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RECOGNITION OF SEX-BIASED CLIENT-COUNSELOR INTERACTIONS AS A FUNCTION OF SUBJECTS' GRADUATE TRAINING, SEX, AND TYPE OF TASK

The Ohio State University

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RECOGNITION OF SEX-BIASED CLIENT-COUNSELOR INTERACTIONS AS A FUNCTION OF SUBJECTS' GRADUATE TRAINING, SEX, AND TYPE OF TASK

DISSERTATION

Presented in Partial Fulfillment of the Requirements for the Degree Doctor of Philosophy in the Graduate School of The Ohio State University

By

Mary Anne Orcutt, B.A., M.A.

* * * * *

The Ohio State University

1979

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CHAPTER I

STATEMENT OF THE PROBLEM

The Women's Liberation Movement has helped to bring public awareness and recognition that men and women should not be limited in their life styles, vocations, and aspirations by prescribed sex roles. Rather, people should be able to choose freely among options without restriction by sex; these social and cultural changes have begun to be implemented by legislation and education. From a psychological viewpoint, however, sex role stereotypic behavior is just beginning to be understood in terms of its development, how it is reinforced, and how value and cultural systems maintain these behaviors.

Psychotherapy/counseling is a social institution that may help to reinforce and maintain the status quo of sex roles. A number of studies (Parloff et al., 1960; Welkowitz et al., 1967) have suggested that improved clients come to share their therapists' value systems, and there seems to be little question that therapy itself may be construed as an influence process (Strong & Matrosse, 1973; Goldstein, Heller, & Sechrest, 1966) in which a therapist's values are salient in terms of client outcome (Halleck, 1971; Rokeach, 1973, p. 333). Extrapolating from these studies, it is not unreasonable that therapists/counselors with traditional sex role values might reinforce exploration within
traditional alternatives to a greater extent than exploration within less traditional roles, thus maintaining the status quo.

There have been a number of studies that report strong sex role stereotypic attitudes in therapists. Broverman et al. (1970) found that psychotherapists had different standards of mental health for men and women that conformed with traditional sex role stereotypes. Therapists were found to rate men and women as having different needs (Neulinger et al., 1970) and they attributed more psychological maladjustment to left politically-active female clients than to their male counterparts (Abramowitz et al., 1973). Several studies have shown that counselors may exhibit sex bias in working with women with nontraditional career goals (Thomas & Stewart, 1971; Schlossberg & Pietrofesa, 1973; Medvene & Collins, 1976). Recently, more specific research questions have been asked; these studies have found that for certain types of clients, with certain types of problems, that there may be some differential biases that occur with male versus female therapists (Hill, 1975; Orlinsky & Howard, 1976; Hill et al., 1977). This line of research has implications for the gender of therapist that works with a client with a specific problem, in order to achieve maximum therapeutic effectiveness.

Recently, evidence has indicated more flexible sex role attitudes and less sex-biased practices among clinicians (Engelhard, 1976; Pheterson et al., 1971; Maxfield, 1976; Oppedisano-Reich, 1976; Billingsley, 1977; Petro & Putnam, 1979). This may mean that
counselors are evolving more liberal attitudes on their own, without special training. These findings moderate generalizations that might be made regarding sex bias in therapy settings.

A major problem with the state of the research in this field is the methodology and experimental design of the studies. The two prominent methods are attitude surveys, and comparing diagnoses/assessments of male and female clients. Tedeschi and Lindskold (1976) and Tanney and Birk (1976) have pointed out the frequent incongruence between expressed attitudes and behaviors, particularly given the social desirability of appearing nonexist (i.e., on an attitude survey). Studies looking at differential diagnoses and assessments of male versus female clients have been criticized for the types of conclusions that have been drawn, their lack of generalizability to the real clinical setting, the confounding of sex role stereotyping with sexism, and limited access to clinical information typically available in the therapy setting (Stricker, 1977; Stearns et al., 1978; Abramowitz & Dokecki, 1977).

In sum, the findings regarding sex bias and sex role stereotyping in the therapy setting are, at this point in time, confusing and contradictory. Despite this, we do know that all therapists are not equally aware of their own socialized sex role stereotypes. In fact, some clinicians may not be fully aware of how their values regarding women's role in society may affect both their therapeutic effectiveness and their supervisory efficacy in working with trainees.

It is assumed that counselors want to facilitate psychological growth in their clients, regardless of sex, and that most counselors who manifest sex bias do not mean to do so purposefully. Thus,
increased awareness of sex role stereotype issues (regardless of current level of awareness) and how they affect counseling should foster a greater amount of attention to self-management of sex biases, due to the counselor's commitment to helping her/his clients. The present study examines the ability of counselor trainees to recognize sex bias in counselor-client interactions, and attempts to develop a new method for assessing awareness other than attitude surveys and diagnostic statements.

There may be more than one level of awareness from which people operate in regard to sex bias. We may not be able to patently categorize each person into either an Aware or Unaware category (i.e., they may recognize value-laden comments without nominally calling it sex bias). Obviously, the conditions under which they are to respond regarding sex bias, will affect people's attention to such an issue. For instance, if one is specifically asked to look for sex bias, or to respond to an attitude questionnaire about sexism, most people might show themselves to be quite aware. Unfortunately, the demands of the task and the current social desirability of being nonsexist might confound the validity of such a study. As mentioned earlier, this parallels the attitude surveys-attention is explicitly drawn to sex roles and sex bias.

Another level of awareness might exist when the task does not specifically call attention to sex bias, yet for some people, the value and/or training in feminism and sex equality is so high, that s/he may simply always attend to this, regardless of the task. This level of awareness might include recognizing slight innuendos that betray sexist
attitudes and biased use of linguistics, whereas people with less salient feminist values might be less attuned to such subtleties.

In the selective attention literature, a system of salient values that influences attention is termed pertinence (Norman, 1966) or perceptual sensitization (Vanderplas & Blake, 1949; Bruner, 1951). Support has been found for the notion that people recognize salient or pertinent cues (as defined by value systems) more efficiently than they recognize non-salient cues, in both the visual and the auditory realms (Postman et al., 1948; Vanderplas & Blake, 1949). It has also been determined that attention can be directed by external or environmental cues, such as requesting that a subject attend to a certain aspect of the presented stimulus (Perry, 1976). The latter element of selective attention is probably critical in the learning, or internalization, of the perceptual sensitization/pertinence schema.

The counselor/therapist who does not recognize, or is not aware of, sexism when it is seen or heard (i.e., in supervising a trainee) will not be aware of sexist behaviors that she/himself emits during the counseling hour. The assumption that counselors will manifest some sex-biased behaviors without the "trained ear" type of awareness is based on two notions. First, research has shown that almost all aspects of life are reinforcing of traditional sex role stereotypes (from media to parents to teachers), and all counselors/therapists were most likely socialized to value these prescribed sex roles. Adherence is without conscious thought to the implications of doing so. Second, psychological theories of therapy exist that perpetuate myths about men and
women (i.e., Freud), that with unquestioned acceptance, also lead to
differential beliefs about the psyche of males versus females.

This study asks the questions: from what level of awareness of
sex bias and stereotyping are graduate trainees operating? Is aware-
ness determined only from environmental demands (i.e., being told to
look for sex bias), or are trainees attuned to sex bias such that they
detect and attend to subtle sexism even when the task is more global
or nonspecific to sex bias? If they do not specifically label the
counselors' behavior as sexist, are they able to identify the style
as a less effective style, and/or do they describe the counselor in
qualitatively different terms than they would a nonsexist counselor?
Do males and females operate at the same level of awareness?

These questions have important implications for, first,
how a training program should proceed in the facilitation of sex-fair
values. Second, because of the faulty methodologies and the con-
tradictory findings of the research, we still need to know the state of
sex bias awareness among therapists and trainees. The optimal method,
observation and rating of true counseling sessions is not yet feasible.
However, this study attempts to assess awareness of subjects in the
context of supervision of a counselor/client interaction. This is a
method that has previously been untried. One advantage is that it
studies a behavioral analogue of a task that most professionals will
someday perform, with either graduate trainees or paraprofessionals.
Thus, in addition to assessing awareness of sex bias in general,
it more specifically assesses the trainee's ability to detect sex bias
as a supervisory issue. The resulting data should be helpful in
furthering knowledge about awareness of sex bias among those whom we wish to train, and assessment that may help to plan training so that it is more effective.
Chapter II

Review of the Literature

The review of the literature will be divided into three major subject groups: the theory and research on values convergence between therapists and their clients, sex bias and sex role stereotyping, and the perceptual process as it is shaped by selective attention.

Value Convergence

Therapy is often construed as an influence process (Strong & Matrosse, 1973; Goldstein, Heller, & Sachrest, 1966) and/or a social reinforcement process (Krasner, 1962) in which convergence occurs, such that the values of the client become increasingly similar to those of the therapist. Convergence may be defined as a lessening of discrepancy in judgments made by two or more people, in the successful therapeutic interaction, this manifests as a shift in the belief system of the client, or the ability of the therapist to influence the client to modify her/his beliefs or behaviors (Frank, 1961). Pepinsky and Karst (1962) refer to this change as an acquisition by the client of the psychological grammar of the therapist, which is comprised of a) categories of belief and action, and b) rules of belief and action.

Values may be communicated explicitly or implicitly: more frequently, it is the latter. It is agreed that therapists do not and,
indeed, cannot function outside of their own value systems throughout the therapy process (APA, 1953; Ginsberg, 1950; Parloff et al., 1960; Beutler, 1972). Kessel and McBrearty (1967) say that "what the therapist hears or fails to hear, what he chooses to interpret or not to interpret, his questions, statements, and other reactions, both verbal and nonverbal, are all to a large extent determined by the therapist's values" (p. 672). The response of clients/patients to this is conformance in their words, thoughts, and dreams to the theories and terms of the counselor: "if the therapist values dreams, patients dream; if therapists value sexual material, patients produce it, etc." (Patterson, 1959, p. 67).

Some clinicians and theorists feel that an important aspect of therapy is to actually teach her/his values to the client (Glad, 1956; London, 1964; Williamson, 1958). Ellis (1962) feels that emotional disturbance is due to faulty, self-defeating value systems, and that clients should be persuaded to adopt a new set of values and beliefs. Even Rogers (1961) has acknowledged that therapists are deeply engaged in influencing and predicting behavior, and Truax (1968) has concurred, saying that client-centered therapists shape clients' conversation by positive reinforcements for certain verbal responses. Attempts at moral neutrality (i.e., self-realization, democracy, and free choice) are all reflective of a value system as well (London, 1964). Counselors and therapists are not value free in their interaction with clients, regardless of theoretical orientation, and regardless of whether they explicitly teach values.
Lowe (1976) sees therapists as having several concurrent roles that relate to values: 1) that of a new authority (values that work), 2) that of a secular priest (therapy being the source for a new direction, and 3) as a political theorist and social philosopher (including roles in social reform and social justice). All of these roles put the therapist in a highly influential position. Rawlings and Carter (1977) define four other factors that contribute to this ability to influence and change value systems and behaviors: command (or expertise), friendship (similarity and liking for the client), a placebo effect, and cognitive dissonance. This powerful influence of psychotherapy can be misused as social control by making personal problems of political issues (Tennov, 1975). People can be discouraged from seeking alternate solutions: ones that disturb the social, economic, or political status quo.

