Back to the kitchen?: The effects of sex and occupational stereotyping on clinical evaluation

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BACK TO THE KITCHEN?

THE EFFECTS OF SEX AND OCCUPATIONAL STEREOTYPING ON CLINICAL EVALUATION

by

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CHAPTER 1

INTRODUCTION

"Women are members of a caste. . . . . collectively victimized by a lifelong process of sexual stereotyping contrived to make the world safe for male supremacy (Roszak and Roszak, 1969, p. x1)." As the 1960's and 1970's have seen the awakening of a "new feminism," so it has become more and more clear that women are discriminated against in modern society. As the statistics mount, it verges upon a cliche. The small percentage of women holding positions in higher education (Astin and Bayer, 1972), acting as top executives in the world of business, and active in the professions of law and medicine is ample testimony that equality does not exist, as yet (Joreen, 1970; Alpenfels, 1962). Laws regulating use of credit, ownership of property, and legal residency still testify to a social attitude that a woman is only reliable when properly under the control of her man. Times and attitudes are changing, but there is evidence of both the wish for further change and the need for it. The Equal Rights Amendment is progressing slowly toward ratification. Yet in 1972 State Senator Jack McDonald of
Montana had remarked "If Jesus had wanted people to be equal, he would have had six men and six women apostles." (Uda, 1974)

It therefore appears a fair statement that bias regarding women is a pervasive element in our culture and socio-political structure. One might assume that it pervades the areas of mental health and mental illness as well. Broverman, Broverman, Clarkson, Rosenkrantz, and Vogel (1970) examined the notions of the mentally healthy male, female, and "person" (sex unspecified). They found that the healthy male and the healthy person (sex unspecified) were closely correlated. The healthy female, in contrast, was seen as more dependent, whimsical, and immature than the healthy "person." Nowacki and Poe (1973) in a similar study also found that there is a differential conception for male and female mental health.

Bilick's work (1973) supplied further confirmation of the associations made to "male" and "female" characteristics. She hypothesized that if patients of one gender were described with stereotyped characteristics of the other gender, they would be judged unfavorably. Instead, her findings showed that regardless of gender, patients with "feminine" characteristics were seen as having the poorest level of adjustment and least likelihood of change.

Chesler (1972), in her stimulating and disturbing
book *Women and Madness*, hypothesizes that women are caught in a double bind between social demands and role requirements. The homemaker is the traditional role for the mature female - she is expected to stay at home and tend house and children. She is expected to be nurturant, self-sacrificing, and blissfully content. Rewards both financial and prestigious, however, are reserved for competitive, aggressive behavior, in occupations which require intellectual achievement, or at the least, assertive and extroverted action. These values pervade our culture and these, of course, are "unfeminine" qualities. Girls in school learn that it is important and rewarding to be top student in the class. They also learn that girls are not supposed to do better than boys. No one tells them how to reconcile the two.

Alpenfels (1962) expresses the same idea: "The overriding aim of education for women in the United States has been to make it as good as that for men. The dominant fact of life for women is that society thereupon makes different demands and no longer cares what women do with the education they receive. But attitudes are absorbed along with knowledge and facts . . . The woman who has a profession but no husband or children nevertheless continues to feel somewhat less than a woman. And the woman who has both a husband and children but no profession
continues to feel somewhat less than a person (p. 85)."

Chesler (1972) argues that society teaches women to be self-denigrating, submissive, and (by a short extension) depressed, apathetic, dependent, and hysterical; in short, neurotic. When this reaches a sufficient point, the middle class woman seeks the help of a psychotherapist (generally male) so she can "straighten herself out." The lower class woman, lacking the financial and societal resources of her sister, usually receives her first contact with mental health facilities in a state mental hospital.

The opposite reaction to the double bind of femininity (or any other stress-filled situation) is one of anger or violence. This is responded to even more quickly; the middle class woman is rushed to a psychiatrist or a hospital, and the lower class one to a "violent" ward. An "acting-out" illness is deviant mental illness for women. Chesler (1972) presented statistics on the mental illness categories in which one sex is the majority. Women are the majority in the categories of Psychotic Depressive, Manic Depressive, Psychoneurotic, Psychophysiological, Psychotic, Schizophrenic, Paranoid, and Drug Intoxication (poison). Men are the majority sex in the categories of Alcohol Addiction, Alcohol Intoxication, Drug Addiction, and Personality Disorders. These figures are drawn from a range of mental health facilities and cover the years

Chesler attributed the sudden upsurge of women seeking psychiatric help and being hospitalized to recent social trends. Women now live longer than ever, and longer than men. Their "job" therefore is likely to vanish, leaving them with no place where they belong. Secondly, society is now more skillful at separating the "violent" from the "mad," i.e. at separating criminals from the mentally ill. Thus some women who would have gone to prison go to hospitals instead. Her overall point was that the present structuring of social roles for females is a major factor in "driving them crazy." Other authors (Landau, 1973) concur.

One might argue, however, that while females may at times carry their appropriate social role to an extreme (where it becomes pathology), society still is constructed around the notion of women in the more passive role. Females who break from this are therefore more likely to be maladjusted. Rychlak and Legerski (1967) performed a study in which their male and female subjects (including delinquent and normal girls) described themselves as identified with either an ascendant-dominant (AD) parent or with a retiring-passive (RP) parent. In discussing their results they stated that "... it would appear that only retiring-passive boys, who parallel these be-
haviors with those of their mothers, and ascendant-dominant girls, who attribute this pattern to their fathers, are found to suffer in personal adjustment (p. 46)."

Williams (1973) reviewed the Rychlak and Legerski article and examined its hypothesis concerning females. In her study she used 59 girls at a Roman Catholic high school as subjects. In these results, only 14% of the subjects identified with the retiring-passive mother, and only 24% with a RP parent of either sex. The measure of personality adjustment (California Psychological Inventory) suggested that Ss identifying with AD fathers had healthier profiles than Ss identifying with RP mothers.

