation was enacted twice, once using a female actor as the client and then using a male actor as the client. These videotaped vignettes were then shown to male and female psychotherapists. Their responses to the vignettes were measured after

each videotape was shown using a feeling list measurement instrument.

Factor scaling was used to create measurement scales assessing distress, caring, uninvolvement and attraction. Repeated measures analyses of variance analyzed the data for differences in the responses of male psychotherapists and the responses of female psychotherapists regarding each of the four dependent variables.

The research question concerned only stress, not other emotional responses. However, the research was presented as concerning feelings, so a variety of feelings were measured to disguise the specific nature of the investigation. The discussion of the research question and the operational hypotheses are exclusively based on the analysis of variance of the distress scale which measured uncomfortable feelings.

The Operational Hypotheses

1. Male therapists will experience more uncomfortable feelings than female therapists in reaction to a client who is ambiguous.

The null hypothesis: The uncomfortable feelings male therapists experience in reaction to a client who is ambiguous will be the same as or less intense than the uncomfortable feelings female therapists experience in reaction to a client who is ambiguous.

There was no significant difference between the uncomfortable feelings experienced by female therapists and the

uncomfortable feelings experienced by male therapists in reaction to vignettes of clients who were ambiguous. The null hypothesis cannot be rejected.

2. Male therapists will experience more uncomfortable feelings than female therapists in reaction to sexual stimulation from a client.

The null hypothesis: The uncomfortable feelings male therapists experience in reaction to sexual stimulation from a client will be the same as or less intense than the uncomfortable feelings female therapists experience in reaction to sexual stimulation from a client.

There was no significant difference between the uncomfortable feelings experienced by female therapists and the uncomfortable feelings experienced by male therapists in reaction to vignettes depicting sexual stimulation. The null hypothesis cannot be rejected.

3. Female therapists will experience more uncomfortable feelings than male therapists in reaction to a client's seeking relief from the therapist.

The null hypothesis: The uncomfortable feelings female therapists experience in reaction to a client's seeking relief from the therapist will be the same as or less intense than the uncomfortable feelings male therapists experience in reaction to a client's seeking relief from the therapist.

There was no significant difference between the uncomfortable feelings experienced by male therapists and the uncomfortable feelings experienced by female therapists in reaction to the vignettes depicting client's seeking relief from the therapist. The null hypothesis cannot be rejected.

4. Female therapists will experience more uncomfortable feelings than male therapists in reaction to an alliance rupture in the therapeutic relationship.

The null hypothesis: The uncomfortable feelings female therapists experience in reaction to an alliance rupture in the therapeutic relationship will be the same as or less intense than the uncomfortable feelings male therapists experience in reaction to an alliance rupture in the therapeutic relationship.

There was no significant difference between the uncomfortable feelings experienced by male therapists and the uncomfortable feelings experienced by female therapists in reaction to vignettes depicting an alliance rupture. The null hypothesis cannot be rejected.

The Research Question

Is there a difference between the clinical situations that stress male psychotherapists and the clinical situations that stress female psychotherapists?

As shown in the findings to the operational hypotheses, this study found no indication of a difference between the clinical situations that stress male

psychotherapists and the clinical situations that stress female psychotherapists. To the contrary, this study found that male psychotherapists and female psychotherapists are surprisingly alike in their reactions to clinical situations.

Male and female psychotherapists, alike, responded differently to different clinical situations. There was a statistically significant difference in the discomfort evoked in the therapist subjects by the different clinical vignettes. This indicated that some clinical situations are more stressful to therapists than others. However, male and female therapists agreed on which clinical situations evoked more uncomfortable feelings.

Whether the client was male or female also affected the intensity of discomfort experienced by the therapist subjects. There was a statistically significant difference in the discomfort evoked in the therapist subjects depending on whether the experimental condition was enacted by a male client or a female client. Again, male and female therapists agreed on whether a male client or a female client evoked more uncomfortable feelings.

As subject groups, male therapists and female therapists were very much alike in their responses. Within each group, however, there was a range of responses given. For both the male and female subjects, over eighty-seven percent

of the scores ranged at least six (out of seven) points on the Likert scale.

Other Findings

In addition to the distress scale, two other scales were used to measure the reactions of subjects to the clinical vignettes, the caring scale and the uninvolved scale. Analyses of the scores on these two scales produced similar findings to those based on the distress scale. There was no statistically significant difference between the caring responses of male therapists and the caring responses of female therapists to the clinical vignettes. There was no statistically significant difference between the uninvolved responses of male therapists and the uninvolved responses of female therapists to the clinical vignettes. All three scales measured remarkably similar reactions in male and female therapists.

On all three scales, there were statistically significant differences in the reactions of the therapists to the four different clinical situations. Therapists varied in their caring responses, their distressed reactions, and their lack of involvement. However, this variation was based not on the therapists' gender, but on the particular client/clinical situation configuration.

Based on this small sample, it seems possible that certain types of clients, expressing certain types of feelings, call up a universal reaction in therapists.

If so, these reactions to clients may be important, diagnostically.

While the gender of the therapist was hypothesized to be a meaningful variable, it actually turned out that the gender of the client was a meaningful variable. On two of the three scales, the caring scale and the distress scale, there were statistically significant differences in the reactions of therapists depending on the gender of the client. These findings were confounded by the different reactions to the different vignettes, so no generalizations can be made.

The clinical situations depicting sexual stimulation were interpreted, and enacted, in very different ways by the male and female clients. The female client depicting sexual stimulation was coy and flirtatious while alluding to the temptation to have phone sex with her boyfriend. The male client depicting sexual stimulation was very earnestly and explicitly describing what excited him in a sexual encounter. While both of these enactments were sexual, they were not comparable. It is possible that the sex of the client was not the variable that accounted for the differing responses to these two vignettes.

Likewise, the clinical situations depicting ambiguity were interpreted, and enacted, in very different ways. The female client depicting ambiguity was spacy in manner and scattered in her thinking. She jumped from one subject to

the next, in mid-sentence, and the actual content of her monologue was very confusing. It was difficult to understand what she was talking about. In contrast, the male client depicting ambiguity was very concrete in his thinking and his voice was a monotone. The content of his monologue was sensible, if somewhat vague, but its meaning was totally obscure. It was difficult to know why he was talking about those particular things. It is possible that the difference in the clinical material itself, rather than the difference in client gender, accounted for the differing responses to these two vignettes.

The clinical situation depicting an alliance rupture and the clinical situation depicting seeking relief from the therapist were categorically very similar. Yet, the personalities of the actors gave a very different feel to the male and female versions of these two situations.

As noted in the Introduction, the difficulty in identifying the significance of gender as an independent variable is manifold. The complexity of these four clinical situations and the uniqueness of each actor's interpretation make it unlikely that gender of the client was the only variable affecting the subjects' responses.

However, it may be impossible to make comparable vignettes using male and female clients. Are coy, flirtatious men experienced in the same way as coy, flirtatious women? Are emotionally needy men and emotionally needy

women experienced in the same way? Are angry men and angry women viewed the same? It is possible that the gender of the client changes the meaning of the clinical situation.

The one dependent variable in which there was a statistically significant difference between the responses of male therapists and the responses of female therapists was "attracted." Male therapists were more attracted to female clients than to male clients, and female therapists were more attracted to male clients than to female clients. However, all the attracted scores were less than "somewhat." This difference between male and female therapists does not seem particularly meaningful given that attracted was not one of the predominant emotional responses to any of the clients by any of the subjects.

The Research Methodology: Reliability and Validity

The design of this research was based on the assumption that videotapes portraying clients would elicit feelings in the therapist subjects and that the subjects would accurately report their emotional responses. An analogous study (Frodi et. al. 1978) used videotapes of infants crying as a stimulus to measure the difference between parents' responses to the faces and cries of premature infants and parents' responses to the faces and cries of full-term infants. The self-reported perception of parents was positively correlated with physiologic measures

taken during the viewing, thus indicating that this was a valid method of investigating emotional responses.

This research investigation used field testing rather than the controlled environment of a laboratory. The field testing placed the therapist subjects in their own professional offices. The research was conducted during the time of day in which the therapists typically saw clients. The therapist subjects who came to the researcher's office, though not in their own offices, were still in a therapeutic environment.