Denial of the power and control that therapists have is to abdicate social responsibility. Krasner (1965) states that counselors must be aware of their own values and the effects that they may have on the behaviors of clients; it is a myth that the therapist is not basically responsible for the resulting changes in clients. Szasz (1961) contends that the future of psychiatry lies in the field of values, not in medicine; difficulties in living are not disease entities, but rather are societally or culturally-imposed. The constructs of "health", "illness", and "normality", even within the medical model, are difficult to define without some reference to morals and values (London, 1964). To deny this social responsibility, and not to be aware of one's own value systems as a therapist, is usually to maintain the status quo,
or reinforce only societally-approved behavior (advocating adjustment to society) unknowingly (Ginsberg, 1950; Tennov, 1975; Halleck, 1971).

Many psychologists advocate the explicit expression of values, so that clients 1) may choose whether s/he wishes to enter into therapy with this counselor 2) may be aware of the direction in which influence attempts will be made, thus minimizing manipulation (Halleck, 1971; Roe, 1959; Tennov, 1975, Beier, 1966). The counselor carefully identifies these values as her/his own, and avoids imposing them on the client.

A number of empirical studies have validated the theoretical effects of values within the counseling/therapy setting. Rosenthal (1955) gave a battery of tests to twelve patients before and after psychotherapy, and also to their therapists. Findings indicated that patients who improved tended to modify their systems of moral values in the direction of their therapists' moral values. Patients who were unimproved or worse tended to move away from the therapist's value system.

Parloff et al. (1957) found that discharged patients had values that were closer to those of the therapist than did patients who were judged to be unimproved. Values in this case were defined by the ranked importance of issues arising in therapy. Their conclusions postulate that the therapists' values were somehow revealed during the intervention process. Similar findings were found in a study by Hill (1969). The patient's satisfaction with therapy was more related to whether the therapist's goals were achieved than to whether s/he achieved her/his own pretherapy goals. This would indicate that the counselor's values are considered "best" by the patient.
In a study of therapist-client interactions, verbatim recordings of eight dyads were made, which were analyzed in terms of linguistics (Lennard, 1960). This data showed support for the convergence process in therapy. It is interesting to note that, regardless of the methodology or type of data used (whether attitude and value surveys, or language analysis) that the research uniformly supports the proposition of values convergence. (Two exceptions are Holzman (1962) who found convergence for outpatients but not inpatients, and Nawas and Landfield (1963) who found increased preferences among patients for their own construct dimensions on the Role Construct Repertory Test. These two studies seem to stand alone in not fully supporting the notion of convergence.)

Pentony (1966) found that the further therapy progressed, the greater the tendency for the client's values to resemble the values of client-centered counselors. Two alternative explanations were given for this: 1) that the client was taking on the values of the counselor, or 2) that client-centered counselors are homogeneous in values, and clients take on a generalized healthier outlook toward living that is consistent with these counselors' values. In an extension of this study, Welkowitz et al. (1967) examined this very issue, and found that value similarity was greater between therapists and their own patients than therapists and random not-own patients. This would indicate that clients are modifying their values to be more homogeneous with their own therapist's values, not to the values of therapists in general. Among the 38 therapists and 44 patients who served as subjects, value similarity tended
to increase as a function of length of time in therapy, particularly if the therapist perceived patient improvement.

There seems to be a significant counselor variable that influences the convergence process as well. Truax et al. (1968) rated the amount of persuasiveness used by a therapist by taking six three-minute taped interview samples, and having them judged on a three-point scale by trained graduate students. They rated improvement of the patient by three independent reports: that of the therapist, the patient, and an independent interviewer. Findings indicated that therapists who were low in persuasibility produced significantly more patients who showed deterioration than did highly persuasive therapists. This would indicate that a values similarity between counselor and client, and/or an explicit statement of values by the therapist is crucial in order to attain maximum therapeutic effectiveness, and maintain ethical behavior.

Two recent unpublished dissertations have utilized a rather large number of subjects, both attaining supportive results to the above studies. Spink (1972) studied 103 patients at a private community mental health center and 25 therapists, all of whom completed the Rokeach Rank Ordering Value Scale. After 15 therapy sessions, all patients were post-tested on the same inventory. Clients' terminal values were significantly more like those of her/his therapist than before therapy. Kaufmann (1973) utilized 50 therapist-client dyads, and calculated regression equations for the duration of therapy and the convergence of values. Convergence factors were able to significantly predict the duration of therapy, accounting for 62% of the
variance. This finding would imply that time-limited therapy might allow clients more leeway in determination of their own value system.

Several articles have looked at the values convergence process as it relates to trainees and their supervisors. On a theoretical basis, Nadelson and Notman (1977) propose that a supervisor's values serve as a filter of the therapist's intervention, and that one of the roles of a supervisor must be to help to maintain the therapist's awareness of how her/his values and attitudes may be influencing the therapy process. The authors state that the values issues that are related to sex role expectations are very important when working with both men and women (trainees and clients), because of the current changes in expectations and role flexibility, and the countertransference issues of viewing certain normative behaviors as being ideal. Brodsky (1977) advocates the use of male and female supervisors to help counteract this problem, so that the role alternatives may be maximally explored, when a trainee may inadvertently reinforce normative sex role behavior.

In an empirical investigation of supervision, Karr and Geist (1977) found that supervisors had an impact on the relationship variables that the trainee utilized with her/his clients. There was a significant positive relationship between supervisor and therapy conditions on the variables of concreteness, genuineness, and respect. These variables can be construed as implicit values of the supervisor about how therapy is best conducted and these are communicated through the supervisory style.

In trying to predict success in psychoanalytic training, Bardock et al. (1960) found that there was a similarity in the interest patterns
of therapists in training who were judged to be successful students, and their supervisors (as measured by the Strong Vocational Interest Blank and the Allport Vernon Study of Values). Further, on a retest of interests, slow but successful students were found to have drawn closer to the faculty interest pattern and to have overtaken the fast students. This phenomenon may be similar to the convergence pattern that is seen within the therapy setting; the greater the duration of interaction, the greater similarity in interest and value patterns.

Finally, in a study of NDEA guidance and counseling students, Rochester (1967) found that trainees' values became more similar to their trainers' during a guidance institute training program. Most trainees reverted to their prior values after eight months to one year, except that religious and moral values remained similar to the instructor.

These studies have several important findings. First, the relationship between a supervisor and her/his trainee appears to be just as salient as the therapy relationship. This means that supervisors must be acutely aware of their own impact upon not only trainees but the clients with whom their trainees work. Secondly, this influence may be used in order to help trainees consider various value-laden or bias issues, such as sex role stereotyping, which almost inevitably will be raised in the therapeutic process, due to the socialization of normative sex role values that most members of our culture experience. Finally, this needs to be an ongoing process, because of the relative temporal instability of some of this value convergence.
In summary, the literature strongly suggests that a therapist's values are highly salient in the therapy process, and that convergence of values will occur for the client. This process is acknowledged even by those therapy theorists who claim to be non-directive in approach (i.e., Rogers), and further, many psychologists have advocated a careful examination of one's own values as a therapist and as a supervisor. An explicit communication of a therapist's value system may minimize imposition of these beliefs onto the client, and allows the client a chance to choose a therapist with a more consistent value system, if desired. Further, it is charged that therapists must take responsibility for the impact that their values may have on a client.

Sex Bias

The literature on sex bias in the behavior and attitudes of therapists/counselors is equivocal in its empirical findings, and highly controversial. For every positive set of findings (i.e., Broverman et al., 1970), another research finding has had opposite results (Maxfield, 1976). Some writers have levied criticisms at the current empirical methodologies (Stricker, 1977; Stearns et al., 1978), and others have rebutted with counter-criticisms (Gilbert, 1977; Hare-Mustin, 1977; Delk, 1977; Abramowitz & Abramowitz, 1977; Lerman, 1979). However, as more specific research questions have been asked, there have been findings indicating a lack of sex bias awareness in regard to some issues, within some populations of therapists, with some types of clients. Psychologists and psychiatrists have continued to advocate the
need for continuing and increased awareness in the area of sex role stereotypes and sex bias in therapy, to further minimize these effects.

In the first part of this review, the positive findings of sex bias in therapist/counselors will be examined, followed by a survey of the negative findings and the methodological critiques. Finally, outcomes and evaluations of training programs aimed at increasing awareness of sex biases and sex role stereotypes will be discussed.

Several theorists have advocated that the fields of psychiatry and psychology should take an active part in bringing about change in institutions and communities that oppress people (Tennov, 1975; Halleck, 1971). Tennov (1975) differentiates convergence of values and morals from the convergence of values that occur with traditional images of women, in that stereotypes are an oppressive syndrome that places females in a lower status position. To treat women differentially from men in the therapy setting constitutes sex bias, not a value choice. In the past, therapy has led to acceptance of this oppression. By simply adhering to social norms, or facilitating exploration of only traditional alternatives for women, a therapist exhibits sex bias. Halleck (1971) sees the vectors favoring conformity as more powerful than those for change, and currently psychotherapists are more repressive as a social force than facilitative of social or political change.

Chesler (1972), Rawlings and Carter (1977), and Tennov (1975) describe both the power differential between counselor and client, and the psychodynamic theories of personality and therapy as being significant in maintaining this oppression of female clients. Many women may not actually be ill; rather they are afflicted by constricted
cultural role expectations. Chesler states that even radical or feminist therapists who want to help women may still share the profession's and culture's bias against women.

There have been a number of studies that report strong sex-role stereotyped attitudes in therapists. Broverman et al. (1970) found that psychotherapists had different standards of mental health for men and women that conformed with traditional sex role stereotypes. Both male and female clinicians rated healthy women as being more submissive, less independent, less adventurous, less objective, more easily influenced, and more emotional than healthy men. Neulinger et al. (1970) found that therapists rated men and women as having different needs (as defined by the Edwards Personal Preference Survey); men were thought to have high dominance, achievement, and aggressive needs, while women were characterized by high nurturance, deference, succourance, and abasement needs.

Abramowitz et al. (1973) gave clinicians bogus clinical protocols that varied only in sex and political inclination. They found that less liberal examiners attributed significantly more psychological maladjustment to left politically-active female clients than to their male counterparts.

Female clients with nontraditional career goals, in another study, were judged to be more in need of counseling than those with conforming career goals (though women counselors were more accepting of both client types than were men) (Thomas & Stewart, 1971). Schlossberg and Pietrofesa (1973) had similar results: counselors (both male and female) were biased against women entering a masculine occupation. A study that compared psychotherapists, graduate students in clinical/
counseling psychology, and secondary school counselors (Medvene & Collins, 1976), found that school counselors were the most likely to rate occupations as inappropriate for women. This finding might indicate that the specific training of a group of counselors/therapists is the crucial variable for the amount of sex role stereotyping that occurs.