Williams (1973) concluded, "For the present, the notion that females need to identify with a retiring, passive parent in order to manifest viable patterns of personality functioning requires an attitude of scepticism (p. 7)." Williams (1973) speculated optimistically, "... we may be observing the effect of a change ... in sex role behaviors ... and in the limits of what kinds of behaviors and values are acceptable in the self-concept of young girls and in society's capacity for tolerance of these changes (p. 6)."

Williams in 1973 was optimistic. Others, not far removed in time, were less encouraging. Roszak and Roszak (1969) comment that "... off the college campuses
and outside small, intense circles of metropolitan militancy, the home truths of women's liberation continue to seem alien, quaint, and absurd (p. viii)." Yet, one would anticipate that within the professional circles of the well educated the stereotypes must be dead. Research suggests that this is not the case. Bias against the married and working woman is another area in which negative attitudes are spread throughout the society.

Kaley (1971) reviewed literature which demonstrated the expected bias against women in higher positions. For example, in a Civil Service Commission report (Mead and Kaplan, 1965) it was reported that men regarded women in supervisory positions as less efficient, while women saw no difference. Kaley was interested primarily in examining the attitudes of professional men and women, however, since they constitute the majority of the married professional woman's working associates and are likely to be influential upon her self concept. She hypothesized that since liberal viewpoints are often associated with higher levels of education and experience, professional males (more than any other male group) should have positive attitudes toward the married female professional. In accord with this, professional females should also be more positive in attitude toward the married female professional than other female groups. Her subjects
(acknowledged as not a random sample) were all married professional personnel affiliated with a university research agency and social service agency.

She found that the attitudes of men and women were significantly different. The married professional men expressed a negative attitude toward the professional married woman's ability to cope adequately with her home and work roles. Among the females, the case workers also had negative attitudes toward the married female professional, while teachers and research psychologists had positive attitudes toward the female professional's capacity to maintain both roles adequately. Kaley felt these results were important especially because of their potential impact upon self concept and the occupational plans of young, bright females.

In an earlier longitudinal study (Nelson and Goldman, 1969) the attitudes of high school students and young adults toward the gainful employment of married women were examined. The study showed that over a period of six years both males and females became more accepting of female employment. There was one significant exception: the males did not become more accepting of such employment for their own wives.
Psychology as Part of the General Culture

Turning away for a moment from the matrix of attitudes toward females, psychotherapy itself has become the focus for socio-political criticism in recent years. Therapy is unquestionably carried out primarily by white, male members of the well educated middle class. These individuals are extremely likely to carry within themselves the values dominant within our culture. Accordingly, it is likely that these values are an influential force in therapy.

Thomas Szasz (1970) and others make the point that therapists become (consciously or unconsciously) the maintainers and enforcers of the status quo, and that within this socio-political framework there will probably be discrimination against the dissidents and minorities (Hallek, 1971; Braginsky and Braginsky, 1973). Haase (1964) found socio-economic class to be influential in examiner bias. Kurtz, Kurtz and Hoffnung (1970) found that lower and middle class labeling of patients had a significant effect upon ratings made by 16 psychiatric residents. Lee (1968) used a doctor/patient interview and manipulated the perceived class of the patient from lower class to upper class. The diagnosis was significantly poorer for the lower class patient. Trachtman (1971) replicated Haase's study, adding as an additional
variable some differential characteristics of the clinician (authoritarianism and status anxiety). For the 60 clinical psychologists used as subjects, the bias by social class of patient was supported, although it was unrelated to the characteristics of the clinicians.

Smith (1973) performed a study in which cues of sex or ethnic group were varied to see the effect upon clinical evaluation by counselors. In this study anti-minority bias was not significant for either sex or ethnic group.

Braginsky and Braginsky (1973) investigated the effects of perceived political deviance and like/dislike for mental health practitioners upon patient diagnosis. Not surprisingly, they found that perceived political extremism and dislike of mental health practitioners earned the patient a much poorer diagnosis.

Therefore, despite considerable cautioning, especially in the field of counseling (Adinolfi, 1971; Farmer, 1971; Stevens, 1971; Shainess, 1972; Smith, J. A., 1972; Schlossberg, 1972; Berry, 1972; Hansen, 1972; Rice and Rice, 1973; Fitzgerald, 1973; Westervelt, 1973; Fitzgerald and Harmon, 1973; Vetter, 1973; Schlossberg and Pietrofesa, 1973), the psychotherapist could be expected to label a woman as "sick" more readily than a male counterpart, especially if she is performing deviant actions.

Abramowitz, Abramowitz, Jackson, and Gomes (1973)
examined political extremism of both the right and left, and effects of that and sex of patient upon counseling psychologists' diagnoses. Political attitude of the psychologists was also measured. They found that while a number of the predictions were unconfirmed, non-liberal male and female psychologists evaluated leftist active females as significantly "sicker" than other groups. In another analysis of the same data, (Abramowitz and Abramowitz, 1973) they found that female therapists evaluated female clients more harshly than male therapists did. As will be seen below, however, research data on the effect of sex of the rater is not conclusive.

The sum of the above research would seem to predict that women in therapy who profess a "liberated" viewpoint are destined to be evaluated harshly by their male therapists (and possibly by their female therapists as well). Surely a thoughtful therapist could take this into consideration. Rice and Rice (1973) argued persuasively, "Since it is likely that male therapists (as a product of our society) share certain chauvinistic attitudes at present, part of a woman's greater feelings of hostility toward men, including her therapist, seem appropriate and justified. Such feelings should be honestly acknowledged and dealt with in the therapeutic relationship (p. 192)."

Or, if feelings of hostility are difficult to accept, surely
the therapist of today can accept the growing expansion of women into career areas outside the home, and into new, formerly "masculine" occupations. Stevens (1971) commented that successful therapy now must involve "... recognition that a woman's conscious attempts to change her social situation ... are constructive and necessary moves ... (p. 8)"

Have these enlightened attitudes in fact taken root in present day psychotherapy? Recollection of the attitudes of professional men toward married professional women (Kaley, 1971) will perhaps make the research results disheartening but scarcely surprising. Thomas and Stewart (1971) found that female clients with "deviant" career choices (such as engineering) were seen by both female and male counselors as in need of more counseling than comparable clients with conforming career choices. Pyke and Ricks (1973) found similar results with their female clients.