The videotaped vignettes were intended to represent four specific clinical situations: (1) an alliance rupture; (2) sexual stimulation; (3) seeking relief from the therapist; and (4) ambiguity. Though any clinical communication is complex and multilayered, the briefness of the vignettes (under two minutes) made it possible to keep them focused.

A panel of experts was used to determine if these vignettes portrayed the clinical situations as conceptualized. The experts were also asked to judge if each vignette was likely to be interpreted as something other than the specified clinical situation. There was unanimous agreement among the judges that the videotaped vignettes validly portrayed the intended clinical situations.

The feeling measurement list was constructed to measure the emotional reactions of the subjects. The list contained seventeen feelings to be measured using a Likert

scale. The list was constructed on the basis of previous research into therapists' feelings. Since this research used videotapes of clients rather than actual therapist-client relationships, some changes were made in the choice of feelings in accord with the change in context. A pilot study was done to test this measurement instrument before beginning the research.

Subjects' responses, over the course of the eight vignettes, ranged from one to seven for each of the seventeen feelings. This variation suggests that the measurement instrument was sensitive to a range of responses.

Factor scaling was used to create three scales of feelings: distressed, caring, and uninvolved. Both inter-case and inter-item reliability of these scales were assessed using Cronbach's alpha. All three scales had good reliability ratings.

The results of this study, while not in keeping with the hypothesized findings, suggest that this methodology is a valid method for investing therapists' reactions to clinical situations. The different clinical vignettes evoked significantly different responses that were captured on scales based on the feeling measurement list.

Conclusion

Research and theory have suggested that tension between work role and gender role for therapists results in a difference between the clinical situations that stress male

therapists and the clinical situations that stress female therapists. This was an exploratory investigation of that question.

The findings of this study did not indicate any difference between the clinical situations that stress male therapists and the clinical situations that stress female therapists. On the contrary, the male and female therapist subjects in this study were remarkably alike in their emotional responses to the clinical vignettes. There are several possible interpretations of these findings.

It is possible that therapists' reactions to watching videotaped vignettes of actors role-playing clients are not analogous to the reactions therapists have to clients in the context of a relationship. Perhaps in the context of an ongoing therapeutic relationship, where transference and countertransference reactions are fundamental to the relationship dynamics, therapists experience the theorized tension between work role and gender role. If so, it would require a different methodology to research it.

It is possible that male social workers, a self-selected group in a female-dominated profession, do not experience the same gender role imperatives typical of males in this culture. If so, research would need to be done using male psychologists and male psychiatrists to see if they differ from male social workers in their reaction to clinical situations.

It is possible that professional training and experience lead to the development of a secure professional sense of self that is similar for male and female therapists. If so, this professional sense of self, the work ego, may be less vulnerable to gender imperatives than theory speculates. The therapist subjects in this sample, as a group, were mature, experienced professionals.

It is also possible that tension between work role and gender role takes a unique form for each therapist. While there may be strong gender role norms in this culture, each person's gender identity reflects a specific, personal accommodation including ethnic, class, and familial expectations regarding men and women. Therapists may, indeed, experience tension between work role and gender role. But the nature of this tension may vary as much within each gender as it does between genders.

Given that we live in a highly gendered society, it seems likely that gender plays a meaningful role in all relationships, including therapeutic relationships. However, it is difficult to study a variable of such complexity.

APPENDIX 1

VIDEOTAPED VIGNETTES: THE EXPERIMENTAL CONDITIONS

CRITERIA FOR EXPERTS:

Experimental Conditions: Videotaped Vignettes

This study is concerned with the feelings that clients evoke in their therapists. These feelings are usually conceptualized as countertransference. This study does not differentiate between feelings belonging to the therapist and feelings belonging to the client. It is assumed that most countertransference experiences involve both the client's feelings and the therapist's feelings.

The following clinical situations have been chosen as being typical of what a therapist is likely to encounter. They are also situations likely to evoke a range of feelings in therapists. The four experimental conditions are: 1) when a client is angry at his therapist; 2) when a client, or his material, is sexually interesting; 3) when a client seems very needy and tries to elicit relief from his therapist; and 4) when a client is vague or ambiguous such that the therapist can't understand why the client is saying what he is saying.

The following vignette outlines are intended to convey the idea of each vignette: 1) the concept of the feeling being communicated and 2) the possible behavioral indicators of the feeling. The actual vignettes will not necessarily include each major concept, nor will each major concept necessarily be represented by all the listed indicators. It is possible that a vignette will not include any of the

concepts or indicators listed, yet you might still find it is valid in portraying the essence of the experimental condition. It is possible that a vignette might contain all of the listed concepts and indicators, yet still not really capture the intended feeling.

The operationalized variables are intended to indicate typical ways by which affect is communicated. However, what is most important in these vignettes is the actual expression of feeling by the clients. As an expert, you will be asked to judge if each vignette conveys the intended expression of feeling.

Experimental Condition #1: Alliance Rupture

These vignettes are intended to portray a rupture in the relationship between therapist and client. They will feature a client's overt expression of negative feelings toward the therapist which is the most direct indication of an alliance rupture (Safran et. al. 1990).

This study is trying to investigate how therapists feel when their clients are angry at them, don't like them, or don't want to talk to them. Therapists are trained to tolerate such moments. They usually understand such moments diagnostically, i.e., what they convey about the client's transference, psychopathology and/or phase of treatment. Therapists use clinical judgments to decide how to respond in these moments.

However, therapists, as men and women, have their own feelings and conflicts which may be touched in these moments. Being the recipient of someone else's anger can be difficult. This study attempts to identify what kind of feelings therapists experience in moments such as these.

When viewing the next two tapes, please consider whether or not they portray an alliance rupture. Are the "clients" convincing and authentic enough to evoke a feeling response in the therapists watching the tapes?

FEMALE CLIENT

Does the client convey:

yes	no	
____	____	anger at the therapist
____	____	words indicating anger
____	____	tone of voice indicating anger
____	____	facial expressions indicating anger
____	____	withdrawal from the therapist
____	____	words indicating withdrawal
____	____	silence
____	____	turning or looking away
____	____	criticism of the therapist
____	____	disparaging remark about therapist
____	____	challenging his competence

As an expert, is it your judgment that this vignette validly portrays an alliance rupture? Yes ____ No ____ If no, why not? _____

_____

Most clinical situations can be interpreted in many ways. Do you think this vignette is LIKELY to be interpreted as something other than an alliance rupture? Yes ____ No ____ If yes, how do you think this vignette is likely to be interpreted? _____

Do you think this vignette will be effective in evoking the kinds of feelings a therapist typically experiences during an alliance rupture? Yes ____ No ____ If no, why not?__

_____

_____ _____

signature date

MALE CLIENT

Does the client convey:

yes	no	
____	____	anger at the therapist
____	____	words indicating anger
____	____	tone of voice indicating anger
____	____	facial expressions indicating anger
____	____	withdrawal from the therapist
____	____	words indicating withdrawal
____	____	silence
____	____	turning or looking away
____	____	criticism of the therapist
____	____	disparaging remarks about therapist
____	____	challenging his competence

As an expert, is it your judgment that this vignette validly portrays an alliance rupture? Yes ____ No ____ If no, why not? _____

_____

Most clinical situations can be interpreted in many ways. Do you think this vignette is LIKELY to be interpreted as something other than an alliance rupture? Yes ____ No ____ If yes, how do you think this vignette is likely to be interpreted? _____

Do you think this vignette will be effective in evoking the kinds of feelings a therapist typically experiences during an alliance rupture? Yes ____ No ____ If no, why not?__

_____

_____ _____

signature date

Experimental Condition 2: Sexual Stimulation

In these vignettes, the clients will be feeling sexual or will be concerned with sexual matters. In some manner, they will draw attention to their own sexuality.

There are many different situations whereby a client may be sexually stimulating to a therapist. The client may do this purposely, or it may be unintentional. The client may be conscious of his own sexuality, or may not have any awareness that he is being sexually stimulating.