In a more recent study, Delk and Ryan (1977) found that male therapists stereotyped their clients significantly more than did female therapists. Hill (1975) found that a female counselor with a female client produced more discussion of feelings. Another study that looked at the effect of the sex of the therapist on the therapeutic process found that single, unmarried, and childless women who worked with female therapists felt significantly more open, comfortable, self-possessed, encouraged, and less self-critical than did those working with male therapists (Orlinsky & Howard, 1976). Older women and those female clients who were wives and mothers reported no significant differences in their experiences with a male versus a female therapist. This study has implications for the need for the specificity of the research questions that are asked (i.e., which therapist, for which client, with what problem...), as advocated by Paul (1966).

Hill et al. (1977) tested more explicit hypotheses regarding counselor reactions to female clients, and concluded that type of problem determined ratings of seriousness, number of sessions needed, and client's ability to profit from counseling. In addition, client age and counselor sex had effects on ratings of empathy and seriousness (this supports the findings of Orlinsky & Howard, 1976, cited above).
This would indicate that some types of client problems may be best dealt with by one particular sex of counselor.

Sherman et al. (1978) surveyed practitioners as to their attitudes and information (as based on empirical data) about women. They found that there were no differences between disciplines, but that female therapists were better informed, more liberal, and less stereotyped in their attitudes than were men. Many therapists showed a lack of pertinent information, and had attitudes that were likely to conflict with their female clients.

The Task Force on Sex Bias and Sex Role Stereotyping in Psychotherapeutic Practice (APA, 1975) surveyed women members of the American Psychological Association via an open-ended questionnaire designed to elicit descriptions of incidents of sex bias in therapy. Their data were primarily descriptive, and they found that there were four general areas or categorizations of sex bias: 1) fostering traditional sex roles, 2) bias in expectations and devaluations of women, 3) sexist use of psychoanalytic concepts, and 4) responding to women as sex objects including seduction of female clients. This fourth category was examined more closely in another nationwide survey of psychologists. Holroyd and Brodsky (1977) examined attitudes and practices regarding erotic contact with patients, and found that 5.5% of male and .6% of female respondents reported having had sexual intercourse within three months of termination of therapy. These are instances where a therapist is unethically using her/his power over the client for reasons of sexual gratification, and indicates that female clients may more frequently be the victim of such behavior.
Recently, contradictory evidence has indicated more flexible sex role attitudes, and less sex biased practices among clinicians. This may mean that counselors are evolving more liberal attitudes on their own, without special training. In fact, increased awareness may be due to the original studies (i.e. Broverman et al., 1970) that have been widely cited, and have probably become known to the majority of clinicians. Engelhard (1976) found that counselors were more accepting of the dual role for women (that of mother and worker) and of broader sex role definitions, than they were just six years earlier. In several studies, there were no differences in rating of male and female clients, except that the female clients were rated as being slightly better adjusted by female raters than by the males (Haan & Livson, 1973; Abramowitz & Abramowitz, 1973). Pheterson et al. (1971) concluded that personal history, presenting problem, and symptoms were more important than gender in person perception of a client. Hill et al.'s findings (1977) did not indicate the presence of sex bias among counselors, but did suggest that some types of client problems were best dealt with by one particular sex of counselor (though this was not uniformly male or female, for female clients). Helms (1978) extended this study to a naturalistic counseling setting, and found similar results.

It may be noted from the aforementioned studies, that there are two prominent methodologies: attitude surveys and comparing diagnoses/assessments made of male and female clients. Both methods have been critiqued by researchers. Tedeschi and Lindskold (1976) and Tanney and Birk (1976) warn that expressed attitudes should be accepted cautiously, as they are not necessarily representative of behaviors.
Social desirability may color the extent to which therapists are willing to admit sex bias, though practices may continue. Additionally, Stearns et al. (1978) claim that return rate for surveys is low, and that anecdotal reports (i.e., APA Task Force, 1975) make it difficult to distinguish between sexism and general ineptitude on the part of the therapist.

Stricker (1977) criticizes analogue studies (those assessing diagnosis of male versus female clients) for making conclusions such as 'women are seen as more submissive than men', as many of the ratings were on the same side of the neutral point of a Likert scale (i.e., 2.53 vs. 2.34). Stricker feels that the conclusions of these studies are presented in such a way that one is led to believe that absolute and dichotomous judgments were made by the therapists. Secondly, they were asked to rate a typical male, not an individual. Stearns et al. (1978) feel that sex role stereotyping has been confounded with sexism in this case, and that generalizability to therapy settings is limited. Subjects are also deprived of access to other types of clinical information that they would glean from direct contact with the client (Abramowitz & Dokecki, 1977).

Previous diagnostic studies finding double standards and sex bias may have enough methodological weaknesses to call the conclusions into question. Stricker asserts that the recent literature shows that male and female clinicians do not significantly differ in their assessments of clients (Maxfield, 1976) and that symptoms account for the majority of differences in diagnoses rather than sex (Oppedisano-Reich, 1976; Maxfield, 1976). It is important to note, however, that these two
studies are both analogues, and are thus subject to the same criticisms that Stricker levies against previous research.

In a study of practicing psychotherapists, Billingsley (1977) found that therapists responded to the client's pathology rather than client's sex in planning treatment goals. Interestingly, male therapists chose significantly more feminine treatment goals (i.e., interest in appearance, accepting the influence of others, awareness of feelings of others) and female therapists chose significantly more masculine goals (i.e., ability to think logically, objectivity), regardless of the sex of their clients. (The male and female-valued items were taken from Broverman et al.'s Stereotype Questionnaire.) The pseudo-clients in this study had severe pathologies; the author suggests that therapists may respond more to sex, when there are few other difficulties to consider (i.e., situational distress, or mild pathology). Again, however, there was no indication of sex bias.

Shapiro (1977) looked at counselor responses to atypical versus typical female clients, as defined by their sex roles. Counselors exhibited more behavioral bias with typical clients than with atypical clients, and reacted more positively to the atypical clients, though female counselors were slightly less biased in attitudes and behaviors than the male counselors. Shapiro suggests that counselors are now cognizant of the problems that the atypical woman faces, however, it may be the conventional woman who is a victim of therapy. This is certainly evidence of a bias, but the study finds the exact reverse of results previously cited.
Finally, Petro and Putnam (1979) have replicated the Broverman et al. (1970) study with school counselors, and found very few behavioral characteristics that the counselors perceived as differentiating men and women, indicating that there may be a liberalization of sex role attitudes that were affected by the women's movement.

Some researchers have attempted to assess the effect of treatment programs on sex bias and sex role stereotyping. Thistle (1975) found that mixed sex consciousness-raising groups facilitated therapist-trainees' growth (as measured by the TOI and group leaders' reports) and change in sex role attitudes. Again, however, there are the problems of social desirability of attitudes, and extrapolation of them to the counseling interview. In a study of practicing helping-professionals (Kahn, 1975), however, a C-R group yielded no significant differences between the treatment and a no-treatment control group on the Bem Sex Role Inventory, an attitude scale, and ratings/assessments of client vignettes. It is possible that the length of the program was too short, that working professionals were defensive and therefore less receptive to training regarding sex bias, or that lack of unobtrusive or less transparent instrumentation affected the results. In another study with community mental health professionals, Briggs (1975) found no significant differences between experimental and control groups or pre-post testings in utilizing a structured sex-role awareness training program. It could be concluded from these studies, that we need to know more about the parameters of sex bias and how it
manifests in counselors and trainees, before training programs can be devised. Secondly, defensiveness needs to be minimized, and finally, new assessment instruments must be developed.

Only one treatment study has incorporated some innovative and previously untried techniques. Gilbert and Valdthrop (1978) studied undergraduates who were enrolled in a course in individual counseling. Half of the students were taught core-counseling skills only. The other half had, in addition to this, structured role plays and exercises concerning sex role behaviors/characteristics of men and women, that were used to facilitate awareness of value systems. Subjects were deceived as to the nature of the study, thus minimizing the social desirability variable. Findings showed that the experimental group had more liberal attitudes towards women's roles, greater sensitivity to sex bias in two video-taped counseling vignettes of female clients, and more positive clinical evaluation of clients in the vignettes. This study seems to be one of the more complete and methodologically-sound research projects on this topic.

A number of recommendations have been made in order to remedy and prevent the possibility of sexism in psychotherapy. The task force (APA, 1975) suggested consciousness-raising groups for therapists to develop sensitivity and awareness of sex role stereotyping, formal criteria and procedures to evaluate the education and training of psychotherapists, including statements regarding sexism in the Ethical Standards of Psychologists, and development of guidelines for nonsexist psychotherapeutic practice.
In response to this last recommendation, Division 17 (Counseling Psychology) of the APA (1978) recently developed standards for counselors/therapists of women. Areas in which training and awareness are considered crucial are: problems unique to women, awareness that the world is not sex-fair, biological, social, and psychological issues that have impact on women, and how the counselor/therapist's values influence one's ability to work with women. Rice and Rice (1973), Barrett et al. (1974) and the APA Task Force (1978) specify similar standards.

In summary, it seems that we still know very little about the presence and prevalence of sex bias and/or lack of awareness of these issues, due to the highly contradictory state of the research, and the problematical methodologies that have been used. As is obvious in many of the studies that were reviewed, there does not seem to be a main effect of sex bias across all counselors, or even across one gender. Instead, studies need to address much more specific research questions. Additionally, alternative methodologies must be developed in order to continue research in this area. These changes in research design and methodology need to take place before training programs in sex bias awareness can be maximally effective and efficaciously devised and implemented.

Selective Attention

This section will briefly review the literature on selective attention as it relates to the salience of certain values and schemas.

Norman (1968) hypothesizes that selection and attention are governed by the pertinence of the input, or the meaningfulness of the
cues. Pertinence is based on the expectations of future inputs and properties of the input that is being attended to. These selection biases play an important role in some perceptual phenomena. He claims that this is not a perceptual feature, but a cognitive one. The gestalt psychologists believe that a stimulus or set of stimuli become the emergent "figure", and may be differentiated from the "ground" by their meaningfulness or pertinence as a unitary and irreducible concept (Kohler, 1947).

Jerome Bruner (1951) conceptualizes this notion of pertinence in different terms. Cues in the environment are said to confirm hypotheses derived from basic and enduring needs and values; one's motivations determine what is seen. Postman et al. (1948) found support for this hypothesis—using a tachistoscope, they presented words that represented the values from Allport and Vernon's Study of Values. The length of exposure time required to recognize the words was significantly shorter for words associated with the subject's more salient values. These findings were replicated in the auditory realm by Vanderplas and Blake (1949), who stated that their results clearly showed that values play a selective role in recognition efficiency (this is termed perceptual sensitization). Postman et al. (1948) also suggest the concept of value resonance: the persistence of responses which are value-oriented, even when the associated stimulus is absent from the immediate environment.