Benetato (1973) sent questionnaires at random to 400 therapists and received 84 replies. Asked what a man's greatest fulfillment would be, 85% listed career or profession, and 14% listed marriage. None listed fathering a child as man's greatest fulfillment. Asked the same question about a woman's fulfillment, 77% replied marriage, 17% listed birth of a child, and 4% listed career or pro-
fession. Female therapists contributed most of that 4% figure.

Purpose of the Study

With the present state of research in the area, a further step seems logical. Psychotherapists may view the married woman who works outside the home as more deviant, and therefore evaluate her as "sicker" than she might be viewed otherwise. What are the implications of this? Far reaching and disturbing, to be sure. At present 38% of the American work force is composed of women. Three-fifths of those women are married (U.S., Department of Labor, 1973). This would be an element of clinical bias that could operate on a sweeping scale. No empirical research, however, has attacked this issue directly, and this study was designed to accomplish this task.

Hypotheses of the Study

On the basis of previous research, it was hypothesized that, given identical symptoms, a male taking a socially acceptable role (job outside the home) would be seen as less "ill" than a female taking a socially acceptable role (job within the home). Second, it was hypothesized that a female taking a less socially acceptable
role (job outside the home) would be seen as "most sick" of the three, and that this would hold true even when the job outside the home was not one with heavily "masculine" connotations, such as engineer, construction worker, or the like.

Next, the question of symptoms was considered. Since on the basis of statistics (Chesler, 1972) neurosis is more common among women and personality disorders are more common among men in the clinic and hospital populations, the nature of such symptoms might be interactive with other factors in demonstrating "sex role deviance." Chesler (1972) points out, however, that men are more free than women to stray from their stereotypes without condemnation. Therefore, the second hypothesis was that the predicted order of prognosis would hold for both kinds of pathology. Since it is "unfeminine," however, to have a personality disorder, the differences between the male and the two females were predicted to increase on those histories where personality disorder symptoms were presented.

Secondary Hypotheses

For the secondary hypotheses of this study, the effects of sex and age of clinicians rating the imaginary clients were examined. Research on the effects of the
Clinician's sex has produced varying and at times contradictory results. Broverman et al. (1970), Kosherak and Masling (1972), and Bilick (1973) found no difference between ratings made by male and female therapists. Abramowitz and Abramowitz (1973) found that female therapists evaluated female case histories more harshly than male therapists did. For male case histories there were no significant differences. Haan and Livson (1973) found that male therapists evaluated females more harshly than female therapists did. Lewittes, Moselle, and Simmons (1973) found that therapists of both sexes evaluated members of their own sex more leniently than members of the opposite sex.

In this area a pessimistic expectation was proposed, in contrast to those who hope female therapists will judge female clients less harshly than their male colleagues (Chesler, 1971). It was anticipated that there would be no significant difference in evaluation due to sex of the clinician.

Age differences do not appear to have been considered in previous clinical evaluation studies. There is, however, research suggesting that groups of high school and college age persons share the biases of the society as a whole, (Touhey, 1974; Vogel, Broverman, Broverman, Clarkson, and Rosenthal, 1970; Rosenkrantz, Vogel, Bee, Broverman,

There is also evidence of a strong feminist movement and awareness among some psychotherapists of that movement (Agel, 1971; Angrist, 1972; Berry, 1972; Farmer, 1971; Fitzgerald, 1973; Fitzgerald and Harmon, 1973; Rice and Rice, 1973; Schlossberg, 1973; Schlossberg and Pietrofesa, 1973; Shainess, 1972; Smith, J. A., 1972; Stevens, 1971; Vetter, 1973; Westervelt, 1973). This awareness appears, to some extent, to be more an attribute of the younger rather than the older members of society.

For this reason, it was hypothesized that there would be a significant difference between ratings made by older and younger clinicians. The median age of subjects was taken as an arbitrary dividing point. All clinicians median age or less were placed in the "Younger" group, and all others were placed in the "Older" group. It was hypothesized that while the order of prognosis would remain the same, the perceived difference between the three clients would be reduced in evaluations by the "Younger" group. In effect, the evaluations of Jane as compared to John, Mary as compared to John, and Jane as compared to Mary would be less harsh when performed by the younger group.
Pilot Study

Previous research has shown that some occupations are viewed as strongly masculine or strongly feminine (Sedgwick, 1973; Rossi, 1964). In order to keep the descriptions of the working clients identical (except for experimental variables) regardless of sex, it was necessary to use an occupation which was as neutral in terms of sex stereotyping as possible. Otherwise, unwanted bias would be introduced into the case histories by presenting a female taking a "masculine" occupation or vice versa.

The literature does not provide a recent empirical determination of such a neutral occupation. For this reason a pilot study was run. Fifty-eight students of Psychology 110 at the University of Montana were given a questionnaire to complete. It consisted of 41 occupations, each followed by a Likert-type scale of seven spaces. One end of the scale was labeled "Male" and the other "Female." The students were instructed by a cover sheet to mark the scoring space which best expressed their idea of whether a given occupation was probably performed by a man or a woman. (See Appendix A) Results were evaluated with a t-test to determine if mean values differed from the sex neutral position (position four on the seven point scale) on a greater than chance basis \( p < .05 \).
The item whose mean did not significantly differ from four and whose mean was closest to four was selected as the occupation to be used. On the basis of these criteria the occupation of "bank employee" was selected.
CHAPTER 2

METHOD

Subjects

The subjects were clinical or counseling psychologists or graduate students in clinical or counseling psychology, holding a degree at the M.A. level or above. Subjects were obtained at the Rocky Mountain Psychological Association Convention held May 8, 9, 10, and 11, 1974 at the Cosmopolitan Hotel in Denver, Colorado. Subjects' voluntary participation was solicited through an announcement in the convention schedule. Due to the number of registrants known to have attended the convention, it was the experimenter's impression that many clinicians were present who, for various reasons, never approached the table where the study was conducted.

Prospective subjects were asked to take a few moments to complete a questionnaire. Of 69 potential subjects who approached the table, three declined to participate. All three were male; two were roughly forty years of age and one was roughly seventy years of age. Data from one subject had to be discarded as the subject held only a B.A. level degree. Therefore, data from 65 subjects
were available for analysis. Thirteen of the subjects were female and 52 were male.