Sometimes a client's growth or sense of empowerment can take on a sexual aura. If a client feels good about himself, feels alive, it can have a vitality that is akin to sexuality. Some clients are very physically attractive. Therapists may find themselves sexually attracted to these clients even if the clients are not concerned with sexual material or their own sexuality.

While sexual feelings toward clients may be natural, the taboos against relating sexually toward clients are such that therapists may not experience these feelings as acceptable. Therapists may be very uncomfortable with the idea of being sexually aroused by a client. Therapists may use other feelings, i.e. detachment or irritability, to defend against such feelings.

When viewing the next two tapes, please consider whether or not they portray clients whose communication is sexually interesting.

FEMALE CLIENT

Does the client convey:

yes	no	
____	____	attention drawn to the body
____	____	sexy or revealing clothes
____	____	seductive body posture
____	____	seductive body movement
____	____	discussing sexual matters
____	____	talk of sexual relationships
____	____	talk of own sexuality
____	____	talk of physical experiences
____	____	flirting with the therapist
____	____	teasing or coyness
____	____	sexual innuendos
____	____	sexual tone of voice

As an expert, is it your judgment that this vignette validly concerns sexuality ? Yes ____ No ____ If no, why not?

_____

Most clinical situations can be interpreted in many ways. Do you think this vignette is LIKELY to be interpreted as something other than concerning sexuality? Yes ____ No ____ If yes, how do you think this vignette is likely to be interpreted? _____

_____

Do you think this vignette will be effective in evoking the kinds of feelings a therapist typically experiences when a client is sexually interesting? Yes ____ No ____ If no, why not?

_____

_____ _____

signature date

MALE CLIENT

Does the client convey:

yes	no	
____	____	attention drawn to the body
____	____	sexy or revealing clothes
____	____	seductive body posture
____	____	seductive body movement
____	_____	discussing sexual matters
____	____	talk of sexual relationships
____	____	talk of own sexuality
____	____	talk of physical experiences
____	____	flirting with the therapist
____	____	teasing or coyness
____	____	sexual innuendos
____	____	sexual tone of voice

As an expert, is it your judgment that this vignette validly concerns sexuality? Yes ____ No ____ If no, why not? ___
_____

Most clinical situations can be interpreted in many ways. Do you think this vignette is LIKELY to be interpreted as something other than concerning sexuality? Yes ____ No ____ If yes, how do you think this vignette is likely to be interpreted?
_____

Do you think this vignette will be effective in evoking the kinds of feelings a therapist typically experiences when a client is sexually interesting? Yes ____ No ____ If no, why not?
_____

_____ _____

signature date

Experimental Condition #3:
Seeking Relief from the Therapist

In these vignettes, clients will turn to the therapist for direct relief from their suffering. Rather than being able to be introspective, the clients will want the therapist to do something to make them feel better.

Clients may exhibit this type of behavior for all sorts of reasons. They might be feeling particularly needy or helpless. It might be their typical manner of relating to others, especially those in authority positions. It might be a defensive retreat from the therapist, or a retreat from the task of self-exploration.

In these situations, the clients are, actively or passively, trying to enlist their therapists into relinquishing an interpretive mode. The clients want their therapists to do or say something to relieve their anxiety and make them feel better.

This study does not attempt to differentiate between the various meanings that this type of behavior might have, even though that could have an effect on the therapist's feelings and response. How a therapist responds to this type of entreaty depends on many factors.

Please consider whether or not the next two tapes portray clients who are trying to get their therapists to do or say something that will make them feel better.

FEMALE CLIENT

Does the client convey:

yes	no	
____	____	wanting therapist to solve a problem
____	____	advice seeking
____	____	asking therapist to make a decision
____	____	wanting therapist to make something happen in therapy
____	____	passivity
____	____	trying to elicit explanations
____	____	trying to elicit interpretations
____	____	wanting therapist to make a feeling go away
____	____	imploring therapist
____	____	professing helplessness

As an expert, is it your judgment that this vignette validly portrays seeking relief from the therapist? Yes ____ No ___
If no, why not? _____

Most clinical situations can be interpreted in many ways. Do you think this vignette is LIKELY to be interpreted as other than seeking relief from the therapist? Yes ____ No _
If yes, how do you think this vignette is likely to be interpreted?

_____

Do you think this vignette will be effective in evoking the kinds of feelings a therapist typically experiences when a client is seeking relief? Yes ____ No ____ If no, why not? _____

_____ _____

signature date

MALE CLIENT

Does the client convey:

yes	no	
____	____	wanting therapist to solve a problem
____	____	advice seeking
____	____	asking therapist to make a decision
____	____	wanting therapist to make something happen in therapy
____	____	passivity
____	____	trying to elicit explanations
____	____	trying to elicit interpretations
____	____	wanting therapist to make a feeling go away
____	____	imploring therapist
____	____	professing helplessness

As an expert, is it your judgment that this vignette validly portrays seeking relief from the therapist? Yes ____ No ___
If no, why not? _____

Most clinical situations can be interpreted in many ways. Do you think this vignette is LIKELY to be interpreted as other than seeking relief from the therapist? Yes ____ No _
If yes, how do you think this vignette is likely to be interpreted?

_____

Do you think this vignette will be effective in evoking the kinds of feelings a therapist typically experiences when a client is seeking relief? Yes ____ No ____ If no, why not? _____

_____ _____

signature date

Experimental Condition #4: Ambiguity

In these vignettes, what the client is talking about will be unclear. If the content is clear, then the meaning of the communication will be obscure.

There are times when a therapist does not know what a client is talking about, or why a client is telling him something. This is different from situations in which a therapist can readily ask for clarification.

In these situations, a client is continuing to talk, seemingly involved in what he is saying. It would be necessary to abruptly interrupt the client for a therapist to request clarification or point out the confusing nature of the communication. A therapist, therefore, is likely to allow the communication to continue while not understanding the point of the communication.

Sometimes a therapist is not aware that such a situation is taking place, but, instead, finds himself bored or his attention drifting. Sometimes a therapist finds himself thinking, "why is he telling me this?" or "what is she talking about?" This study concerns the feelings a therapist might have at such moments.

Please consider whether or not the next two vignettes portray situations where it is unclear what the client is talking about or why the client is saying what he is saying.

FEMALE CLIENT

Does the client convey:

yes	no	
____	____	content is confusing
____	____	non sequiturs
____	____	lacking clear references
____	____	pronouns are confusing
____	____	jumps from one topic to another
____	____	meaning is confusing
____	____	lack of affect
____	____	content is too concrete
____	____	nature of associations confusing
____	____	rambles

As an expert, is it your judgment that this vignette validly portrays ambiguity in the therapy? Yes ____ No ____
If no, why not? _____

Most clinical situations can be interpreted in many ways. Do you think this vignette is LIKELY to be interpreted as other than ambiguity in the therapy? Yes ____ No ____ If yes, how do you think this vignette is likely to be interpreted?

_____

Do you think this vignette will be effective in evoking the kinds of feelings a therapist typically experiences when they don't understand what a client is talking about?
Yes ____ No ____
If no, why not? _____

_____ signature

_____ date

MALE CLIENT

Does the client convey:

yes	no	
____	____	content is confusing
____	____	non sequiturs
____	____	lacking clear references
____	____	pronouns are confusing
____	____	jumps from one topic to another
____	____	meaning is confusing
____	____	lack of affect
____	____	content is too concrete
____	____	nature of associations confusing
____	____	rambles

As an expert, is it your judgment that this vignette validly portrays ambiguity in the therapy? Yes ____ No ____
If no, why not? _____

Most clinical situations can be interpreted in many ways. Do you think this vignette is LIKELY to be interpreted as other than ambiguity in the therapy? Yes ____ No ____ If yes, how do you think this vignette is likely to be interpreted?