In a study investigating the role of attention in impression communication (Perry, 1976), subjects viewed a videotape of a person. One group was asked to attend to the person's physical characteristics, the second group was told to form accurate personality impressions,
and Group III received no instructions. All groups were asked for both a recall of physical characteristics and a personality impression. Group I recalled significantly more physical characteristics \((p<.001)\) and Group II communicated significantly more accurate personality impressions. Perry concluded that attention plays a major role in interpersonal judging processes. For more complex cognitive tasks requiring inferential judgments, there also appears to be some retrieval from long-term memory as well, that influences ability to make these judgments. This process also seems to be facilitated by directed attention mechanisms.

To summarize the scant literature that addresses selective attention as it relates to values, attention may be directed by two different types of mechanisms, one of which is internal, the other is external. The internal mechanism may be termed perceptual sensitization or pertinence, and seems to be mediated by values, needs, and motivations. This is a cognitive structure that determines which stimuli will be attended to. The external mechanism is one that is mediated by the environment by cues, directions, etc., that instructs or draws one's attention to a certain stimulus or category of stimuli. It seems that the presence of either mechanism could produce an increment of awareness of the relevant stimuli, and that the two mechanisms may work in tandem in order to produce a maximal attentiveness effect.

**Summary**

The review of the literature has noted relevant studies to value convergence in therapy, sex bias and sex role stereotyping in therapy,
and the perceptual process as it is shaped by selective attention.

Therapy is an influence process in which a therapist's values are communicated, implicitly and explicitly, to the client. During the therapeutic process, convergence occurs, and this process seems to occur simultaneously with perceptions of client improvement. This phenomenon is evident even with therapists who claim to be non-directive or client-centered. Because of this influence/power, a therapist must be aware of her/his own value system and the potential impact that this could have on the direction of therapeutic goals and outcomes. (This same process has been found to exist in the supervisory relationship.) Many psychologists have advocated an explicit communication of one's value system in order to minimize imposition of values onto clients and supervisees, and so that the client may have the option to choose a therapist who has more consistent beliefs with her/him.

One type of value or belief imposition that may go on in therapy is one that is related to acceptable roles and behaviors for women versus men. Sex bias constitutes a form of oppression that does not permit an exploration of all possible alternatives, regardless of sex role stereotypes, and may serve to maintain the status quo.

Research regarding sex bias in therapy shows contradictory evidence for an overall effect (that therapists and counselors are sexist), or a main effect for sex of counselor (that males or females are more sex-biased). However, studies that have researched more specific questions, have shown that there may be certain types of presenting problems and client variables that induce counselors with certain characteristics (i.e., age, sex, experience) to exhibit sex bias. Further, there is
some evidence that therapists lack pertinent information (based on empirical data) about women, which may serve to increase the possibilities for sex bias.

There is a continuing controversy regarding the methodologies and findings of studies on sex bias. The ultimate conclusion seems to be that in order to expand our knowledge in this area, we need to develop alternate methodologies, new instrumentation, and ask more specific research questions.

In the final section of this chapter, the selective attention literature was reviewed, as it pertained to values and the perceptual process. There seem to be two different mechanisms that affect selective attention to sex bias or any set of attitudes/values. First, a system of salient values may affect the pertinence or perceptual sensitization, such that a person recognizes cues that are related to those values more easily than one who does not have these values. Second, attention can be directed by external or environmental cues—this mechanism is probably instrumental in learning or developing awareness of various constructs of schemes.

All of these areas of research seem to be pertinent to a further understanding of how psychotherapy/counseling may reinforce and maintain the status quo of sex roles through implicit and explicit influence. By changing their level of awareness of issues of sex bias, therapists can better facilitate psychological growth with their clients, regardless of sex.
CHAPTER III

METHOD

Purpose

The purposes of this study were: 1) to identify differences between graduate students in Counseling Psychology, Social Work, and Guidance and Counseling on the supervision, awareness of sex bias, and CRF variables; 2) to identify differences between male and female graduate students on the supervision, awareness of sex bias, and CRF variables; 3) to identify differences between the two conditions of manipulated awareness of sex bias in counseling on the supervision, awareness of sex bias, and CRF variables; 4) to study the interaction between type of graduate training, sex of trainee, and manipulated level of awareness on the supervision, awareness of sex bias, and CRF variables.

Subjects

The subjects for this study consisted of students in Counseling Psychology, Social Work, and Guidance and Counseling (Education) who were currently enrolled in courses in the master's degree curriculum in their respective fields of study. Volunteers were solicited through graduate courses to participate in a study on supervision of counseling. Twenty-five students were drawn from each program: 17 women and 8 men from both Counseling Psychology and Social Work, and 15 women, 10 men
### TABLE 1

**DESCRIPTIVE DATA FOR THE THREE SUBJECT GROUPS**

<table>
<thead>
<tr>
<th></th>
<th>Counseling Psychology</th>
<th>Social Work</th>
<th>Guidance &amp; Counseling</th>
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<tbody>
<tr>
<td></td>
<td>X</td>
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<td>X</td>
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<tr>
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</tr>
<tr>
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<td>.52</td>
<td>.28</td>
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<tr>
<td>Quarters in Grad. School</td>
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<td>1.5</td>
<td>3.4</td>
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</table>

<table>
<thead>
<tr>
<th></th>
<th>Counseling Psychology</th>
<th>Social Work</th>
<th>Guidance &amp; Counseling</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>%</td>
<td>n</td>
<td>%</td>
</tr>
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<td>16</td>
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<tr>
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<tr>
<td>Has taken minority course</td>
<td>16</td>
<td>4</td>
<td>48</td>
</tr>
</tbody>
</table>

\(^1\)All of this data was gathered via the Personal Data Form.
from Guidance and Counseling. Table One presents a description of the three subject groups.

Construction of Tapes

Each of the two audio tapes was a ten-minute counselor-client interaction. Both counselors and clients were given scripts to practice before the actual taping. All actors were female, and the counselors were advanced level graduate students in Counseling Psychology.

The role for each of the counselors was one in which they were to be subtly sexist in their responses to the client, but were equally expert, attractive, and trustworthy, given this limitation. The recordings were made by a successive approximation process to attain equivalency on the sex bias variable. This turned out to be a very difficult task, because everyone had different ideas about what constituted more sexist behavior. Two tapes were made, and four advanced graduate students were asked to rate them on blatancy and amount of sex bias. Their reports indicated a split regarding which tape was more sex-biased, and in addition their suggestions about making changes in the tapes were just as ambiguous.

The tapes were remade four times, changing just a few lines each time, to attempt to approximate equivalency, until the raters were able to agree on the blatancy and amount of sex bias in the tape. The sex bias variable was controlled not only by the type of problem that the client presented, but also by the number and blatancy of sex-biased statements made by each counselor, at approximately the same times during the ten-minute counseling session.
Tape equivalence was finally measured in three ways. First, advanced graduate students in Counseling Psychology were given copies of the scripts to examine, and were asked to rate the tapes on overall equivalence for expertness, attractiveness, trustworthiness, and sex bias. The scripts were judged to be equivalent on these four dimensions by four independent raters. Secondly, four advanced graduate students in Counseling Psychology were told that the counselor trainees in both tapes were sex biased, and were asked to rate the two counselors on the CRF variables (this step served to hold the sex bias constant, so that awareness versus unawareness of this variable did not affect the ratings of these other three variables). Again, the tapes were rated as approximately equivalent. Finally, three advanced (Ph.D. level) graduate students were asked to listen to the tapes with exactly the same set of instructions that the subjects would have. At Time One, one of the subjects was highly aware of the sex bias, while the other two were not, thus the interaction of this awareness with the CRF variables made the scores difficult to compare. At Time Two, though, all subjects were aware of the sex bias, and there was approximate equivalence of the CRF variables across tapes.

After the data were collected, a post hoc check for the equivalence of tapes for this particular sample of individuals was made. A general linear models procedure was used to look at possible effects due to the tapes. At Time One, there was no significant overall tape effect, as determined by a multivariate analysis of variance (F=2.00, n.s.). The four dependent variables that were initially held constant in establishing tape equivalency (expertness, attractiveness,
trustworthiness, and sex bias), were examined via the general linear models procedure for Tape x Sex x Graduate Area at Time One, and the first three variables showed nonsignificance. The fourth variable, sex bias, was significant ($p < .01$) but this was not attributable to a significance in the tape (the univariate was not significant).

For Time Two, the multivariate analysis test for no overall tape effect was found to be significant ($F=5.33, p < .001$). A summary of the general linear models may be found in Appendix A. Expertness was nonsignificant, but trustworthiness and bias had significant effects that could be attributed to either sex or graduate area, and not to the tape effect. However, for the variable of attractiveness, there was a significant univariate effect for tape ($F=7.80, p < .007$). This finding may indicate that there is an order effect: that is, that those who heard Tape A first, then Tape B, as opposed to those who heard them in the reverse order, perceived differential counselor attractiveness on the second tape because of the order. An alternate explanation may be that the second set of instructions (re: sex bias) interacted with the tape sequence, such that differences in attractiveness were maximized by subjects when they rated the second recording. In any event, the meaning of this finding is not clear. However, at Time One, without this additional set of instructions, the two tapes were equivalent.

The following roles were used in the tapes:

**Tape A**—A woman who is married has come to see a counselor because of a conflict with her husband: he wants to have a family, and she does not. Both the client and her husband have careers, and the client wishes to continue with hers, further, she has never enjoyed children. She is feeling pressured to do something that she does not want to do, and has come to discuss it with a counselor.
The counselor is warm and understanding, but focuses more on the husband's feelings of disappointment than on the client's. She also hints that the client may have misled her husband before marriage—blaming her for not bringing up this issue before marriage, and suggesting that her decision (as opposed to both of their decisions) may be putting a strain on the marriage. The counselor later suggests that her decision not to have children may be irrational, and needs to be thought out again, despite the fact that the client has clearly stated that she does not want a family. Finally, the counselor suggests that they explore options in the next session, such as her husband helping to care for the children, without any acknowledgement that another option may be to not have a family.

Tape B- The client is a divorced woman who has one son, who has just started school. The client is depressed, and attributes this to her son starting school, and her realization that her life is boring. She feels she isn't needed very much by her son anymore, and her job is meaningless as well.

The counselor is warm and understanding, but focuses on the fact that the woman has gone through a divorce, saying that the depression and feelings of worthlessness are typical for a woman who has "lost" her husband (as opposed to the divorce having been her choice, or a mutual choice, which the counselor does not know). She says that it is understandable that she would feel this way without anyone to depend on her. The counselor never explores the woman's job futility, but assumes that the depression must be because of a lack of a relationship. The counselor suggests that the client should start developing new interests so that she can meet new people to start dating (the interests are made to sound instrumental to meeting men, and that it should be easier because she is attractive).

The counselor also says that little boys need independence (as if this wouldn't be a problem with a little girl), and that the son should be brought in to make sure he is adjusting without a father (again, another way of suggesting that she should be married again).