**Procedure**

Arrangements were made with the convention manager for the experimenter to use persons attending the convention as subjects. Owing to the physical limitations of the hotel mezzanine, it unfortunately was not possible to create the ideal situation of seating the experimenter at the registration tables. Instead she was placed in the only other space available, at a table on the opposite wall and approximately 30 feet away.

The questionnaire employed consisted of three sheets. The cover sheet explained the study as a master's thesis and listed the experimenter and her major professor. (See Appendix B) A sign reading "Clinical Evaluation Study" was displayed on the experimenter's table, and this was the title given for the questionnaire. The cover sheet also provided a method of debriefing subjects by requesting them to sign their names and addresses on a list furnished by the experimenter, so that they could receive more information about the study. All subjects were mailed a brief explanation of the study and a summary of the results (See Appendix E).

The second portion of the questionnaire was one of
six case histories. An initial paragraph described one of three imaginary persons, all students: a male (John) planning to work after graduation, a female (Jane) planning to work after graduation, and a female (Mary) planning to be a homemaker after graduation. These three persons were intended to represent a male taking an occupation compatible with his sex, a female taking an occupation "incompatible" with her sex, and a female taking an occupation "compatible" with her sex. The male case history was used as an anchor point of comparison, since the primary focus was upon the effects of being female and being a female who takes a job outside the home upon assessed mental health.

To examine the hypothesis concerning symptoms, the next portion of the case history described one of two kinds of "problem." In the Neurotic condition the student was described in terms of Coleman and Broen's (1972) anxiety neurotic. He or she was described as anxious for no reason, unable to concentrate, having trouble sleeping, being irritable with friends and fiance, etc. (See Appendix C). In the Personality Disorder condition, the student was depicted in accord with a mild version of Coleman and Broen's (1972) antisocial personality. He or she was described as impulsive, having a low frustration tolerance, and having a tendency to project blame
and reject authority. In concrete terms, these were described as a lack of concern over flunking two required classes, assigning responsibility for this to the professor, general hostility toward the professor, breaking three dates at the last moment with the fiance to go out with others, and the like (See Appendix C).

Beyond the changes necessary to examine the hypotheses, the case histories were carefully constructed to be identical. For all case histories the individual was presented as a student at a university, approximately a junior in academic standing (three quarters before graduation), 21 years of age, and engaged to be married right after graduation to a person whom he or she had known for several years and had dated for over a year. For the imaginary students who were to be working outside the home, the occupation was one which was as sex-neutral as possible in terms of contemporary attitudes. This occupation, "bank employee," was selected through a pilot study described previously.

Research in the area of person perception (Adinolfi, 1971) suggests that persons are best able to evaluate others who are either (a) similar to themselves, (b) familiar to them, or (c) persons whom they like. Since most psychologists come from a middle class background, are well educated, and are likely to have had at least
some contact with college students, a college student client appeared to be one which would be easier to evaluate accurately than more "deviant" populations. The degree of "illness" was made rather mild for the same reason.

The third portion of the questionnaire was a set of five questions relating to clinical evaluation and prognosis. The questions were (1) What need for therapy do you perceive? (2) How typical do you feel this case to be (of a student population)? (3) What do you consider to be the likelihood the client will recover (to a functional level) without therapy? (4) With therapy, what do you estimate as the client's chances for recovery (to a functional level)? and (5) What do you consider to be the likelihood these problems or more serious ones will recur in future? These questions were answered by marking on a nine blank Likert-type scale, with the two extremes of the scale labeled appropriately. For example, for the first question (need for therapy) the two ends of the scale were "None" and "Great." (See Appendix D) Following the work of Abramowitz et al. (1973) and Lee (1968), it was assumed that pencil and paper evaluations are closely associated with actual evaluations made in a clinical setting with an equivalent amount of information.
The questionnaires were distributed in a fashion such that randomization was assured as well as a distribution of males and females across all six of the possible questionnaires.

In order to minimize the possibility of biasing responses, the experimenter politely refused to discuss the study while the data were being collected. A number of subjects experienced some difficulty in responding to the questionnaire, and many wished to add comments. The experimenter in essence replied to questions of this kind by asking the subject to complete the questionnaire as best he/she could, and then make comments upon the back. Further discussion of the issues raised by subjects appears below.
Statistical Procedures

The second question of the questionnaire (how typical of a student population) was intended as filler only, and was not included in the data analysis. Given that drastically unequal and disproportionate cell frequencies were obtained, the results for each of the four remaining evaluation questions were analyzed according to a completely randomized model specifying main effects and two factor interactions only. The model proposed by Overall and Spiegel (1969) which adjusts all sources of variation for all others was used to compute effects. The procedure is basically a least-squares analog of analysis of variance in which regression techniques are applied to categorical variables which specify the comparisons to be made. Tests of significance are performed in a manner very similar to that used in analysis of variance. For example, one finds the mean square for sex of subjects, adjusted for the other independent variables and their interactions, and compares it to a residual mean square. Results are summarized in Tables 1, 2, 3, and 4.

Within the sex and occupation effect, three compar-
Question 1: What Need for Therapy Do You Perceive?
### TABLE 2
Summary of results for Question 2

<table>
<thead>
<tr>
<th>Source</th>
<th>SS</th>
<th>df</th>
<th>MS</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td>(A) Sex plus occupation</td>
<td>13.63</td>
<td>2</td>
<td>6.82</td>
<td>2.04</td>
</tr>
<tr>
<td>(B) Neurotic x Personality Disorder</td>
<td>0.31</td>
<td>1</td>
<td>0.31</td>
<td>1.00</td>
</tr>
<tr>
<td>(C) Male x female clinicians</td>
<td>0.83</td>
<td>1</td>
<td>0.83</td>
<td>1.00</td>
</tr>
<tr>
<td>(D) Older x younger clinicians</td>
<td>5.02</td>
<td>1</td>
<td>5.02</td>
<td>1.50</td>
</tr>
<tr>
<td>(A) x (B)</td>
<td>2.72</td>
<td>2</td>
<td>1.36</td>
<td>1.00</td>
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<tr>
<td>(A) x (C)</td>
<td>1.90</td>
<td>2</td>
<td>0.95</td>
<td>1.00</td>
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<tr>
<td>(A) x (D)</td>
<td>1.11</td>
<td>2</td>
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<tr>
<td>(B) x (C)</td>
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<tr>
<td>(B) x (D)</td>
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<td>1</td>
<td>2.10</td>
<td>1.00</td>
</tr>
<tr>
<td>(C) x (D)</td>
<td>0.19</td>
<td>1</td>
<td>0.19</td>
<td>1.00</td>
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<tr>
<td>Error</td>
<td>166.80</td>
<td>50</td>
<td>3.34</td>
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</table>