_____

Do you think this vignette will be effective in evoking the kinds of feelings a therapist typically experiences when they don't understand what a client is talking about?
Yes ____ No ____
If no, why not? _____

_____ _____
signature date

CREDENTIALS OF EXPERTS

Name _____

Address _____

_____

Social Work School attended _____

Degree and year of degree _____

Are you an Illinois Licensed Clinical Social Worker? _____

Number of years of clinical practice? _____

Current professional positions: _____

_____

_____

_____

Other professional affiliations or credentials: _____

_____

_____

TRANSCRIPTS OF THE VIDEOTAPED VIGNETTES

Transcript of alliance rupture: female client

The female client sits staring off. She moves, somewhat, in her chair. She looks upset and is silent. This silent, opening sequence lasts for 25 seconds. She says, "You know, I really thought that coming here was going to make me feel better (she then moves forward in her chair) and it's quite frankly made me feel worse. So..." She pauses, moves around in her chair seeming agitated, then speaks, exaggerating her words, "So, why don't we just call it a day, huh?" Her voice turns sharp, "fine...we'll just sit here." Fifteen seconds pass. She is staring at the camera. In a sharp voice, she says, "What! What do you want me to say? I have nothing to say to you." In a sarcastic, exaggerated voice she says, "Sorry." She stares, silently. She sits back in her chair, staring and silent. The tape ends.

This videotaped vignette lasts one minute, forty-five seconds.

Transcript of alliance rupture: male client

The tape starts with the client saying, in a loud voice, "If you've in fact shown me what this is about...this relationship, therapist/troubled person is about, then I've learned. And I know exactly what it means now. And frankly, I can do it on my own. Okay?" He sits silently, looking off, looking angry. He is breathing very deeply. Suddenly, he says, "Say something! It's extremely frustrating. Tell me something, throw in a new point, how's that, how's that...how about throwing in something that I didn't already say first, okay. Because everything that's already come out of me, everything that I have already declared, is out. And I've an excellent memory and I don't need to have it rehashed. Alright? Maybe we should print a transcript so we don't spend so much time muddling through what we've already gone over. Because, frankly, that's getting tiring too and it's getting extremely frustrating. And forgive me if I'm getting a little angry here, but I tell you, the same old shit, every week, starts to wear me a little thin. And coming in and seeing you, staring across from me, every goddamn week, is wearing me thin." He looks off, breathing deeply. Then he wipes his nose. The tape ends.

This videotaped vignette lasts one minute, fifty-four seconds.

Transcript of sexual stimulation: female client

The client is an attractive redhead. She is leaning forward as the tape starts, she is saying, "...never see him. We're always on the phone, just because he's so far away." She moves back into the chair, with her knee up. It looks as if she's lying in bed. She is playing with her hair as she talks. "And, uh, so then we're talking really late at night and both of us are lying in bed, getting ready to go to sleep." She is stroking the neckline of her blouse. "Uhm, and I just, and I never know how far I should go. I don't want our conversations to...hmm, I don't want to set a precedent, you know, this is how I'll put him to sleep over the telephone, you know?" She looks at the camera, conspiratorially, and says, as if with a wink, "You know." She moves forward, stroking her neckline again. "But I think, I think I want him to know I'm not going to be able to be there, and kiss his eyelids when he's going to sleep, or, hmm, whatever else..." She looks off. "And he'll say things to me," she leans back. She is continually moving in a way that calls attention to her body, "...not really explicit, I think we're both sort of feeling out this territory. And it seems like it might be on the brink of something..." Coyishly, she says, "I don't know what..." She trails off. "I never know," she is running her hands through her hair, upward behind her head. "...I never know what he wants." Her voice and her position change. "And

it's fun..." She moves around in her seat, her voice becoming perky. "Sometimes we'll kid about sex, and we'll talk about the past things that we've done."

This videotaped vignette lasts one minute, fifty-four seconds.

Transcript of sexual stimulation: male client

The client is looking straight at the camera, speaking earnestly, "...making your partner feel good, that is very exhilarating. And, uh, that's what really kind of gets me off. More than my own personal, like, physical feelings; like, it's more, it's more sexually exciting to make someone else," he lowers his voice, "feel sexually excited than it is to simply be the recipient of a caress or something. And I think it has to do with pushing limits. Like, when you're with a woman and you know you're making her feel good and it's almost painful, you're making her feel so good. Or, she's having an orgasm and, and just, you just keep going," he moves his hands in gesture, "until it's like too, too much, you know. And that is really exciting. When you touch a woman and you know that makes her feel," his voice is very low, "good and that makes you feel good." He speaks up, "Or when you're being touched and it's the same situation, where she's trying to make you feel good and that's making her feel good. And I think it has a lot to do with the whole pleasure/pain. It's sexually exciting to feel pain. The line between pleasure and pain is sometimes indiscernible and that's what really ... turns me on." The tape ends.

This videotaped vignette lasts two minutes, three seconds.

Transcript of seeking relief from therapist: female client

The client looks at the camera with big eyes. "I think my mom is crazy. Not clinically crazy, but I think she's nuts. And I know that I've told you plenty about her, so, in the past few weeks, so if you've come away from that with any insight that might help me deal with this, then I would be eternally grateful. Anything...?" She looks encouragingly at the camera. "Cause I know how hard it must be for you to sift through all this shit I tell you. So, hmm..." She looks, eagerly, "I would be willing to work through it, were you to give me something to springboard off of." She pauses, "She's crazy, so... You know, I'm yearning, I'm begging you... Anything?" She pauses, waiting expectantly. Then her shoulders drop, "You know, I'm going to leave here without a clue of what to do unless you steer me... Is that asking too much? I don't want to put you in an awkward position. If you could put me on the right track I would feel so much better leaving here." The tape ends.

This videotaped vignette lasts one minute, fifty-five seconds.

Transcript seeking relief from therapist: male client

The client is holding his head in one hand and is gesturing with the other hand, "...and we'll have the biggest smiles in the world and we've not even have been talking for the past two minutes and, you know, something like that should say something, right? And it's funny, cause people think we're going out, and uh, uh, not between us, someone out of the blue asks us if we're going out or not. I think that there's something there. But, but, then something will happen and we'll not be talking for a while and, or, or..." He looks imploringly at the camera, "Why will we not be talking for a while? You know, and, and, I don't know, maybe she really does like him. I mean, maybe she likes both of us. Is that possible?" He looks up. "Or maybe she's waiting for me to say something and," he looks up again, "then she'll get rid of him. Could she be doing that? Could she be just waiting? Would someone like you, who's seen lots of situations where they just hold on..." He looks up for a response. "Is this like some classic case situation where you know something, like, that this has to go some way or she really means something else? Or she really means what she said, or is she fluctuating? Sometimes she means it and sometimes she doesn't? Could that be

possible? I don't know. Maybe. I mean, I don't know, what do you think?" He looks up and waits for an answer. The tape ends.

This videotaped vignette lasts one minute, forty seconds.

Transcript of ambiguity: female client

The client has a spacey tone of voice and seems distracted. The looks off, she scratches her shoulder, etc. "One of them has no closet and it's really strange. It, hmm, almost reminds me of... To illustrate, maybe I could...I could...uh,no, maybe not, no... You know, she calls me slacker which is so funny. 'Slacker!' And actually there was this person there who said, 'What are you? A snapper?' And I thought, 'my god, this man's living under a rock.' So I explained to him...I don't think he got it, really." She sighs. "So it was this big argument. What are we going to do without this closet? There's no closet here." She sighs, "God, how did it work? Bridget took the hallway and Odie...god, did he just fold his clothes?" She pauses. "Traffic's just absolutely annoying today. It seems like every single top street is gone. It's gone. They're repaving it in some manner or form. This truck actually ran over the, uh, the thing." Client gestures with her hand to indicate the thing the truck ran over. "It's odd...really, really odd." The tape ends.

This videotaped vignette lasts one minute, fifty-one seconds.

Transcript of ambiguity: male client

The client speaks continuously in a monotone voice. "...I had put my paint somewhere, and those guys had...my roommates had cleaned up. And, and I spent, like, a half hour looking for it. And I had a really good little brush with it too. And I knew I put it somewhere cause I knew I needed it this weekend and it wasn't where it was. That was, like, a half hour of trying to find my paints. A nice blue, the neon colors...bright green, bright orange, bright pink, bright blue and white. There's a lot of white on my car, it's...no...but, we weren't going to use my car. We were going to use the red car. So I bought white. And so then Charlie went to the copy place to enlarge all that stuff and I was cutting... I was taking the plastic bags and putting the stuff in it and stapling it at the top. Uh, hmm, I did, like 50 of those. And, uh, started getting a little tired and Eric came home. Eric started helping with stuff. And I had rented a movie. I don't know why I had rented a movie. But I had rented one hoping to watch it. But even though I didn't watch it, I had to take it back. So, I went and took the movie back. The tape ends.