These roles were formulated around definitions of sex bias as set forth by the APA Task Force (1975). These are 1) fostering traditional sex roles, 2) bias in expectations and devaluation of women, 3) sexist
use of psychoanalytic concepts, and 4) responding to women as sex objects. In these vignettes, both of the clients are presenting problems of a nature that the counselor could easily utilize one or several of the above characteristics/areas of sex bias (primarily the fostering of traditional sex roles). Description of the sex-biased elements of each tape can be found in Appendix B.

Instruments

The instruments used in this study were: 1) Supervisory Issues Form, 2) Counselor Rating Form, and 3) the Personal Data Form.

The Supervisory Issues Form is an open-ended questionnaire that asks the subject to assess and describe the types of issues that s/he would want to bring up with the supervisee, and has two ratings: 1) an effectiveness rating of the counselor, and 2) projected comfort level (or willingness) in working with this counselor trainee. (See Appendix C for the complete form.)

The Counselor Rating Form (CRF) (Barak & Lacrosse, 1975) measures subjects' perceptions of expertness, attractiveness, and trustworthiness of the counselor. Strong (1968) defines expertness as evidence of a counselor's competence- s/he is confident, relaxed, interested, and reactive to the client. Attractiveness is perceived by the client who feels compatibility, liking, and similarity with the counselor. The counselor has attitudes and experiences in common with the client. The trustworthy counselor is one perceived as honest, open, and sincere, with no hidden motives.
The CRF consists of 36 seven-point bipolar items, 12 on each of the three dimensions. Scores on each dimension range from 12 to 84. Reliability has been established for these three scales in several studies (Barak & Dell, 1977; Barak & LaCrosse, 1975; LaCrosse & Barak, 1976), and the coefficients range from .850 to .908 for split-half reliability. (The CRF may be found in Appendix D.)

The Personal Data Form was used to determine type of graduate program and sex of subject, and asks several questions relating to length of time in program, aspirations for further training, related course work, and experience in counseling and supervision. (See Appendix E.)

Procedure

Subjects were tested in small groups. They were asked to fill out the Personal Data Form first. They were given two forms, the Supervisory Issues Form (SIF) and the Counselor Rating Form (CRF) for each of the two tapes. Subjects were read the following instructions:

This study looks at the process of supervision of counseling. Many of you, by virtue of the fact that you are in the process of obtaining a graduate professional degree, will probably have the occasion, sometime in your career, to supervise either students who are training in your own field, peers, or paraprofessionals. At this point, very few research studies have looked at how supervision is done, or what issues are attended to by supervisors, and that is the purpose of this study.

It is understood that the participants in this study have probably never done supervision of counseling before, and that is fine. Most professionals who begin supervising students or paraprofessionals have had little, if any, formal training to do so. Regardless of your current level of training, you have some ideas about what a "good" counselor/therapist does, and it is these ideas that I would like you to keep in mind while listening critically to these tapes.
You will be listening to two 10-minute tapes of two different counseling sessions. Both of the client's problems deal with decisions regarding lifestyle and relationships. You are to listen to these as if you were the supervisor for this case, that is, that after listening to this counselor/client interaction, that you would be meeting with the counselor trainee to discuss the case, her/his behavior and responses during the session, and feedback/constructive criticism. Instead of actually meeting with the trainee, I would like you to fill out the two forms in front of you (the Supervisory Issues Form, and the Counselor Rating Form). Please look the forms over now. One is an open-ended questionnaire that asks you to discuss various issues that you feel are important to bring up to the supervisee (be as specific as possible), and later asks you to rate the counselor's overall effectiveness, and how comfortable you would feel working with this trainee. The second form is a list of adjectives on which you will rate the counselor. Please take a minute to read the instructions attached to the questionnaire.

Before beginning, I would like you to fill out the personal data form. Anyone desiring feedback about the study's results may put their name and phone number on the bottom of this form, and I will get back with you when the study is completed. Your results are anonymous and the names will be torn off of the rest of the form.

Please listen carefully while the tape is playing. Please do not discuss the tapes or your assessments/ratings of the tapes with others. Thanks.

At the end of the first tape, and after subjects had filled out the first set of questionnaires, subjects were given a one-page handout to read before they listened to the second tape. This defined sex bias in therapy according to the criteria outlined by the APA Task Force (1975), and gave examples of each type of sex bias. This was presented as one issue that might be dealt with by a supervisor with her/his trainee (and thus an issue they could include on the SIF). Subjects were asked to keep this additional issue in mind as s/he listened to the next tape. (A copy of this handout can be found in Appendix F.)
The two tapes, A and B, were counterbalanced, so that half of the subjects who participated in the study heard tape A first, and half heard tape B first. Each subject heard the opposite tape for their second tape, with the additional set of instructions about sex bias as a supervisory issue.

When subjects had completed ratings for both tapes, they were debriefed as to the purposes and objectives of the study, and were given the opportunity for feedback concerning findings of the study at the conclusion of the research.

This study employed a 3 x 2 x 2 repeated measures design, the variables being graduate program (Counseling Psychology, Social Work, or Guidance & Counseling), sex of subject, and Time One versus Time Two. The design is summarized graphically below:

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<th>Program</th>
<th>Time One</th>
<th>Time Two</th>
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</thead>
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<tr>
<td>Psych.</td>
<td>Male (n=8)</td>
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</tr>
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<td>Social</td>
<td>Female (n=17)</td>
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<td>Male (n=8)</td>
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</tr>
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<td>Guidance &amp; C</td>
<td>Female (n=15)</td>
<td></td>
</tr>
<tr>
<td>Counseling</td>
<td>Male (n=10)</td>
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</tr>
</tbody>
</table>

Figure 1
Summary of Experimental Design

There were six dependent variables: the three scale scores from the CRF (expertness, attractiveness, and trustworthiness), an overall effectiveness rating of the trainee/counselor, a willingness to supervise score, and a rating of subjects' awareness of sex bias. These latter...
three were all derived from the SIF: the effectiveness rating and the willingness to supervise ratings were both seven-point Likert scales to which the subject responded. Awareness of sex bias was derived by evaluating the open-ended written responses on the SIF.

The sex bias ratings were made by a male and a female undergraduate research assistant, who had been trained specifically for this task. They read each SIF, blind as to condition (Time One versus Time Two), the sex, and the graduate program of the subject. They then made independent judgments, on a 1-5 scale of the awareness of sex bias of the subject. In the case of disagreements (about 20% of the forms to be rated), the two of them and the experimenter, who was also blind to the above variables, discussed the judgments until an agreement could be reached. (The criteria for sex bias awareness in each tape can be found in Appendix A, and the five point scale that was used for scoring can be found in Appendix G.)

Hypotheses

The hypotheses were:

1) There are no differences between the three graduate programs on the following measures, in either condition of awareness.
   a) awareness of sex bias
   b) willingness to supervise
   c) counselor effectiveness
   d) expertness
   e) attractiveness
   f) trustworthiness

2) There are no differences between the male and female subjects on the following measures:
   a) awareness of sex bias
   b) willingness to supervise
   c) counselor effectiveness
   d) expertness
   e) attractiveness
   f) trustworthiness
3) In the informed condition (Time Two), ratings are higher than ratings in the uninformed condition (Time One) on the following measure:
   a) awareness of sex bias

4) In the informed condition, ratings are lower than ratings in the uninformed condition on the following measures:
   a) willingness to supervise
   b) counselor effectiveness
   c) expertness
   d) attractiveness
   e) trustworthiness

5) There are no significant interactions between the variables of graduate program, sex of subject, and condition (Time One versus Time Two).

6) The higher the awareness of sex bias, regardless of condition (Time One versus Time Two), the lower the ratings are on:
   a) willingness to supervise
   b) counselor effectiveness
   c) expertness
   d) attractiveness
   e) trustworthiness

Analysis

The first five hypotheses were tested by a repeated measures multivariate analysis of variance (Winer, 1971) for a 3x2x2 design with unequal n. To take a closer look at significant findings, a Scheffé post hoc test was used. The sixth hypothesis was tested by correlational procedures.
CHAPTER IV
RESULTS AND DISCUSSION

Results

The means and standard deviations for the dependent variables across the six subject groups (Sex x Graduate Area) are presented in Table 2 and 3. The multivariate and univariate tests for significance are shown in Tables 4 and 5, respectively. The multivariate test for the main effect of the three independent variables, Sex of subject, Graduate Area, and the repeated measure (Time), were each found to be significant at the $p < .001$ level (the values of $F$ were: Sex: $F=4.31$; Graduate Area: $F=5.08$; Time: $F=19.77$). The only interaction effect that was significant was Graduate Area x Time ($F=1.88, p < .043$).

In looking at the data more closely, there were two univariate dependent variables that were significant for the test of Sex: attractiveness of counselor ($F=4.14, p < .046$), and trustworthiness ($F=10.46, p < .002$). In the multivariate test for Graduate Area, awareness of sex bias was the only significant univariate ($F=12.11, p < .001$). There were four univariate tests that were significant for the repeated measure: counselor trustworthiness ($F=14.10, p < .001$), awareness of sex bias ($F=79.76, p < .001$), counselor effectiveness ($F=6.68, p < .012$), and willingness to supervise ($F=21.54, p < .001$). For the interaction effect of Graduate Area x Time, the significant univariates were
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### Table 3

**Means and Standard Deviations of the Dependent Variables at Time Two**

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**Willingness to supervise**

* = significant multivariate effects
n.s. = not significant
counselor expertness ($F=446.11, p < .025$), trustworthiness ($F=57.39, p < .006$), and counselor effectiveness ($F=8.13, p < .013$). There were several other significant univariate $F$ tests, but because the overall multivariate tests were not significant, those findings are not presented here. The dependent variables are interrelated, thus there is no justification for looking at them independently.

To take a closer look at the significant findings, post hoc tests were used to determine which groups were significantly different from one another. A Scheffé test (Winer, 1971) was used to differentiate Graduate Area groups on the univariate effect for sex bias. The findings (see Table 6) show that Counseling Psychology students were significantly different from the Guidance & Counseling students ($F=12.72, p < .05$), but there were no other significant group differences.