Question 2: What Do You Consider to Be the Likelihood the Client Will Recover (To a Functional Level) Without Therapy?
### TABLE 3
Summary of results for Question 3

<table>
<thead>
<tr>
<th>Source</th>
<th>SS</th>
<th>df</th>
<th>MS</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td>(A) Sex plus occupation</td>
<td>1.70</td>
<td>2</td>
<td>0.85</td>
<td>&lt;1.00</td>
</tr>
<tr>
<td>(B) Neurotic x Personality Disorder</td>
<td>~0</td>
<td>1</td>
<td>~0</td>
<td>&lt;1.00</td>
</tr>
<tr>
<td>(C) Male x female clinicians</td>
<td>0.10</td>
<td>1</td>
<td>0.10</td>
<td>&lt;1.00</td>
</tr>
<tr>
<td>(D) Older x younger clinicians</td>
<td>0.01</td>
<td>1</td>
<td>0.01</td>
<td>&lt;1.00</td>
</tr>
<tr>
<td>(A) x (B)</td>
<td>0.07</td>
<td>2</td>
<td>0.04</td>
<td>&lt;1.00</td>
</tr>
<tr>
<td>(A) x (C)</td>
<td>0.93</td>
<td>2</td>
<td>0.47</td>
<td>&lt;1.00</td>
</tr>
<tr>
<td>(A) x (D)</td>
<td>0.14</td>
<td>2</td>
<td>0.07</td>
<td>&lt;1.00</td>
</tr>
<tr>
<td>(B) x (C)</td>
<td>1.01</td>
<td>1</td>
<td>1.01</td>
<td>&lt;1.00</td>
</tr>
<tr>
<td>(B) x (D)</td>
<td>2.46</td>
<td>1</td>
<td>2.46</td>
<td>2.37</td>
</tr>
<tr>
<td>(C) x (D)</td>
<td>~0</td>
<td>1</td>
<td>~0</td>
<td>&lt;1.00</td>
</tr>
<tr>
<td>Error</td>
<td>52.07</td>
<td>50</td>
<td>1.04</td>
<td></td>
</tr>
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</table>

**Question 3:** With Therapy, what do you estimate as the client's chances for recovery (to a functional level)?
### TABLE 4
Summary of results for Question 4

<table>
<thead>
<tr>
<th>Source</th>
<th>SS</th>
<th>df</th>
<th>MS</th>
<th>F</th>
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</thead>
<tbody>
<tr>
<td>(A) Sex plus occupation</td>
<td>2.83</td>
<td>2</td>
<td>1.42</td>
<td>&lt;1.00</td>
</tr>
<tr>
<td>(B) Neurotic x Personality Disorder</td>
<td>~0</td>
<td>1</td>
<td>~0</td>
<td>&lt;1.00</td>
</tr>
<tr>
<td>(C) Male x female clinicians</td>
<td>0.42</td>
<td>1</td>
<td>0.42</td>
<td>&lt;1.00</td>
</tr>
<tr>
<td>(D) Older x younger clinicians</td>
<td>0.02</td>
<td>1</td>
<td>0.02</td>
<td>&lt;1.00</td>
</tr>
<tr>
<td>(A) x (B)</td>
<td>5.74</td>
<td>2</td>
<td>2.87</td>
<td>1.19</td>
</tr>
<tr>
<td>(A) x (C)</td>
<td>1.23</td>
<td>2</td>
<td>0.62</td>
<td>&lt;1.00</td>
</tr>
<tr>
<td>(A) x (D)</td>
<td>1.72</td>
<td>2</td>
<td>0.86</td>
<td>&lt;1.00</td>
</tr>
<tr>
<td>(B) x (C)</td>
<td>1.05</td>
<td>1</td>
<td>1.05</td>
<td>&lt;1.00</td>
</tr>
<tr>
<td>(B) x (D)</td>
<td>1.59</td>
<td>1</td>
<td>1.59</td>
<td>&lt;1.00</td>
</tr>
<tr>
<td>(C) x (D)</td>
<td>0.01</td>
<td>1</td>
<td>0.01</td>
<td>&lt;1.00</td>
</tr>
<tr>
<td><strong>Error</strong></td>
<td>120.90</td>
<td>50</td>
<td>2.42</td>
<td></td>
</tr>
</tbody>
</table>

Question 4: What Do You Consider to Be the Likelihood These Problems or More Serious Ones Will Recur in Future?
isons were to be made: a comparison between John and Mary to test whether sex leads to judgment of poorer mental health, given that both have occupations which are considered compatible with their respective sexes; a comparison between Jane and Mary, to test whether mental health is judged as worse for females with occupations "incompatible" with their sex; and a comparison of John and Jane, to see if sex and "incompatible" occupation in combination lead to a judgment of poorer mental health for the woman than the man. Since the overall sex and occupation dimension was non-significant, however, these comparisons were not computed. Because of the computing procedure utilized, individual comparisons could not attain significance if omnibus tests did not. The omnibus test comparing John, Jane, and Mary is labeled as (A) in Tables 1, 2, 3, and 4.

Comparison of the Neurotic and Personality Disorder case histories was made. This test is labeled as (B) in the tables. Comparison was also made of the evaluations made by male therapists as opposed to female therapists; and the evaluations made by older clinicians as opposed to younger clinicians. Older clinicians were described as those above the median age for all subjects, while younger clinicians were those of median age or less. The median age was 37 years. These comparisons are
labeled as (C) and (D) respectively in Tables 1, 2, 3, and 4.