This videotaped vignette lasts one minute, fifty-six seconds.

RELEASE FORM FOR ACTORS

Permission to Use Videos for Research Purposes

I, _____, understand that the videos that I am acting in will be used for research purposes only.

I give my permission to show these videos to psychotherapists as part of a dissertation research study of therapists' reactions to hypothetical clinical situations.

I give my permission to show these videos to therapists as part of any follow-up research project subsequent to the dissertation research.

I also give my permission to show these videos to therapists as part of any presentation on the research findings.

_____ _____

signature date

APPENDIX 2

MATERIAL USED WITH RESEARCH SUBJECTS

INFORMED CONSENT OF RESEARCH SUBJECTS

This research project is being done by Julie Coplon in partial fulfillment of the degree of Doctor of Social Work from Loyola University of Chicago.

The purpose of this research is to study therapists' feelings in response to typical clinical situations. You will be shown videotapes of "clients" (portrayed by actors) and you will be asked to identify the feelings evoked in you by each vignette. A simple questionnaire will be provided for this purpose. After you have seen all of the vignettes, you will be given another brief questionnaire to complete.

All responses will be confidential. The data will be analyzed in aggregate.

There are no known risks to subjects participating in this research project. However, research subjects have a right to withdraw their participation at any time, for any reason.

If you would like to receive a summary of findings at the conclusion of this research, please detach this section and return to Julie Coplon.

Name_____

Address_____

INSTRUCTIONS FOR SUBJECTS

You will be shown eight videotaped vignettes depicting situations that sometimes occur when working with clients. The "clients" you are about to see are actors, role-playing their parts. Each vignette shows a different client. You may have experienced similar situations with clients of your own.

This study attempts to identify the different feelings therapists have in response to different clinical situations. Watch each vignette as if the client were speaking directly to you and you were the therapist. Imagine that you have been working with this client for six months and that this is a session with your client.

Clients evoke a whole range of feelings in their therapists. What do you feel as you watch and listen to this client? Please try to be aware of all the different feelings you experience. Feelings may be rational or irrational, consistent or contradictory, intense or slight, fleeting or enduring.

After you have seen each vignette, you will be given a simple "feeling scale" to complete. A feeling may be intense, even if it is fleeting. This study concerns the variety and intensity of feelings evoked, regardless of how transitory the feeling might have been. <u>Please circle a number for each feeling listed even if you did not experience the feeling.</u>

INSTRUCTIONS TO SUBJECTS GIVEN VERBALLY
BY THE RESEARCHER

1) The subject was to pretend to have seen the client for six months. The researcher was not looking for a diagnostic reaction, but was interested in the therapeutic relationship after any diagnostic phase was complete. The subject was told: Pretend this is Tuesday morning and you just saw this client. How were you feeling when you were sitting there with the client?

2) This study does not differentiate between countertransference feelings originating in the therapist and countertransference feelings originating in the client and evoked in the therapist. Whatever the therapist felt while listening to the client was to be noted.

3) The therapist may find himself remembering a similar client and re-experiencing the feelings he actually had with such a client. Those feelings were to be recorded too since the real point of the research was to investigate how therapists feel with "clients like this."

4) The study was looking at <u>intensity</u> of feeling. It did not matter if the feeling was fleeting, or representative of an overall reaction. A sharp pang of a feeling should be circled "7" even if it only lasted a few seconds.

5) Circle a number for every feeling listed. If the therapist did not have the feeling, he should circle "1" for not at all.

6) The sound quality varied from tape to tape. Some words were difficult to hear. The researcher suggested that the therapist watch and listen to the whole tape. Just like in sessions, it might not be necessary to hear every word to understand the intent of the communication. However, if it was distracting to the therapist, he could ask the researcher what was said. The therapist was also welcome to see the tape more than one time if he had trouble hearing what was said.

CLIENT #1

I FELT	very			somewhat			not at all
sympathetic	7	6	5	4	3	2	1
thoughtful	7	6	5	4	3	2	1
involved	7	6	5	4	3	2	1
interested	7	6	5	4	3	2	1
empathic	7	6	5	4	3	2	1
detached	7	6	5	4	3	2	1
tense	7	6	5	4	3	2	1
attracted	7	6	5	4	3	2	1
impatient	7	6	5	4	3	2	1
guilty	7	6	5	4	3	2	1
bored	7	6	5	4	3	2	1
defensive	7	6	5	4	3	2	1
confused	7	6	5	4	3	2	1
concerned	7	6	5	4	3	2	1
anxious	7	6	5	4	3	2	1
irritated	7	6	5	4	3	2	1
uncomfortable	7	6	5	4	3	2	1
_____ other	7	6	5	4	3	2	1

Did this client remind you of any client you have worked with?

Yes _____

No _____

CLIENT #2

I FELT	very			some-what			not at all
bored	7	6	5	4	3	2	1
defensive	7	6	5	4	3	2	1
empathic	7	6	5	4	3	2	1
involved	7	6	5	4	3	2	1
confused	7	6	5	4	3	2	1
detached	7	6	5	4	3	2	1
impatient	7	6	5	4	3	2	1
sympathetic	7	6	5	4	3	2	1
uncomfortable	7	6	5	4	3	2	1
interested	7	6	5	4	3	2	1
anxious	7	6	5	4	3	2	1
tense	7	6	5	4	3	2	1
guilty	7	6	5	4	3	2	1
thoughtful	7	6	5	4	3	2	1
attracted	7	6	5	4	3	2	1
concerned	7	6	5	4	3	2	1
irritated	7	6	5	4	3	2	1
_____ other	7	6	5	4	3	2	1

Did this client remind you of any client you have worked with?

Yes _____

No _____

CLIENT #3

I FELT	very			some-what			not at all
involved	7	6	5	4	3	2	1
empathic	7	6	5	4	3	2	1
uncomfortable	7	6	5	4	3	2	1
thoughtful	7	6	5	4	3	2	1
concerned	7	6	5	4	3	2	1
tense	7	6	5	4	3	2	1
detached	7	6	5	4	3	2	1
attracted	7	6	5	4	3	2	1
confused	7	6	5	4	3	2	1
sympathetic	7	6	5	4	3	2	1
bored	7	6	5	4	3	2	1
defensive	7	6	5	4	3	2	1
impatient	7	6	5	4	3	2	1
guilty	7	6	5	4	3	2	1
anxious	7	6	5	4	3	2	1
irritated	7	6	5	4	3	2	1
interested	7	6	5	4	3	2	1
_____ other	7	6	5	4	3	2	1

Did this client remind you of any client you have worked with?

Yes _____

No _____

CLIENT #4

I FELT	very			somewhat			not at all
guilty	7	6	5	4	3	2	1
empathic	7	6	5	4	3	2	1
interested	7	6	5	4	3	2	1
concerned	7	6	5	4	3	2	1
thoughtful	7	6	5	4	3	2	1
bored	7	6	5	4	3	2	1
impatient	7	6	5	4	3	2	1
uncomfortable	7	6	5	4	3	2	1
involved	7	6	5	4	3	2	1
sympathetic	7	6	5	4	3	2	1
irritated	7	6	5	4	3	2	1
anxious	7	6	5	4	3	2	1
attracted	7	6	5	4	3	2	1
tense	7	6	5	4	3	2	1
confused	7	6	5	4	3	2	1
defensive	7	6	5	4	3	2	1
detached	7	6	5	4	3	2	1
_____ other	7	6	5	4	3	2	1

Did this client remind you of any client you have worked with?

Yes _____

No _____

CLIENT #5

I FELT	very			somewhat			not at all
irritated	7	6	5	4	3	2	1
concerned	7	6	5	4	3	2	1
involved	7	6	5	4	3	2	1
confused	7	6	5	4	3	2	1
guilty	7	6	5	4	3	2	1
uncomfortable	7	6	5	4	3	2	1
thoughtful	7	6	5	4	3	2	1
tense	7	6	5	4	3	2	1
detached	7	6	5	4	3	2	1
defensive	7	6	5	4	3	2	1
attracted	7	6	5	4	3	2	1
impatient	7	6	5	4	3	2	1
bored	7	6	5	4	3	2	1
sympathetic	7	6	5	4	3	2	1
anxious	7	6	5	4	3	2	1
empathic	7	6	5	4	3	2	1
interested	7	6	5	4	3	2	1
_____ other	7	6	5	4	3	2	1

Did this client remind you of any client you have worked with?