A Scheffé test was also used to further explore the significant univariate effects of the Graduate Area x Time interaction main effect (see Table 6). Results indicate that on the expertness variable, that both the Social Work and Counseling Psychology groups were significantly different from the Guidance & Counseling group ($F=13.52, p < .05$; $F=11.40, p < .05$, respectively). However, the post hoc test for group differences for trustworthiness did not reveal any significant findings. For counselor effectiveness, only the Counseling Psychology and Guidance & Counseling groups were significantly different ($F=19.42, p < .01$).
<table>
<thead>
<tr>
<th>Comparison</th>
<th>MS</th>
<th>F</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sex Bias (G main effect)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CP vs. SW</td>
<td>2.656</td>
<td>1.639</td>
<td>n.s.</td>
</tr>
<tr>
<td>SW vs. GC</td>
<td>8.466</td>
<td>5.23</td>
<td>n.s.</td>
</tr>
<tr>
<td>CP vs. GC</td>
<td>20.608</td>
<td>12.72</td>
<td>.05</td>
</tr>
<tr>
<td>Error</td>
<td>1.62</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Expertness (G x T)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CP vs. SW</td>
<td>10.35</td>
<td>.09</td>
<td>n.s.</td>
</tr>
<tr>
<td>SW vs. GC</td>
<td>1578.46</td>
<td>13.52</td>
<td>.05</td>
</tr>
<tr>
<td>CP vs. GC</td>
<td>1305.61</td>
<td>11.40</td>
<td>.05</td>
</tr>
<tr>
<td>Error</td>
<td>114.5</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Trustworthiness (G x T)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CP vs. SW</td>
<td>32.42</td>
<td>.314</td>
<td>n.s.</td>
</tr>
<tr>
<td>SW vs. GC</td>
<td>974.61</td>
<td>10.00</td>
<td>n.s.</td>
</tr>
<tr>
<td>CP vs. GC</td>
<td>660.66</td>
<td>6.84</td>
<td>n.s.</td>
</tr>
<tr>
<td>Error</td>
<td>96.63</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Effectiveness (G x T)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CP vs. SW</td>
<td>7.03</td>
<td>2.78</td>
<td>n.s.</td>
</tr>
<tr>
<td>SW vs. GC</td>
<td>11.28</td>
<td>6.06</td>
<td>n.s.</td>
</tr>
<tr>
<td>CP vs. GC</td>
<td>36.12</td>
<td>19.42</td>
<td>.01</td>
</tr>
<tr>
<td>Error</td>
<td>1.86</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

CP = Counseling Psychology
SW = Social Work
GC = Guidance and Counseling
Correlations between awareness of sex bias and the other dependent variables are shown in Tables 7 through 10. Table 7 summarizes the data for all subjects in Time One, Table 8 presents correlations at Time Two, across all subjects. At Time One, sex bias was significantly correlated with attractiveness ($R = -.302, p < .008$) and counselor effectiveness ($R = -.231, p < .046$), and at Time Two, expertness ($R = -.420, p < .002$) and trustworthiness ($R = -.362, p < .001$) were negatively and significantly correlated with sex bias, in addition to the previous two (attractiveness: $R = -.407, p < .003$; effectiveness: $R = -.352, p < .002$). Tables 9 and 10 look at the correlations by sex in Time One and Time Two.
TABLE 7

CORRELATIONS OF SEX BIAS WITH OTHER DEPENDENT VARIABLES, TIME ONE, ACROSS ALL SUBJECTS

<table>
<thead>
<tr>
<th></th>
<th>Expertness</th>
<th>Attractiveness</th>
<th>Trustworthiness</th>
<th>Effectiveness</th>
<th>Willingness to Supervise</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex Bias 1</td>
<td>R</td>
<td>p</td>
<td>R</td>
<td>p</td>
<td>R</td>
</tr>
<tr>
<td></td>
<td>-.204</td>
<td>.079</td>
<td>-.302</td>
<td>.008*</td>
<td>-.159</td>
</tr>
<tr>
<td></td>
<td>-.159</td>
<td>.172</td>
<td>-.231</td>
<td>.046*</td>
<td>.132</td>
</tr>
</tbody>
</table>

*All variables are at Time One
* p < .05

TABLE 8

CORRELATIONS OF SEX BIAS WITH OTHER DEPENDENT VARIABLES, TIME TWO, ACROSS ALL SUBJECTS

<table>
<thead>
<tr>
<th></th>
<th>Expertness</th>
<th>Attractiveness</th>
<th>Trustworthiness</th>
<th>Effectiveness</th>
<th>Willingness to Supervise</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex Bias 2</td>
<td>R</td>
<td>p</td>
<td>R</td>
<td>p</td>
<td>R</td>
</tr>
<tr>
<td></td>
<td>-.420</td>
<td>.0002*</td>
<td>-.407</td>
<td>.0003*</td>
<td>-.362</td>
</tr>
<tr>
<td></td>
<td>-.362</td>
<td>.001*</td>
<td>-.352</td>
<td>.002*</td>
<td>-.171</td>
</tr>
</tbody>
</table>

*All variables are at Time Two
* p < .05
TABLE 9

CORRELATIONS OF SEX BIAS WITH OTHER DEPENDENT VARIABLES, TIME ONE,
BY SEX

<table>
<thead>
<tr>
<th></th>
<th>Expertness(^1)</th>
<th>Attractiveness</th>
<th>Trustworthiness</th>
<th>Effectiveness</th>
<th>Supervise</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex</td>
<td>R</td>
<td>p</td>
<td>R</td>
<td>p</td>
<td>R</td>
</tr>
<tr>
<td>Female</td>
<td>-.197</td>
<td>.175</td>
<td>-.297</td>
<td>.038*</td>
<td>-.198</td>
</tr>
<tr>
<td>Male</td>
<td>-.346</td>
<td>.083</td>
<td>-.381</td>
<td>.055*</td>
<td>-.231</td>
</tr>
</tbody>
</table>

\(^1\)All variables are at Time One
*p < .05

TABLE 10

CORRELATIONS OF SEX BIAS WITH OTHER DEPENDENT VARIABLES, TIME TWO,
BY SEX

<table>
<thead>
<tr>
<th></th>
<th>Expertness(^2)</th>
<th>Attractiveness</th>
<th>Trustworthiness</th>
<th>Effectiveness</th>
<th>Supervise</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex</td>
<td>R</td>
<td>p</td>
<td>R</td>
<td>p</td>
<td>R</td>
</tr>
<tr>
<td>Female</td>
<td>-.401</td>
<td>.004*</td>
<td>-.416</td>
<td>.003*</td>
<td>-.441</td>
</tr>
<tr>
<td>Male</td>
<td>-.533</td>
<td>.005*</td>
<td>-.523</td>
<td>.006*</td>
<td>-.445</td>
</tr>
</tbody>
</table>

\(^2\)All variables are at Time Two
*p < .05
Discussion

As shown in the results section, there were significant main effects for Sex, Graduate Area, Time (repeated measure), and Graduate Area x Time. Each of these effects will be discussed below in the context of the relevant univariate findings.

In general, there was a trend for females to have slightly higher scores on all variables when compared to males (see Table 11). This is interesting, in that even though females were slightly more aware of sex bias than were men (3.08 versus 2.69), they continued to rate other counselor variables consistently higher than men. The two significant univariates were counselor attractiveness and trustworthiness. This could indicate that female trainees, when listening to a female counselor, feel more similarity, liking, and trust for her because of a higher identification with her than men might experience. The overall trend of higher ratings on the variables by females could reflect the same process.

As shown by the results, there are no significant differences between males and females in their ratings of counselor expertness, effectiveness, or their willingness to supervise these trainees. There is also no significant difference in their ability to detect sex bias. This latter finding is consistent with recent research findings (Hill et al., 1977, Moxfield, 1976).

The significant main effect for Graduate Area could be interpreted to mean that, as a function of their training, counselor trainees perceive the same counselors in different ways. The means of five of
<table>
<thead>
<tr>
<th>Sex</th>
<th>Expertness</th>
<th>Attractiveness</th>
<th>Trustworthiness</th>
<th>Sex Bias</th>
<th>Effectiveness</th>
<th>Willingness to Supervise</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>62.01</td>
<td>61.68</td>
<td>64.11</td>
<td>3.08</td>
<td>4.42</td>
<td>5.50</td>
</tr>
<tr>
<td>Male</td>
<td>57.96</td>
<td>58.60</td>
<td>58.63</td>
<td>2.69</td>
<td>4.27</td>
<td>5.24</td>
</tr>
</tbody>
</table>

p < .046  
p < .0026
the variables indicate that there were no consistent counselor rating patterns between the three disciplines. However, the significant univariate for sex bias awareness showed that the Counseling Psychology and Guidance and Counseling groups to be significantly different, with Counseling Psychology showing the greatest awareness of sex bias of the three groups, and the Guidance group showing the least awareness. This may be indicative of the amount of attention given to the topic of sex bias in counseling/therapy in the various curriculums, and would suggest that increasing awareness in trainees may be contingent on these matters being addressed in training programs.

An alternate explanation could be that sex bias awareness was related to the age of participants in the three disciplines. The Counseling Psychology participants were the youngest as a group (\( \bar{X} = 26.0 \)), Social Work was next (\( \bar{X} = 28.0 \)), and Guidance and Counseling subjects were the oldest (\( \bar{X} = 34.8 \)). Because of the more recent attention to socialization patterns of females and males, and to sexism/feminism on college campuses, it may be that younger trainees simply have had more exposure and life experiences in the nontraditional realm. Conversely, older students may have had more traditional upbringings and had a more traditional college experience, thus they are less aware when a counselor displays biased behavior, as it is more consistent with their experiences.

The significant main effect for Time, or the repeated measure, showed all six dependent variables to change in the predicted direction, four of them significantly so. First, the intervention (reading about sex bias in therapy) was able to not only help subjects identify and
label counselor behavior as sex-biased, but also aided in accurate specification of how and why the interaction was sex-biased. Subjects who were initially aware seemed able to be more specific and aware of how the sex bias affected the interaction on Time Two. This would indicate that this type of directed attention could be helpful as a tool for awareness-expansion and education for sex-fair counseling/therapy, regardless of current level of awareness. This method may approximate a combined didactic (reading) and experiential (analogue as a supervisor) training.

The other counselor variables (expertness, attractiveness, trustworthiness, effectiveness) and willingness to supervise were all rated as being lower at Time Two than at Time One, the latter three being significant. Thus it seems, the directed attention to sex bias inversely affected the trustworthiness and overall effectiveness of the counselor, and the subjects' willingness to supervise this trainee. This could indicate that awareness of sex bias itself inversely affects perceptions of these other variables. Alternately, this could have been a perceived demand of the task. This possibility is examined more closely through the correlational data, later in this discussion.

The last significant multivariate effect was Graduate Area x Time. Four of the univariate variables (expertness, attractiveness, trustworthiness, and effectiveness) had the same pattern (see Figure 2) and all of these, except attractiveness were significant effects. The Counseling Psychology and Social Work subjects both perceived the counselor at Time Two as being lower on all of the above variables. However, the Guidance and Counseling sample consistently rated the
FIGURE 2

GRADUATE AREA X TIME INTERACTIONS

1 = Counseling Psychology; 2 = Social Work; 3 = Guidance & Counseling.
FIGURE 2 (continued)

Awareness of Sex Bias

TIME 1

TIME 2

1 2 3

1 2 3

5 4 3 2 1
first counselor as lower on these variables than the other two subject
groups, and rated these variables higher at Time Two (in the opposite
direction of the other two groups). This was the opposite of the hy-
pothesized direction.

Because all groups' awareness of sex bias increased (though the
Guidance and Counseling sample was the least aware), this pattern would
indicate that awareness of sex bias (and the social desirability of
being aware) is salient for students in Counseling Psychology and Social
Work in affecting other judgments they make about counselors' behavior.
However, perhaps because of the lower awareness level of Guidance and
Counseling students, they tend to have a reverse reaction— they may
not perceive the sex bias as being important enough to affect other
counselor dimensions. It could alternatively mean that Counseling
Psychology and Social Work students have had more experience and related
course work that allows them to utilize this particular set of instru-
ments more efficaciously, though the qualitative data does not show
Guidance and Counseling to be consistently lower on experience in coun-
seling or in course work completed.