Findings

None of the comparisons made was significant. Therefore only one expectation was confirmed, the secondary expectation that there would be no difference in evaluation due to sex of the clinician. There were no differences due to sex and occupation of the client, no differences due to the kind of pathology, and no differences due to the age of the clinician rater.
CHAPTER 4

DISCUSSION

Among the primary and secondary hypotheses of this study, in only one case was the expected result obtained. As anticipated, there was no significant difference between ratings made by male clinicians and female clinicians. This result joins a body of rather contradictory findings. Broverman, et al. (1970) and Kosherak and Masling (1972), and Bilick (1973) found similar results, while other authors have found bias on the part of female clinicians against female clients (Abramowitz and Abramowitz, 1973), on the part of male clinicians against female clients (Haan and Livson, 1973), and on the part of clinicians of both sexes against clients of the opposite sex (Lewittes, Moselle, and Simmons; 1973). Clearly generalizations across all clinicians are impossible at present. Further research is needed to pinpoint the reasons for these differences.

A number of aspects should be considered in looking at the unsupported hypotheses. First, it is possible that the expectations of this study are incorrect and that despite the evidence of research in related areas,
clinicians do not show any bias against females working outside the home. In a similar fashion, the unsupported secondary hypotheses may also have been incorrect.

Second, the client described was a student planning to adopt the role of a working married man, a working married woman, or a married homemaker, rather than one already immersed in the role. It is possible that the client's student status, a time of life renowned for transitions and "identity crises," might have had more impact on clinical evaluation than his/her identification as a married person with an occupation.

Third, there is a potential dilemma of comparative base rates. Clinicians may consider the incidence of mild disturbance to be \((X)\) among most working married males, \((X + 1)\) for most married homemakers, and \((X + 2)\) for most married working women. If their evaluations are in reference to such base rates, rather than on some absolute scale of "mental health," then a male with given symptoms might be rated as (compared to his fellows) "quite sick." At the same time, the homemaker with identical symptoms might be seen as (compared to her peers) "a little sick." The implication here is roughly: "They're all a little upset, but this one's only a touch above the usual." Finally, of course, the working married woman with the same symptoms might be seen as "typically
sick," with the implication that for her particular group she is not badly off at all. If comparisons to base rates were in fact operating, they would have entirely eliminated the predicted effects.

One consideration of differential base rates was in fact already incorporated into the study. Since there was statistical evidence for differential base rates when sex was crossed with neurotic and personality disorder symptoms, the two symptoms were both included to examine for effects. As noted above, no significant differences were found.

Other factors may also have had weight in affecting results. It is possible that the subject population of the present study is not typical of the clinician population. The subjects were in the main from the greater Rocky Mountain area, and they were among the population of those clinicians who choose to attend conventions. They were also predominantly male (80%), and 74% were between the ages of 30 and 50 years. These latter facts, however, may in actuality be typical of most clinical psychologists.

Two other factors should be noted. Although the experimenter had hoped to be placed directly at the registration table, this was not, in fact, possible. As a result, clinicians were directed to the study largely
through notices, and by a limited amount of personal contact made by the experimenter and the convention manager. To some degree it was a matter of initiative on the part of many to seek out the experimenter's table, and the necessity of this much effort may have been a kind of "altruism factor," and may have altered the results obtained. Next, from anecdotal evidence of remarks and comments, it was the experimenter's impression that a number of subjects did, in fact, accurately guess the experimental hypothesis, or something closely related to it. This could have changed responses to the questionnaires.

It is also possible that the questions as presented are not the most effective instruments possible for measuring clinical judgment. Face validity of the questions as indicators of clinical judgment appears generally good. However, drawbacks to the questions were noted by subjects. Four noted that the answer to the first question would depend on the need for therapy as perceived by the client. Five subjects noted that the client should be evaluated medically before any further determination could be made. For the fourth question (relating to possible recurrence of problems), at least four subjects felt that whether the client had received therapy or not was necessary information before future problems could
be considered. Remaining objections focused largely on questions of definition of "functional level," "recovery," and the like.

The issue of definition of key terms was considered by the experimenter in construction of the questionnaire, and it was felt that elaborate definition in the body of the history would probably accomplish very little at the expense of considerable verbiage. Matters raised by several subjects, however, could probably be dealt with briefly, and would improve the questionnaire. In particular the omission of "with therapy," or "without therapy" in question 4 seems unfortunate.

Finally, the study may also have diminished results to a point of non-significance by making the "symptoms" mild and presented by a college student. This might have led to an evaluation of problems as so mild as to show no separation for the variables being manipulated. This could hold true despite considerable rationale for making the symptoms mild.

The mean values of responses to the questions were 6.29, 5.89, 7.84, and 5.44, and they had standard deviations of 0.37, 0.37, 0.21, and 0.30, respectively. These values argue to some extent against a conclusion that too small a variance existed in the case histories as they were written, or that they were seen by clin-
icians as "not sick at all." In fact, they were perceived by clinicians as approximately "medium sick."

Further research in this area could take into account the drawbacks of the present study and should do so. If these considerations were incorporated, a more definitive examination of possible bias in clinical evaluation might be achieved.
CHAPTER 5

SUMMARY

Research has demonstrated the existence of bias in clinical evaluation on the basis of perceived deviance, when the norm is that of a white, middle class psychologist. Other research has also shown bias in clinical evaluation on the basis of sex. This study combined these two areas and examined possible bias in clinical evaluation against married women working outside the home. Subjects were sixty-five clinical or counseling psychologists holding an M.A. level degree or above. They were volunteers, whose participation was obtained at the Rocky Mountain Psychological Association Convention, 1974. The task for each subject was to make a clinical evaluation of a case history by marking four scaled questions.