Yes _____

No _____

CLIENT #6

I FELT	very			somewhat			not at all
defensive	7	6	5	4	3	2	1
concerned	7	6	5	4	3	2	1
irritated	7	6	5	4	3	2	1
uncomfortable	7	6	5	4	3	2	1
bored	7	6	5	4	3	2	1
involved	7	6	5	4	3	2	1
tense	7	6	5	4	3	2	1
interested	7	6	5	4	3	2	1
confused	7	6	5	4	3	2	1
thoughtful	7	6	5	4	3	2	1
attracted	7	6	5	4	3	2	1
sympathetic	7	6	5	4	3	2	1
empathic	7	6	5	4	3	2	1
impatient	7	6	5	4	3	2	1
guilty	7	6	5	4	3	2	1
detached	7	6	5	4	3	2	1
anxious	7	6	5	4	3	2	1
_____ other	7	6	5	4	3	2	1

Did this client remind you of any client you have worked with?

Yes _____

No _____

CLIENT #7

I FELT	very			some-what			not at all
involved	7	6	5	4	3	2	1
empathic	7	6	5	4	3	2	1
tense	7	6	5	4	3	2	1
irritated	7	6	5	4	3	2	1
bored	7	6	5	4	3	2	1
detached	7	6	5	4	3	2	1
anxious	7	6	5	4	3	2	1
guilty	7	6	5	4	3	2	1
attracted	7	6	5	4	3	2	1
defensive	7	6	5	4	3	2	1
uncomfortable	7	6	5	4	3	2	1
thoughtful	7	6	5	4	3	2	1
interested	7	6	5	4	3	2	1
impatient	7	6	5	4	3	2	1
sympathetic	7	6	5	4	3	2	1
concerned	7	6	5	4	3	2	1
confused	7	6	5	4	3	2	1
_____ other	7	6	5	4	3	2	1

Did this client remind you of any client you have worked with?

Yes _____

No _____

CLIENT #8

I FELT	very			some-what			not at all
thoughtful	7	6	5	4	3	2	1
uncomfortable	7	6	5	4	3	2	1
involved	7	6	5	4	3	2	1
attracted	7	6	5	4	3	2	1
interested	7	6	5	4	3	2	1
irritated	7	6	5	4	3	2	1
detached	7	6	5	4	3	2	1
confused	7	6	5	4	3	2	1
anxious	7	6	5	4	3	2	1
impatient	7	6	5	4	3	2	1
guilty	7	6	5	4	3	2	1
bored	7	6	5	4	3	2	1
tense	7	6	5	4	3	2	1
concerned	7	6	5	4	3	2	1
empathic	7	6	5	4	3	2	1
defensive	7	6	5	4	3	2	1
sympathetic	7	6	5	4	3	2	1
_____ other	7	6	5	4	3	2	1

Did this client remind you of any client you have worked with?

Yes _____

No _____

You may not feel comfortable working with any of the clients depicted. You may not feel uncomfortable working with any of the clients depicted. Based on the vignettes you have just watched, please make a relative choice:

Which client would you <u>most</u> like to work with?

_____

Why? _____

_____

Which client would you <u>least</u> like to work with?

_____

Why? _____

_____

BACKGROUND INFORMATION ON SUBJECTS

Professional training:
Social Worker _____
Psychologist _____
Marriage & Family Counselor ___
Other (_____) ____

Highest professional degree: _____
Year of highest degree: _____

Theoretical orientation (check ALL that apply):
Psychodynamic _____
Problem-solving _____
Family system _____
Developmental _____
Cognitive _____
Behavioral _____
Self-psychology _____
Other (_____) _____

Clinical practice (check ALL that apply):
Individuals _____
Couples _____
Families _____
Groups _____
Children _____
Adolescents _____
Adults _____

Practice setting (check ALL that apply):
Agency _____
Hospital _____
Private _____
Group practice _____
Other (_____) _____

Professional activity (check ALL that apply):
clinical practice _____
supervision _____
administration _____
consultation _____
teaching _____
Other (_____) _____

Total years of active professional experience: _____
Hours per week seeing clients: _____
Do you receive supervision/consultation on your work: yes ___
no ____

Age: _____
Sex: male _____
female _____
Have you ever been in therapy yourself: yes ____ no ____

LETTER RECRUITING RESEARCH SUBJECTS

To: Institute for Clinical Social Work Students and Faculty

I am a doctoral student in social work at Loyola University. I am looking for male and female clinical social workers to participate in my dissertation research.

My research concerns the feelings evoked in therapists by typical clinical situations. Countertransference is usually understood and addressed as a unique response of an individual therapist to an individual client at a particular moment in treatment. This research investigates whether or not there are more universal countertransference experiences called up by particular clinical situations (i.e., an alliance rupture).

As a subject, you will be shown eight videotapes. Each videotape is less than two minutes long and will show an actor role-playing a psychotherapy client. You will be asked to view the tape as if you were the therapist working with that client. After viewing each videotape, you will be asked to circle numbers on a simple "feeling scale" to indicate the feelings evoked in you by the vignette. The entire project will take under an hour.

If you are willing to be a subject in this research project, please call me at 708/869-7003. I will come to your office at a time convenient for you. Of if you would prefer, I can show you the videotapes in my Evanston office.

Please feel free to call me if you have any questions regarding participation in my study. I will be looking for subjects in July, August, September and October. If you would be available as a subject any time during these four months, I would really appreciate it.

Sincerely,

July 7, 1994

Dr. Thomas Kenemore
Institute for Clinical Social Work
Suite 420
30 N. Michigan Avenue
Chicago, IL 60602

Dear Tom,

Enclosed is my letter requesting subjects for my research. If you have any concerns about how I've written the letter, please feel free to call me (708/869-7003). I really appreciate your help with this.

Thanks,

REFERENCES

Alpert, Judith L. (1986). Psychoanalysis and Women: Contemporary Reappraisals, The Analytic Press: Hillsdale, N. J.

Aneshensel, Carol S. and Pearlin, Leonard I. (1987). "Structural Contexts of Sex Differences in Stress," in Barnett, Rosalind C., Biener, Lois, and Baruch, Grace K. (Eds.). Gender and Stress, The Free Press: New York.

Bailey, Kenneth D. (1987). Methods of Social Research, The Free Press: New York.

Barnett, Rosalind C., Biener, Lois, and Baruch, Grace K. (1987). Gender and Stress, The Free Press: New York.

Basch, Michael F. (1983). "Empathic Understanding: A Review of the Concept and Some Theoretical Considerations." Journal of the American Psychoanalytic Association, 31, 1, 101-126.

Belle, Deborah (1987). "Gender Differences in the Social Moderators of Stress" in Barnett, Rosalind C., Biener, Lois, and Baruch, Grace K. (Eds.). Gender and Stress, The Free Press: New York.

Bernardez, Teresa (1982). "The Female Therapist in Relation to Male Roles," in Solomon, K. and Levy, N. B. (Eds.), Men in Transition: Theory and Therapy, Plenum Press: New York.

Bernardez, Teresa (1987). "Gender based countertransference of female therapists in the psychotherapy of women." Women and Therapy, 6, 1-2, 25-39.

Bernstein, Bianca L. and Lecomte, Conrad (1982). "Therapist Expectancies: Client Gender, and Therapist Gender, Profession, and Level of Training." Journal of Clinical Psychology, 38, 4, 744-754.

Bernstein, Doris (1993). Female Identity Conflict in Clinical Practice, edited by Freedman, Norbert and Distler, Betsy. Jason Aronson Inc.: Northvale, N. J.

Billingsley, Donna (1977). "Sex Bias in Psychotherapy: An Examination of the Effects of Client Sex, Client Pathology, and Therapist Sex on Treatment Planning," Journal of Consulting and Clinical Psychology, 45, 2, 250-256.