A third possibility might be that there is a motivational dif-
ference between these three samples. Counseling Psychology students
have self-selected themselves into a Ph.D. program. Social Work students
have chosen a (typically) terminal master's degree program. The
Guidance and Counseling students, with greater frequency, seem to be
teachers who are being required by their employers to get master's
degrees, and are part-time students. Perhaps because this is an external
as opposed to an internally-motivated choice, the motivation somehow
affects their perceptions of counseling situations. In the perceptual literature, this might be described as an instance where the perceptual sensitization to these particular issues requiring fine discrimination (i.e., the sex bias and other counselor variables) has not been maximally developed due to a lower internal motivation level.

The correlations of sex bias to the other variables show that when trainees are aware of sex bias, they see the counselor as less expert, attractive, trustworthy, effective, and they would be less willing to supervise them. Conversely, if graduate students do not perceive the sex bias, then they rate the counselors on these traits as higher on all of these dimensions. At Time One, the negative relationship between sex bias and the other variables was not as strong as at Time Two, however, the same pattern of relationships emerged at Time One. Earlier in this discussion, the possibility was raised that, at Time Two, the negative relationship between sex bias and other counselor dimensions could be attributed to task demands. Because this relationship also existed before the intervention of information about sex bias in therapy, this hypothesis must be rejected. It seems more plausible that the amount of sex bias awareness, regardless of Time, influences perceptions of other traits of counselors. Further, the greater the awareness of sex bias, even when this is manipulated externally, the more salient the negative relationship between sex bias and other counselor dimensions.
Across Times One and Two, for men, counselor effectiveness was negatively and significantly correlated with sex bias, however, this was not so for women. Other counselor variables (attractiveness at Time One, and expertness, attractiveness, and trustworthiness at Time Two) were significantly correlated for both males and females. This could indicate that perceptions of sex bias were more salient in affecting overall effectiveness for men than they were for women. Perhaps females give trainees the "benefit of the doubt" when rating overall effectiveness, or again, this could be a result of the identification of the female subject with the female counselor trainee, as discussed earlier.

In summary, this section has presented the findings of the study, and discussed possible explanations of these results. There were significant results for all three of the main effects of the study, and one interaction, which were looked at more closely by examining the univariate effects and post hoc analyses.
The purposes of this chapter are to 1) provide a summary of the research and to examine the hypotheses in light of the relevant data, 2) present the limitations of the research, 3) discuss the implications of the study, and 4) make conclusions regarding the findings of the study.

Summary of the Method

Seventy-five master's level graduate students from three counseling disciplines, Counseling Psychology, Social Work, and Guidance and Counseling (25 subjects from each graduate area) were asked to listen to two audio tapes of 10-minute counseling sessions. While listening, subjects were asked to take the role of the supervisor for the cases, and to respond to two questionnaires (the CRF and SIF) immediately following each tape. Before the second tape treatment, subjects were given a handout on an issue which they might wish to consider in supervision: sex bias in therapy/counseling. Sex bias was defined and examples were given of how sex bias might be evident in the therapeutic setting. Subjects were then asked to listen to the second tape treatment, and respond to the two questionnaires. Both tape treatments had subtle and equivalent sex bias,
and both were judged to be equivalent on expertness, attractiveness, and trustworthiness as well. The data were analyzed by Graduate Area and Sex of the subject, and Time (3 x 2 x 2) by a related measures multivariate analysis of variance procedure. Correlations of awareness of sex bias with the other dependent variables were also computed.

Relationship of the Data to the Experimental Hypotheses

Hypothesis 1 stated that there were no significant differences between male and female subjects on the dependent variables. This hypothesis was not supported. There was a significant main effect for Sex of subject, and significant univariate effects for attractiveness and trustworthiness, indicating that female trainees perceive the female counselors to be more likable, similar, and trustworthy than the male trainees. This seems to be a process of identification.

Hypothesis 2 stated that there were no significant differences between the Graduate Area in which the participant was currently enrolled. Again, this hypothesis was rejected, because of a significant main effect for graduate area. The only significant univariate effect was for sex bias awareness, with Counseling Psychology subjects showing a significantly greater awareness than Guidance and Counseling students. This indicates that there may be differences in the amount of emphasis given the topic of sex bias in therapy/counseling, and this affects one's ability to detect sex bias. Alternately, it may mean that the overall type of training that a student receives somehow influences their perceptual abilities in regard to sex bias, though this possibility is very tentative. A third alternative is that the perception of sex bias may
be related to the age of subjects (the Guidance and Counseling sample average age was eight years older than the Counseling Psychology sample).

**Hypothesis 3** stated that there was a significant difference between Time One and Time Two— with awareness of sex bias increasing, and the other five dependent variables decreasing. This hypothesis was strongly supported by the significant multivariate effect, and significant univariate effects for trustworthiness, awareness of sex bias, effectiveness, and willingness to supervise. While perceptions of sex bias increased, the other three variables decreased, as hypothesized.

**Hypothesis 4** stated that there were no significant interactions between Sex, Graduate Area, and Time. Only one interaction effect was significant: Graduate Area x Time, and the significant univariates were expertness, trustworthiness, and effectiveness. This seems to indicate that the combined effect of the intervening task (reading about sex bias in therapy/counseling) and accustoming oneself to the instruments and the task in general, had a differential effect on the subjects, as a function of their graduate area: Counseling Psychology and Social Work subjects found the counselor at Time Two to be less expert, trustworthy, and effective, and Guidance and Counseling students found them to be more expert, trustworthy, and effective at Time Two. This difference may be accounted for by 1) differential training that affects Guidance students in terms of their perceptions of counselors, and/or makes sex bias, and desirability of being aware of sex bias less salient, or 2) motivation of the students who may be obtaining required graduate training, as opposed to the attainment of a degree by choice, may influence the degree of perceptual sensitization to some issues (which may be judged as superfluous).
Hypothesis 5 stated that awareness of sex bias was negatively and significantly correlated with the other dependent variables. This hypothesis was strongly supported, for both Time One and Time Two. At Time One, two variables, attractiveness and effectiveness were significantly correlated with awareness of sex bias, and at Time Two, four out of five of the variables, expertness, attractiveness, trustworthiness, and effectiveness were all significantly and negatively correlated with sex bias. Only one significant correlation differentiated the males from the females across time: counselor effectiveness. This indicates that either perceptions of sex bias were more salient for men in affecting ratings of overall effectiveness, or that the female subjects identified with the female counselors in the tapes more than the males did, and hence were less critical in their ratings.

Limitations

The limitations of this study are: the problem of tape equivalence, the sample from which the actors and raters for tape equivalence were drawn, the inter-rater reliability for sex bias raters, and the generalizability of the study.

As mentioned in the method section, attaining tape equivalence was a very difficult task, and in looking at the data for the present subject sample, there still seemed to be some problem with Time Two. This may have been lessened, perhaps, by more extensive pilot testing with a greater number of pilot subjects. However, this was not practical for the reason that all available graduate students were used in the pilot testing that was carried out.
The second limitation was that only advanced graduate students from Counseling Psychology were used to rate the tapes in the pilot testing. This could limit the equivalence factors for the other two graduate area samples, or make the tapes 'more equal' for Counseling Psychology subjects. This was done primarily out of necessity, as there were no other available groups from which students could be drawn. It also might have been almost impossible to attain equivalence of any sort for a more heterogeneous sample, as everyone had different notions about what constituted more sex-biased behavior. Perhaps a group, i.e., Clinical Psychology students, could have been used so that there was less possibility of a biasing effect of equivalence. The two actors who portrayed counselors were also advanced level Counseling Psychology students, though the client actors were unknown to all subjects. Possibly this could have had some effect on the experience of the Counseling Psychology subjects. It was important to have experienced counselors, however, to make the tapes sound more credible, and it was difficult to find other people who were willing to commit themselves to many tedious hours of taping.

Third, raters of the sex bias did not have as high an inter-rater reliability as desired: they disagreed on about 25% of the initial ratings, though these were usually easily resolved through discussion. Perhaps with a longer training period, the reliability could have been improved.

Finally, generalizability may be limited in terms of applying these findings to specific counseling disciplines, as the way these training programs are set up and administered very greatly among schools. Still
important, however, is that there are differences as a result of the type of training received, the amount of emphasis put on sex bias awareness in the program, and/or perhaps the type of student that chooses each of these programs.

**Implications**

The results of this study indicate that females and males seem to have a different rating style when evaluating female supervisees, presumably due to a greater identification by the female trainees. This evaluation style needs to be further explored, and it would be interesting to see if the same relationship exists for male supervisors with male trainees.

A second implication concerns graduate training programs. They need to address the issue of sex bias in therapy/counseling in a systematic fashion, so that this will become an issue to which future supervisors are more attuned, and which these soon-to-be counselors can monitor in their own work with clients. An issue which should be further explored in the research, is whether there is a qualitative difference between types of training programs that differentially enables trainees to perceive sex bias, or whether this is strictly a function of the attention given that particular topic. A second alternative which needs to be studied, is the possibility that demographic or personality characteristics may be significant in ability to detect sex bias, due to differential life experiences (including the impact that the feminist movement has had on oneself and significant others), age (and when s/he grew up: the era in which s/he was socialized), and personality variables such as need for
order and structure, internal versus external locus of control, and authoritarianism/need for dominance.

Awareness of sex bias seems to be a function of two factors. The first is a general sensitization towards the issue of sex bias, that may be generated via an interest or commitment to feminism, awareness of sex discrimination and other inequities that have made this a personally and/or politically relevant issue. Basically, this connotes a value system that is consonant with attaining equality between the sexes. The second factor is one that is externally or environmentally controlled. A person's attention can be directed to the issue of sex bias in order to enhance its perception, and to eventually have the effect of increasing the sensitization level.

One avenue for this directed attention to awareness of sex bias should be through the graduate training program. This may be done by providing readings, encouraging discussions, and facilitating experiences that increase one's abilities to provide maximal assistance to one's clients and supervisees, regardless of their sex. This involves looking critically at society's value system, and recognizing the effect of one's own socialization, which inevitably causes each of us to have some sex-typed assumptions.

It is important to note that both males and females are victims of sex bias, and that both male and female counselors are equally liable to display their socialized sex-stereotyped biases, if these are left unquestioned. (Female counselors were used in this study to demonstrate this point.) An extension to this study would be to use female counselors with male clients, and male counselors with female and male
clients to determine how these configurations affect ratings on the dependent variables.