To examine for bias, case histories were created for three individuals: an engaged male choosing to work outside the home after marriage, an engaged female choosing to work outside the home after marriage, and an engaged female choosing to be a homemaker after marriage. To examine the influence of symptoms on evaluation, two kinds
of symptom were also presented: a mildly "neurotic" person and one showing mild "personality disorder" characteristics. These two elements of possible bias in combination resulted in six case histories. It was also proposed to examine the effects of sex of clinicians and the age of clinicians upon evaluation. Hypotheses were that the male, homemaker, and working female would always be viewed as most healthy, next healthy, and least healthy, respectively. In regard to symptoms, it was hypothesized that differences in perceived mental health would be greater, although in the same order, for the personality disorder cases than for the neurotic cases. It was also expected that sex would make no difference in evaluations, and that younger clinicians would evaluate less harshly, although still in the same order, than older clinicians.

An Overall and Spiegel (1969) least squares analysis was performed. There were no significant differences due to sex and occupation of client, none due to type of sickness, no significant differences due to sex of the clinician, and none due to age of the clinician. While a number of factors may have affected the results, the hypothesized clinical bias against married women who work has not been supported.
REFERENCES


Hansen, L. S. We are furious (female) but we can shape our own development. Personnel and Guidance Journal, 1972, 51(2), 87-93.


Uda, J. *"Do you know what's happening in Missoula?"* Ms., April, 1974, 21.


APPENDIX A

OCCUPATIONS SURVEY

We all know that we think of certain jobs as usually taken by men and others as usually taken by women. Unfortunately for my purposes, no one has measured this directly.

As part of my master's thesis, I need some data on what sex people think of when they think of various occupations. Please fill out the following questionnaire by checking the blanks that seem most appropriate to you.

For example, if you were reading something about a lion tamer, you might realize you thought that the person with that job was probably a man. So you would mark a blank on the left hand side of the scale, where it says MALE. Or, if you read about a belly dancer, you might realize that you thought of that job as probably being done by a woman. So you would mark the right hand side of the scale, where it says FEMALE. Of course, if you felt the job was usually done by one sex, but sometimes by the other sex, your answer would be more toward the middle instead of way out on one side. And if your impression of a job was that it was just as likely to be done by a man or a woman, you would mark the very center of the scale.
Just use your first impressions for answering this - the first thing that pops into your head. There are no right or wrong answers. Mark one of the spaces that best gives your own idea of whether a job is probably done by a man or a woman.

Thank you very much for your cooperation. If you are interested in hearing more about the study, please let your teacher know.
<table>
<thead>
<tr>
<th>MALE</th>
<th>FEMALE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commercial Artist</td>
<td></td>
</tr>
<tr>
<td>High School Teacher</td>
<td></td>
</tr>
<tr>
<td>Dietician</td>
<td></td>
</tr>
<tr>
<td>Bookkeeper</td>
<td></td>
</tr>
<tr>
<td>Bank Employee</td>
<td></td>
</tr>
<tr>
<td>Advertising Artist</td>
<td></td>
</tr>
<tr>
<td>Physical Therapist</td>
<td></td>
</tr>
<tr>
<td>Anthropologist</td>
<td></td>
</tr>
<tr>
<td>Artist</td>
<td></td>
</tr>
</tbody>
</table>
MALE

Food Chemist

Writer

Musician

Publicity Work

Architect

Book Store Manager

History Teacher (High School)

Court Reporter

Social Worker

FEMALE
<table>
<thead>
<tr>
<th>MALE</th>
<th>FEMALE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Journalism</td>
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</tr>
<tr>
<td>Medical Technologist</td>
<td></td>
</tr>
<tr>
<td>Travel Agency Work</td>
<td></td>
</tr>
<tr>
<td>Pharmacist</td>
<td></td>
</tr>
<tr>
<td>Foreign Service</td>
<td></td>
</tr>
<tr>
<td>Telephone Operator</td>
<td></td>
</tr>
<tr>
<td>Editorial Work</td>
<td></td>
</tr>
<tr>
<td>Personnel Director</td>
<td></td>
</tr>
<tr>
<td>Merchandise Buyer in Retailing</td>
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</tr>
</tbody>
</table>
MALE

Business Education Teacher (High School)

Publishing

Veterinarian

Museum Work

Retail Clerk

Radio Broadcasting

Nurse

Youth Organization Work

Real Estate Sales

FEMALE
<table>
<thead>
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<th>MALE</th>
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</tr>
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<td><strong>Office Clerk</strong></td>
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<tr>
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<tr>
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</tr>
<tr>
<td><strong>Biologist</strong></td>
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</table>
APPENDIX B

CLINICAL EVALUATION STUDY

My name is Meredith Taylor and I am a second year graduate student in clinical psychology at the University of Montana. This study will give me one half of the data necessary for my master's thesis research in the area of clinical evaluation. I would appreciate very much your taking the time to fill out the questionnaire which follows.

The thesis is being conducted under the direction of Dr. F. A. Hill. All questionnaires are anonymous.

If you are willing to participate, please respond below and on the following pages.

Basic Information

Occupation:

Highest degree earned: Area of degree:

Year degree awarded:

Age: Sex:

(If Professional) Years as practicing clinician:

Thank you very much for your cooperation. After you have finished the questionnaire, please write your name and address on the list provided. Further details about the study and a brief summary of the results will be
mailed to you.
Please read the following case history and answer the questions to the best of your ability. We recognize that this is not the amount of information which would normally be available in making a clinical evaluation.

John Jones is a 21 year old junior at a university. He plans to graduate in three more quarters and to seek a job as a bank employee. He is engaged to be married right after graduation to a woman he has known for several years and has been dating for over a year.

John came in to the student counseling center complaining of "things not going right." He feels generally anxious for no particular reason. He reports difficulty sleeping, loss of appetite, and trouble concentrating. All of these are interfering with his studying and causing him concern. He reports that he has had trouble making decisions, and that he is now irritable with friends and his fiance. These symptoms in combination have made John rather depressed as well. He said "I just don't know what to do."

Intellectual assessment reveals that there is no reason why John cannot perform as well as his university peers.
Please read the following case history and answer the questions to the best of your ability. We recognize that this is not the amount of information which would normally be available in making a clinical evaluation.

Jane Jones is a 21 year old junior at a university. She plans to graduate in three more quarters and to seek a job as a bank employee. She is engaged to be married right after graduation to a man she has known for several years and has been dating for over a year.