Blalock, Hubert M., Jr. (1982). Conceptualization and Measurement in the Social Sciences, Sage Publications: Beverly Hills.

Bleier, Ruth (1991). "Gender Ideology and the Brain: Sex Differences Research," in Notman, Malkah T. and Nadelson, Carol C. (Eds.), Women and Men: New Perspectives on Gender Differences. American Psychiatric Press, Inc.: Washington, D. C.

Book, Howard E. (1988). "Empathy: Misconceptions and Misuses in Psychotherapy." American Journal of Psychiatry, 145, 4, 420-424.

Brooks, Virginia R. (1981). "Sex and Sexual Orientation as Variables in Therapists' Biases and Therapy Outcomes." Clinical Social Work Journal, 9, 3, 198-210.

Broverman, Inge K., Broverman, Donald M., Clarkson, Frank E., Rosenkrantz, Paul S., and Vogel, Susan R. (1970). "Sex-Role Stereotypes and Clinical Judgments of Mental Health," Journal of Consulting and Clinical Psychology, 34, 1, 1-7.

Brown, Laura S. (1990). "What Female Therapists Have in Common." Cantor, Dorothy W. (ed.), Women as Therapists: A Multitheoretical Casebook, Springer: New York.

Cantor, Dorothy W. (1990). "Women as Therapists: What We Already Know." Cantor, Dorothy W. (ed.), Women as Therapists: A Multitheoretical Casebook, Springer: New York.

Carter, C. A. (1971). "Advantages of being a woman therapist." Psychotherapy: Theory, Research and Practice, 8, 297-300.

Chodorow, Nancy (1978). The Reproduction of Mothering, University of California Press: Berkeley.

Chodorow, Nancy (1989). Feminism and Psychoanalytic Theory. Yale University Press: New Haven.

Collins, Barbara G. (1986). "Defining Feminist Social Work." Social Work, 31, 3, 214-219.

Cook, Thomas D. and Campbell, Donald T. (1979). Quasi-Experimentation, Rand McNally: Chicago.

Davenport, Judith and Reims, Nancy (1978). "Theoretical Orientation and Attitudes toward Women." Social Work, 23, 4, 306-309.

Davis, Liane V. (1985). "Female and Male Voices in Social Work." Social Work, 30, 2, 106-113.

Deutsch, C. J. (1984). "Self-reported sources of stress among psychotherapists." Professional Psychology: Research and Practice, 15, 833-845.

DiLeonardi, Joan W. and Curtis, Patrick Almond (1988). What to Do When the Numbers Are In: A User's Guide to Statistical Data Analysis in the Human Services. Nelson-Hall: Chicago.

Dobrin, Arthur (1989). "Ethical Judgments of Male and Female Social Workers." Social Work, 34, 5, 451-55.

Eastwood, Judith, Spielvogel, Anna and Wile, Joanne (1990). "Countertransference Risks When Women Treat Women." Clinical Social Work Journal, 18, 3, 273-280.

Elson, Miriam (1986). Self Psychology and Clinical Social Work, W. W. Norton & Company: New York.

Farber, B. A. (1983a). "The effects of psychotherapeutic practice upon psychotherapists." Psychotherapy: Theory, Research and Practice, 20, 174-182.

Farber, B. A. and Heifetz, L. J. (1981). "The satisfactions and stresses of psychotherapeutic work: A factor analytic study." Professional Psychology, 12, 621-630.

Felton, Judith R. (1986). "Sex makes a difference: How gender affects the therapeutic relationship." Clinical Social Work Journal, 14, 2, 127-138.

Festinger, Trudy Bradley and Bounds, Rebecca L. (1977). "Sex-Role Stereotyping: A Research Note." Social Work, 22, 4, 314-15.

Fleck-Henderson, Ann (1990). "Ethical Judgments and Gender: Response to Dobrin." Social Work, 35, 2, 179-181.

Fliess, R. (1942). "The Metapsychology of the Analyst." Psychoanalytic Quarterly, 11, 211-227.

Freudenberger, H. and Robbins, A. (1979). "The hazards of being a psychoanalyst." Psychoanalytic Review, 66, 275-296.

Freudenberger, Herbert J. (1990). "Therapists as Men and Men as Therapists." Psychotherapy, 27, 340-343.

Frodi, Ann M.; Lamb, Michael E.; Leavitt, Lewis A.; Donovan, Wilberta L.; Neff, Cynthia; and Sherry, Dennis (1978). "Fathers' and Mothers' Responses to the Faces and Cries of Normal and Premature Infants," Developmental Psychology, 14, 5, 490-498.

Gibelman, Margaret and Schervish, Philip H. (Eds.) (1993). Who We Are: The Social Work Labor Force as Reflected in the NASW Membership, NASW Press: Washington, D. C.

Gilligan, Carol (1982). In A Different Voice. Harvard University Press: Cambridge, MA.

Gomes, Beverly and Abramowitz, Stephen I. (1976). "Sex-Related Patient and Therapist Effects on Clinical Judgment," Sex Roles, 2, 1, 1-13.

Gornick, Lisa K. (1986). "Developing a new narrative: The woman therapist and the male patient." Alpert, Judith L. (ed.), Psychoanalysis and Women: Contemporary Reappraisals, The Analytic Press: Hillsdale, N. J.

Gould, Ketayun H. (1988). "Old Wine in New Bottles: A Feminist Perspective on Gilligan's Theory." Social Work, 33, 5, 411-15.

Hellman, Irving D., Morrison, Thomas L., and Abramowitz, Stephen I. (1987). "Therapist flexibility/rigidity and work stress." Professional Psychology Research and Practice, 18, 1, 21-27.

Hellman, I. D., Morrison, T. L., and Abramowitz, S. I. (1986). "The stresses of psychotherapeutic work: A replication and extension." Journal of Clinical Psychology, 42, 197-205.

Hill, Clara E. (1975). "Sex of Client and Sex and Experience Level of Counselor." Journal of Counseling Psychology, 22, 1, 6-11.

Hopkins, Linda B. (1986). "Dependency Wishes and Fears in Long-Term Psychotherapy: An Examination of Clinical Issues." Psychotherapy, 23, 535-539.

Howard, Kenneth I., Orlinsky, David E., and Hill, James A. (1969). The Therapist's feeling in the therapeutic process." Journal of Clinical Psychology, 25, 83-93.

Ipsaro, Anthony (1986). "Male Client-Male Therapist: Issues in a Therapeutic Alliance." Psychotherapy, 23, 257-266.

Johnson, Mary and Stone, Gerald L. (1989). "Logic and Nurture: Gender differences in thinking about psychotherapy." Professional Psychology Research and Practice, 20, 2, 123-27.

Jones, Enrico E. and Zoppel, Christina L. (1982). "Impact of Client and Therapist Gender on Psychotherapy Process and Outcome." Journal of Consulting and Clinical Psychology, 50, 2, 259-72.

Jordan, J. V., Kaplan, A. G., Miller, J. B., Stiver, I. P., and Surrey, J. L. (1991). Women's Growth in Connection; Writings from the Stone Center. The Guilford Press: New York.

Kaplan, Alexandra G. (1987). "Reflections on Gender and Psychotherapy." Women and Therapy, 6, 11-24.

Kivowitz, Alexandra (1990). "Triangular Empathy: 'The Other' in Psychotherapy with Individuals." Clinical Social Work Journal, 18, 1, 73-84.

Kulish, Nancy M. (1984). "The effect of the sex of the analyst on transference: A review of the literature." Bulletin of the Menninger Clinic, 48, 2, 95-110.

Kulish, Nancy M. (1989). "Gender and transference: Conversations with female analysts." Psychoanalytic Psychology, 6, 1, 59-71.

Lerner, H. G. (1991). Women in Therapy. Jason Aronson, Inc.: Northvale, N. J.

Lester, Eva P. (1990). "Gender and identity issues in the analytic process." International Journal of Psycho-Analysis, 71, 3, 435-444.

LeVine, Robert A. (1991). "Gender Differences: Interpreting Anthropological Data," in Notman, Malkah T. and Nadelson, Carol C. (eds.), Women and Men: New Perspectives on Gender Differences. American Psychiatric Press, Inc.: Washington, D. C.