One simple, but effective technique that might be useful in the context of a comprehensive program for awareness of sex bias is the one utilized in this study (rating two tapes on the SIF and CRF, with the reading on sex bias in between). Besides sharpening one's discrimination skills by the intervention on sex bias in therapy, the two tapes and their biased elements could be discussed in small groups. This would serve to increase the pertinence and meaningfulness of the material. An interesting extension of this study would be to add the discussion element to the present design, to determine long-term effectiveness of a short-term intervention and compare this to a more comprehensive program for trainees. (The current problem with operationalizing the comprehensive program, as advocated by the APA Task Force (1978) and Division 17 of the APA (1978) is that 1) departments may not have the person power to implement additional courses, 2) some department members may not have the personal sensitization to this topic to frequently identify and communicate situations that could be susceptible to sex bias. At this point, then, it may be more realistic to attempt short-term interventions, such as the one presented above.) This technique is also useful in developing supervision skills, and could serve as a focal point for a discussion on methods and means of supervision, as this is a role that many professionals will take.
Conclusions

The purposes of this study were to examine awareness of sex bias and counselor attributes as they were perceived by males and females of three graduate training programs, under two sets of instruction. The data suggests the following general conclusions:

1) There was no significant difference between males and females in their perceptions of sex bias, however, females tended to rate female counselors higher in attractiveness and trustworthiness than male subjects did.

2) There was a significant difference between graduate areas in their awareness of sex bias, indicating that type of training and/or types of people choosing each of these graduate programs affected perceptions of sex bias.

3) There was a significant increase in awareness of sex bias, and a significant decrease in trustworthiness, counselor effectiveness, and willingness to supervise, from Time One to Time Two, with the added instructive sheet on sex bias in therapy.

4) As a function of graduate area, there was a significant relationship with respect to time on expertness, trustworthiness, and counselor effectiveness. This effect may be accounted for by differential training and/or personality characteristics of those choosing different programs.

5) The more aware subjects were of sex bias, the lower the ratings were on other counselor dimensions.
APPENDIX A

TAPE EQUIVALENCE DATA
## TABLE 12
SUMMARY OF UNIVARIATE SIGNIFICANCE TESTS FOR TAPE EQUIVALENCE.

<table>
<thead>
<tr>
<th>Source of Variance</th>
<th>Expert1a</th>
<th>Attractive1a</th>
<th>Trustworthy1a</th>
<th>Bias1a</th>
<th>Expert2a</th>
<th>Attractive2b</th>
<th>Trustworthy2b</th>
<th>Bias2b</th>
</tr>
</thead>
<tbody>
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1Variables are from Time One
2Variables are from Time Two
* significant results at p < .05
a main effect n.s.
b main effect significant
### TABLE 13

**Summary of Tape Equivalence Data for Subjects by Tape, Sex, and Graduate Area, for Time 1 and Time 2**

<table>
<thead>
<tr>
<th>Dependent Variable</th>
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<td>p &lt; .002</td>
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<td>63</td>
<td>3.37</td>
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*Manova test for no overall tape effect (Time 1)*

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<td>n.s.</td>
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*Manova test for no overall tape effect (Time 2)*

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<td>60</td>
<td>5.33</td>
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</table>
TAPE A- Issues of sex bias

Overall Issue: The counselor is fostering traditional sex roles, particularly one of being mother. The role of mother is seen by the counselor as having more value than others, and the husband's desires are more important than the wife's. (The client is being told that she should 'compromise' and have children, despite the fact that she has already said that she does not want a family. The counselor is acting as if she is an agent for the husband's wishes.)

Specific Issues/Statements: 1) The client needs to "remake" her decision regarding children, as her previous decision was irrational.

2) The only option mentioned by the counselor is one of having children, that the husband would help to raise. There is no mention made of having the woman stick to her original decision, and that it is something that the husband may have to deal with.

3) The counselor blames the client for not having discussed her child rearing plans, instead of it being equally a problem for both spouses ("Why didn't you bring this up before you were married?") The husband should really be equally to blame. Also, the notion is presented that she was trying to trick her husband (it was not her "intention" to have children, and she should have apprised her husband of this).

4) "How is your decision affecting the relationship? What kind of strain is your decision putting on the relationship?" Again, blaming this all on her, as opposed to the mutual blame.

5) Counselor pays more attention to the desires/feelings of the husband than to the wife's (the client)-counselor asks several times how the husband feels, doesn't ask how the wife feels. Also, says that he must be disappointed at the prospect of not having any children (male-centered) rather than dealing with her feelings regarding having children and with the relationship.
TAPE B- Issues of sex bias

Overall Issue: The counselor is reinforcing the client for gaining all of her self-worth and esteem from men, and being other-directed as opposed to inner-directed. There is selective reinforcement for nurturant and dependent roles.

Specific Issues/Statements: 1) "Little boys need that independence"-implication is that little girls might not-it is sexist in the use of the word boy instead of a more general term. Later on, it is implied that the son might be having problems since he "only" has a mother, thus making the client feel guilty for not being married, and providing her son with a father.

2) Counselor tells the woman that she must feel "worthless" and unhappy, and that these are common feelings after "losing" a husband. The counselor makes the assumption that she 'lost' the husband, rather than checking out the possibilities that it was mutual, or she ended it.

3) "You haven't gotten a chance to go out on any dates?" basically saying that activities should center around men, and getting back into a relationship. The counselor explores ways to get her back into the pattern of having a man "to depend on and do special things for".

4) Counselor says it is "understandable to feel futile and hopeless when there is no one depending on you". (This again reinforces the nurturant, dependent role.)

5) No time is spent discussing means of self-fulfillment that are not related to men.
APPENDIX C

SUPERVISORY ISSUES FORM
SUPERVISORY ISSUES FORM

Tape # ____________

1) As supervisor of this case, what issues do you feel should be discussed in supervision with this counselor trainee? Are there any particular responses or behaviors of the trainee that you would want to bring up?

2) Was there anything that you particularly liked about the way the trainee handled the session?

3) Is there anything about the client's problem, responses, dynamics, personality style, etc. that you wish to discuss with the trainee?
4) What are your ideas about how the counselor should proceed from here?

5) Please rate the overall effectiveness of this counselor with this client, and explain your rating.

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<tr>
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<th>2</th>
<th>3</th>
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</table>

WHY?

6) How comfortable would you as supervisor feel in working with this trainee? Circle one and explain why.

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<tr>
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<th>3</th>
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WHY?
APPENDIX D

COUNSELOR RATING FORM
COUNSELOR RATING FORM

Listed below are several scales which contain word pairs at either end of the scale and seven spaces between the pairs. Please rate the counselor you just saw on each of the scales.

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


OR


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


OR


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


OR


If both sides of the scale seem equally associated with your impression of the counselor or if the scale is irrelevant, then place a check mark in the middle space:


Your first impression is the best answer.

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

Copyright ©, M. B. LaCrosse, and A. Barak, 1974, 1975. Not to be reproduced without permission.
informed : ignorant
insightful : insightless
stupid : intelligent
unlikeable : likeable
logical : illogical
open : closed
prepared : unprepared
unreliable : reliable
disrespectful : respectful
irresponsible : responsible
selfless : selfish
sincere : insincere
skillful : unskillful
sociable : unsociable
deceitful : straightforward
trustworthy : untrustworthy
genuine : phony
warm : cold
APPENDIX E

PERSONAL DATA FORM
PERSONAL DATA FORM

Name of Graduate Program__________________________________________

Degree you are currently working on____________________

Quarter and year first enrolled______________________________

Tentative quarter and year of graduation____________________

Highest Degree desired_____________________________________

Sex_____________________

Age______________

Have you had courses in the following areas? (Circle one)

 a. Counseling theory Yes No
 b. Assessment Yes No
 c. Supervision Yes No
 d. Counseling of minorities, cultural, or special interest groups Yes No

Please list any counseling experience, practice, or laboratory (role-playing) experience that you have had.

Please list any supervision of counseling that you have done.

If you wish feedback on the results of this study and/or your own results, please write your name and phone number below.

Name________________________ Phone (s) # __________ days
__________________________________________

__________________________________________ eves.
APPENDIX F

SEX BIAS HANDOUT
Before you listen to the next tape, I'd like to bring up one issue that frequently comes up in both counseling and supervision: the issue of sex bias and sex role stereotyping in the counseling/therapy setting.

In an article published by a task force on sex bias (American Psychological Association, 1975), four general areas of sex bias were delineated:

1) fostering traditional sex roles
2) bias in expectations and devaluations of women
3) sexist use of psychoanalytic concepts
4) responding to women as sex objects, including seduction of female clients

Examples of fostering traditional sex roles: therapist assumes the problems of the female can be resolved by her adhering to the roles of wife and mother; the therapist lacks awareness to the female client's career, work, and role diversity; child-rearing attitudes of the client are a necessary index of her emotional maturity; therapist supports the idea that child-rearing is the sole responsibility of the mother; the therapist defers to the husband's needs in the conduct of the wife's treatment.

Examples of bias in expectations and devaluation of women: fosters the idea that women should be passive and dependent, rather than assertive and self-actualizing; may tell sexist jokes or off-hand comments that demean women; therapist uses inaccurate or demeaning labels, such as seductive, manipulative, histrionic, etc.

Examples of sexist use of psychoanalytic concepts: therapist insists on Freudian interpretations; vaginal orgasms are a prerequisite for emotional maturity and thus a goal of therapy; assertiveness and ambition are labeled as signs of penis envy.

Examples of responding to women as sex objects: therapist seduces the client; therapist has a double standard for male and female sexual activities; physical appearance weighs heavily in the therapist's selection of patients or in the setting of therapeutic goals.

Basically, the Task Force states that therapists should be aware of their own values, and not impose them on the client. Inevitably, all of us have some sex bias and sex role stereotypes, because our culture is biased, in terms of the various prescribed roles for men and women. In order to ensure maximum growth of the client, we need to minimize the effect of stereotyped roles we encourage, or in this case, make sure to bring this issue up with our supervisee.

In listening to the next tape, please listen for any sexist or sex bias issues, in addition to the other supervisory issues (more general
ones). Please try to identify what about the interaction, if anything, is biased, and include this on the supervisory issues form. Be as specific as you can.
APPENDIX 3

RATING SCALE FOR AWARENESS OF SEX RAS
RATING SCALE FOR S.I.F.

Score

1  No recognition of any sex bias at all, nor of any of the specific issues pertaining to biases or values.

2  Subject sees that the counselor/trainee is value-laden and pushing these on the client, but does not elaborate on the content area.

3  The counselor/trainee is labeled as sexist or sex-biased, with no explanation of what is biased, or how. The subject does not show an understanding of specific issues relating to sex bias.

4  Subject is aware of at least one specific issue that is an example of sex bias in the counselor/trainee's behavior. The subject has quoted a sex-biased statement or has discussed one of the specific issues as listed for the relevant tape (see Appendix B).

5  The subject is aware of the overall sex-biased influence, and shows a good understanding of how sex bias has determined the direction of the counselor's overall influence attempt.
LIST OF REFERENCES


Delk, J.L. Differentiating sexist from nonsexist therapists, or my analogue can beat your analogue. *American Psychologist*, 1977, **32**, 890-893.


Parloff, M.B., Iflund, B., & Goldstein, N. Communication of "therapy values" between the therapist and schizophrenic patients. Journal of Nervous and Mental Disorders, 1960, 130, 193-199.