Jane came in to the student counseling center complaining of "things not going right." She feels generally anxious for no particular reason. She reports difficulty sleeping, loss of appetite, and trouble concentrating. All of these are interfering with her studying and causing her concern. She reports that she has had trouble making decisions, and that she is now irritable with friends and her fiance. These symptoms in combination have made Jane rather depressed as well. She said "I just don't know what to do."

Intellectual assessment reveals that there is no reason why Jane cannot perform as well as her university peers.
Please read the following case history and answer the questions to the best of your ability. We recognize that this is not the amount of information which would normally be available in making a clinical evaluation.

Mary Jones is a 21 year old junior at a university. She plans to graduate in three more quarters and to be a homemaker after graduation. She is engaged to be married right after graduation to a man she has known for several years and has been dating for over a year.

Mary came in to the student counseling center complaining of "things not going right." She feels generally anxious for no particular reason. She reports difficulty sleeping, loss of appetite, and trouble concentrating. All of these are interfering with her studying and causing her concern. She reports that she has had trouble making decisions, and that she is now irritable with friends and her fiance. These symptoms in combination have made Mary rather depressed as well. She said "I just don't know what to do."

Intellectual assessment reveals that there is no reason why Mary cannot perform as well as her university peers.
Please read the following case history and answer the questions to the best of your ability. We recognize that this is not the amount of information which would normally be available in making a clinical evaluation.

John Jones is a 21 year old junior at a university. He plans to graduate in three more quarters and to seek a job as a bank employee. He is engaged to be married right after graduation to a woman he has known for several years and has been dating for over a year.

John came in to the student counseling center complaining of "things not going right." He recently failed two required classes for his major. He states that, "... the prof is a creep and everyone knows it," and thinks that the failure is the professor's responsibility. He states he does have trouble studying because "things get dull so fast." He also states that recently he has broken three dates at the last minute with his fiancé and gone out with friends instead. He says he realizes this doesn't help things with his fiancé or his studies, but he feels he needs it.

Intellectual assessment reveals that there is no reason why John cannot perform as well as his university peers.
Please read the following case history and answer the questions to the best of your ability. We recognize that this is not the amount of information which would normally be available in making a clinical evaluation.

Jane Jones is a 21 year old junior at a university. She plans to graduate in three more quarters and to seek a job as a bank employee. She is engaged to be married right after graduation to a man she has known for several years and has been dating for over a year.

Jane came in to the student counseling center complaining of "things not going right." She recently failed two required classes for her major. She states that, "... the prof is a creep and everyone knows it," and thinks that the failure is the professor's responsibility. She states she does have trouble studying because "things get dull so fast." She also states that recently she has broken three dates at the last minute with her fiance and gone out with friends instead. She says she realizes this doesn’t help things with her fiance or her studies, but she feels she needs it.

Intellectual assessment reveals that there is no reason why Jane cannot perform as well as her university peers.
Please read the following case history and answer the questions to the best of your ability. We recognize that this is not the amount of information which would normally be available in making a clinical evaluation.

Mary Jones is a 21 year old junior at a university. She plans to graduate in three more quarters and to be a homemaker after graduation. She is engaged to be married right after graduation to a man she has known for several years and has been dating for over a year.

Mary came in to the student counseling center complaining of "things not going right." She recently failed two required classes for her major. She states that, "... the prof is a creep and everyone knows it," and thinks that the failure is the professor's responsibility. She states she does have trouble studying because "things get dull so fast." She also states that recently she has broken three dates at the last minute with her fiance and gone out with friends instead. She says she realizes this doesn't help things with her fiance or her studies, but she feels she needs it.

Intellectual assessment reveals that there is no reason why Mary cannot perform as well as her university peers.
APPENDIX D

What Need for Therapy Do You Perceive?

None   Great

---   ---   ---   ---   ---   ---   ---   ---

How Typical Do You Feel This Case
To Be (Of a Student Population)?

Never Seen   Extremely Typical

---   ---   ---   ---   ---   ---   ---   ---

What Do You Consider to Be the Likelihood the Client Will
Recover (To a Functional Level) Without Therapy?

None   Great

---   ---   ---   ---   ---   ---   ---   ---

With Therapy, What Do You Estimate as the Client's
Chances for Recovery (To a Functional Level)?

None   Great

---   ---   ---   ---   ---   ---   ---   ---

What Do You Consider to Be the Likelihood These Problems
Or More Serious Ones Will Recur in Future?

No Chance   Certain

---   ---   ---   ---   ---   ---   ---   ---

Please return the questionnaire to the experimenter and
fill out your name and address on the list provided.
Thank you again.
Dear

During the Rocky Mountain Psychological AssociationConvention last May at the Cosmopolitan Hotel, you were kind enough to fill out one of the questionnaires for my master's thesis, called a "Clinical Evaluation Study."

I became interested in my chosen area after reading research which demonstrated some bias in clinical evaluation on the basis of perceived deviance (political activism, for example), and also on the basis of sex of the client. There have also been studies suggesting that many professional persons continue to view working women who are married as rather "deviant." I decided to combine these two areas and examine whether or not clinical and counseling psychologists would show a bias against a married female choosing to work outside the home. I compared case histories describing an engaged female planning to work outside the home after marriage with others describing an engaged female planning to be a homemaker, and an engaged male planning to work outside the home after marriage.

Another hypothesis proposed that with two sets of symptoms, one a mildly "neurotic" person and one showing a mild version of "personality disorder," the difference between the three imaginary clients would be evaluated as even greater for the "personality disorder." This was supported by statistics suggesting neurosis is a more typically "female" reaction and the acting-out of "personality disorder" is more typically a "male" response. These two hypotheses in combination generated six case histories. Secondary hypotheses also examined the effect of age and sex of the clinicians rating the histories.

There were no significant results for any of the comparisons. There were no differences due to sex and occupation of the client, no differences due to the kind of pathology, no differences due to the sex of the rater, and none due to the age of the rater. While a number of factors may have affected the outcome, the hypothesized biases have not been demonstrated to exist.
Thank you again for your participation. In a manner of speaking, my lack of results pleases me. If you would like any further details about the study, please don't hesitate to contact me.

Sincerely,

Meredith Taylor