Mackey, Richard A. and Sheingold, Ann (1990). "Thinking Empathically: The Video Laboratory as an Integrative Resource." Clinical Social Work Journal, 18, 4, 423-432.

McEwen, Bruce S. (1991). "Sex Differences in the Brain: What They Are and How They Arise," in Notman, Malkah T. and Nadelson Carol C. (Eds.), Women and Men: New Perspectives on Gender Differences. American Psychiatric Press, Inc.: Washington, D. C.

Miller, Donna (1974). "The Influence of the Patient's Sex on Clinical Judgment," Smith College Studies in Social Work, 44, 2, 89-101.

Miller, Jean Baker (1976). Toward a New Psychology of Women. Beacon Press: Boston.

Miller, Suzanne M. and Kirsch, Nicholas (1987). "Sex Differences in Cognitive Coping with Stress" in Barnett, Rosalind C., Biener, Lois, and Baruch, Grace K. (Eds.). Gender and Stress, The Free Press: New York

Mitchell, Stephen A. (1988). Relational Concepts in Psychoanalysis: An Integration, Harvard University Press: Cambridge.

Mogul, Kathleen M. (1982). "Overview: The Sex of the Therapist." The American Journal of Psychiatry, 139, 1, 1-11.

Monette, Duane R., Sullivan, Thomas J., and DeJong, Cornell R. (1990). Applied Social Research, Holt, Rinehart and Winston, Inc.: Fort Worth.

Munson, Carlton (1979). "Evaluation of Male and Female Supervisors." Social Work, 24, 2, 104-110.

National Association of Social Workers (1980). Code of Ethics.

National Federation of Societies for Clinical Social Work (1988). Code of Ethics.

Newton, P. M. (1973). "Social structure and process in psychotherapy: A sociopsychological analysis of transference, resistance, and change." International Journal of Psychiatry, 11, 480-509.

Notman, Malkah T. and Nadelson, Carol C. (1991). "A Review of Gender Differences in Brain and Behavior" in Notman, Malkah T. and Nadelson, Carol C. (Eds.), Women and Men: New Perspectives on Gender Differences. American Psychiatric Press, Inc.: Washington, D. C.

O'Neil, James M. (1982). "Gender-Role Conflict and Strain in Men's Lives: Implications for Psychiatrists, Psychologists, and Other Human-Service Providers," in Solomon, K. and Levy, N. B. (Eds.), Men in Transition: Theory and Therapy, Plenum Press: New York.

Orlinsky, David E. and Howard, Kenneth I. (1979). "Gender and Psychotherapeutic Outcome," in Brodsky, Annette M. and Hare-Mustin, Rachel T., Women and Psychotherapy: an assessment of research and practice. The Guilford Press: New York.

Osherson, Samuel and Krugman, Steven (1990). "Men, Shame and Psychotherapy." Psychotherapy, 27, 327-339.

Perlman, Helen Harris (1957). Social Casework: A Problem-solving Process, The University of Chicago Press: Chicago.

Philipson, Ilene J. (1993). On The Shoulders of Women: The Feminization of Psychotherapy. Guilford Press: New York.

Pilsecker, Carleton (1977). "Vive la difference." Social Work, 22, 6, 484-486.

Pollack, William Shelley (1990). "Men's Development and Psychotherapy: A Psychoanalytic Perspective." Psychotherapy, 27, 316-321.

Pollard, Stephen W. (1979). "Countertransference and the sex of the patient." Psychoanalytic Review, 66, 1, 19-30.

Racker, Heinrich (1968). Transference and Countertransference, International Universities Press, Inc.: Madison.

Radov, Carol G., Masnick, Barbara R., and Hauser, Barbara B. (1977). "Issues in Feminist Therapy: The Work of a Women's Study Group." Social Work, 22, 6, 507-509.

Raines, James C. (1990). "Empathy in Clinical Social Work." Clinical Social Work Journal, 18, 1, 57-72.

Reimer, Michele S. (1984). "Gender Differences in Moral Judgment: Implications for Clinical Practice." Clinical Social Work Journal, 12, 3, 198-208.

Rhodes, Margaret L. (1985). "Gilligan's Theory of Moral Development as Applied to Social Work." Social Work, 30, 2, 101-105.

Rhodes, Margaret L. (1990). "Ethical Judgments and Gender: Response to Dobrin." Social Work, 35, 2, 179.

Romero, Det P. (1977). "Biases in gender-role research." Social Work, 22, 3, 214-218.

Ruderman, Ellen Bassin (1986). "Creative and Reparative Uses of Countertransference by Women Psychotherapists Treating Women Patients: A Clinical Research Study" in Bernay, Toni and Cantor, Dorothy W. (eds.), The Psychology of Today's Woman. Harvard University Press: Cambridge.

Russo, Nancy Felipe (1991). "Reconstructing the Psychology of Women: An Overview," in Notman, Malkah T. and Nadelson, Carol C. (Eds.) Women and Men. American Psychiatric Press, Inc.: Washington, D. C.

Safran, Jeremy D., McMain, Shelly, Crocker, Peter, and Murray, Paul (1990). "Therapeutic Alliance Rupture as a Therapy Event for Empirical Investigation," Psychotherapy, 27, 154-165.

Schachtel, Zeborah (1986). "The 'Impossible Profession' Considered from a Gender Perspective." in Alpert, Judith L. (ed.), Psychoanalysis and Women: Contemporary Reappraisals, The Analytic Press: Hillsdale, N. J.

Scher, Murray (1990). "Effect of Gender Role Incongruities on Men: Experience as Clients in Psychotherapy." Psychotherapy, 27, 322-326.

Siegel, Rachel J. (1988). "Women's 'dependency' in a male-centered value system: Gender-based values regarding dependency and independence." Women and Therapy, 7, 1, 113-123.

Solomon, Kenneth (1982). "The Masculine Gender Role: Description," in Solomon, K. and Levy, N. B. (Eds.), Men in Transition: Theory and Therapy, Plenum Press: New York.

Solomon, Kenneth (1982). "Individual Psychotherapy and Changing Masculine Roles: Dimensions of Gender-Role Psychotherapy," in Solomon, K. and Levy, N. B. (Eds.), Men in Transition: Theory and Therapy, Plenum Press: New York.

Taubman, Stan (1986). "Beyond the Bravado: Sex Roles and the Exploitive Male." Social Work, 31, 1, 12-18.

Thomas, Susan Amelia (1977). "Theory and Practice in Feminist Therapy." Social Work, 22, 6, 447-54.

Ullian, D. Z. (1981). "Why Boys Will Be Boys: A Structural Perspective." American Journal of Orthopsychiatry, 51, 493-501.

Weber, Susan B. (1983). "Some Perspectives on Women in Therapy and Women as Therapists." Clinical Social Work Journal, 11, 1, 33-51.

Weinbach, Robert W. and Grinnell, Richard M. Jr. (1987). Statistics for Social Workers. Longman: New York.

Weitz, Shirley (1976). "Sex Differences in Nonverbal Communication." Sex Roles, 2, 2, 175-184.

West, Candace and Zimmerman, Don H. (1987). "Doing Gender." Gender & Society, 1, 2, 125-151.

Wethington, Elaine, McLeod, Jane D. and Kessler, Ronald C. (1987). "The Importance of Life Events for Explaining Sex Differences in Psychological Distress," in Barnett, Rosalind C., Biener, Lois, and Baruch, Grace K. (Eds.). Gender and Stress, The Free Press: New York.

Williams, Susan L. (1986). "Reproductive Motivations and Contemporary Feminine Development," in Bernay, Toni and Cantor, Dorothy W. (eds.), The Psychology of Today's Woman. Harvard University Press: Cambridge.

Wong, Martin R. (1982). "Psychoanalytic-Developmental Theory and the Development of Male Gender Identity: A Review," in Solomon, K. and Levy, N. B. (Eds.), Men in Transition: Theory and Therapy, Plenum Press: New York.

Zygmond, Mary Jo and Denton, Wallace (1988). "Gender Bias in Marital Therapy: A Multidimensional Scaling Analysis." The American Journal of Family Therapy, 16, 3, 262-272.